
# Auditor-General of Victoria

*Special Report No. 12*

# Alfred Hospital

*May 1990*

VICTORIA

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Auditor-General
of Victoria

# SPECIAL REPORT NO. 12

# ALFRED HOSPITAL

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*Ordered by the Legislative Assembly to be printed*

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No. 130


May 1990

The Honourable the Speaker
Legislative Assembly
Parliament House
Melbourne, Vic. 3002

Sir

Under the provisions of the *Audit Act* 1958, I transmit a report relating to the Alfred Hospital.

*Yours faithfully*

C.A. BARAGWANATH
*Auditor-General*

# PREVIOUS SPECIAL REPORTS OF THE AUDITOR-GENERAL

| *Report No.* | *Title* | *Date issued* |
|---|---|---|
| 1 | • Works Contracts Overview - First Report | June 1982 |
| 2 | • Works Contracts Overview - Second Report | June 1983 |
| 3 | • Government Stores Operations<br>• Departmental Cash Management | October 1984 |
| 4 | • Court Closures in Victoria | November 1986 |
| 5 | • Provisions of Housing to Government Employees<br>• Post-Project Appraisal Procedures within the Public Works Department | December 1986 |
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| 8 | • Foreign Exchange | November 1987 |
| 9 | • Land Utilisation | November 1987 |
| 10 | • Utilisation of Plant and Equipment<br>• Youth Guarantee | November 1988 |
| 11 | • Financial Assistance to Industry | March 1989 |

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# PART 1

# EXECUTIVE SUMMARY

# 1.1

# FOREWORD

The issue of health care is of vital concern to the community. In presenting this report to Parliament I should make it clear at the outset that I have no major concerns at the quality of health care received by patients of the Alfred Hospital, nor do I have any reservations concerning the dedication and professionalism of the staff of the Alfred Hospital.

Health care has been referred to by the Alfred Hospital as *complex and emotive* and by the Health Department Victoria as *complex and dynamic*. There is considerable scope for disagreement which is reflected in the responses from both the Alfred Hospital and the Health Department Victoria, particularly in the area of medical and nursing services. Hopefully the content of this report, which incorporates both the Alfred's and the Department's views, will serve to further stimulate debate in the community with a view to enhancing the delivery of health services in Victoria.

Varying interpretations can be placed on the audit findings outlined in the report due to the absence of benchmarks against which to measure performance, particularly in the area of medical and nursing services.

### WHAT FACTORS LED TO THE REVIEW OF THE ALFRED ?

The Economic and Budget Review Committee recommended in its November 1987 report to Parliament concerning accountability requirements for public hospitals in Victoria that the Auditor-General conduct value-for-money audits in the public hospital sector.

As public hospitals account for approximately 13 per cent of total budget sector outlays in 1988-89, it was concluded that it would be in the public interest to provide Parliament, the Health Department Victoria and hospital management with an objective and independent assessment of the efficiency and effectiveness of management procedures involved in a public hospital.

It is considered that the findings of the review will to some extent be applicable to all public hospitals and serve as a basis for improved resource management by the Health Department Victoria throughout the hospital sector.

The Alfred Campus of the Alfred Group of Hospitals was selected for review due to the Hospital being:

- one of the largest metropolitan public hospitals in Victoria;
- a multi-disciplinary hospital with a teaching component; and
- involved in an amalgamation with 2 other hospitals.

**WHAT PROBLEMS DID AUDIT ENCOUNTER IN CONDUCTING THE REVIEW ?**

By their very nature my reports must serve the information needs of 2 principal users: Members of Parliament and members of the community at large. Therefore, it is imperative, and indeed it has been my policy since my appointment as Auditor-General of this State, that they be written in a manner which is clear, concise and free from bureaucratic jargon.

I have only one overriding motivation in providing Parliament with an independent and objective audit opinion on the operations of the Alfred Hospital - a strong desire to protect the public interest which means even-handedness and neutrality, not trying to further the interest of one party to the detriment of another.

It soon became apparent to audit that not only is the issue of health care *complex*, *emotive* and *dynamic* but it is an arena where the various players appear to have conflicting priorities and, at times, competing agendas. For example, the Health Department Victoria has commented that it is *proper* for audit observations to be aimed at reducing the cost of services currently provided at the Alfred but are less than impressed with *"other observations apparently reflecting either individual or Hospital desires for increased funding in specific areas"*. By way of contrast, the Alfred Hospital in its responses to the audit findings has several times commented that it could treat more patients if it had more resources. Finally, the union reaction to the possibility of an audit review of work practices at the Hospital (referred to later in this report) would indicate that it is pursuing an agenda separate from both the Hospital and the Health Department Victoria.

Both the Hospital and the Health Department Victoria appear united, however, in their reaction to the section of the report dealing with *"Medical and Nursing Services"* which has been variously described as simplistic, superficial or lacking detailed analysis.

The inference I draw from such comments is that the matter of medical and nursing services is not for the layman but should remain concealed from the community behind a veil of professional mystique.

However, it is a matter of fact that:

- there are 2 200 persons awaiting admission to the Hospital;
- not all critically ill patients could be admitted to the Alfred's Intensive Care Unit; and
- there is scope for the Hospital to improve its administrative and management support systems.

Hopefully, as I stated above, the report will at least serve to stimulate further debate in the community on this issue.

**WHAT ARE THE MAJOR CHALLENGES FACING THE ALFRED ?**

The Alfred is a complex organisation which carries out a multitude of inter-related functions which are performed by a wide variety of specialised units and personnel within tight budgetary constraints. A measure of the dimension and complexity of the management task is highlighted by the need for the efficient co-ordination, and financial and resource management of elements associated with:

- admission and discharge practices including an appropriate case mix between emergency and elective patients;
- bed utilisation;
- medical and nursing staff;
- operating theatres;
- emergency; and
- intensive care.

Achieving throughput targets, minimising length of patient stay and reducing elective waiting lists within budgetary constraints, while also admitting emergency patients and ensuring patient care is not compromised, are factors which have to be realised in a hospital environment.

The major challenges confronting the Alfred relate to budgetary problems, the level of emergency and critical care resources to cope with the demand for these services, lengthy waiting times for elective surgery in certain specialties and the impact on the waiting times being experienced by public patients due to the admission of private patients.

### WHAT ARE THE CONTRIBUTING FACTORS ?

The demand on the services provided by the Alfred is increasing due, in part, to:

- a larger proportion of the population not having private health insurance;
- an ageing population; and
- a higher incidence of trauma patients than in prior years.

In the context of this level of demand the Alfred is faced with the task of:

- providing the required number of cubicles in the Emergency Department and beds in the Intensive Care Unit;
- opening a sufficient number of beds for elective and emergency patients; and
- meeting the expectations of the heart transplant program.

### HOW CAN FUNDS BE PROVIDED TO ALLEVIATE THESE PROBLEMS ?

**In times of finite resources, there are various options available to an organisation such as the Alfred Hospital. It can operate more efficiently and/or seek additional funding from the Government. It is the first alternative that taxpayers surely favour - to see the Hospital promoting greater efficiency and productivity to achieve the same, or an enhanced level of service using fewer resources.**

The review revealed that management had not fully evaluated a number of options to either maximise income to the Hospital or minimise expenditure. For example, the Hospital has considerable property holdings (valued at $29 million in 1989) which are largely under-utilised and which, according to advice received from the Hospital, are held for long-term development needs. The proceeds from the sale of such properties could be of assistance in meeting the Hospital's short-term needs. Whether such assets should be retained for the benefit of posterity at a time when the Hospital acknowledges that if it had more resources it could treat more patients is a matter for the Hospital, the Government and the community to decide.

Other options available to the Hospital which are worthy of consideration are:

- fully evaluating whether productivity gains could have been achieved from streamlining and rationalising services such as catering and cleaning ($1 million per annum);
- minimising the level of subsidisation of providing staff meals ($1 million per annum);
- implementing adequate procedures to reduce the average length of stay;
- assessing the cost-effectiveness of the current level of on-call payments to visiting medical officers; and
- taking sufficient measures to encourage patients with minor ailments to use local general practitioners rather than receiving treatment at the Alfred's general outpatient clinic attached to the Emergency Department.

**Audit is of the view that if these measures had been implemented, at least an additional $30 million ($2 million continuing) could have been realised by the Alfred and applied to meeting costs associated with the provision of improved medical services.**

Audit accepts that from time-to-time additional funding by government may also be needed, particularly to finance activities of an emergency or unforeseen nature over which the Hospital can only exercise limited control, but such funding should only be provided after efficiency reforms have been fully exhausted.

# 1.2

# SUMMARY OF MAJOR OBSERVATIONS

Key observations arising from the review of the Alfred Hospital are set out below:

| MEDICAL AND NURSING SERVICES |
|---|
| During 1989 the Alfred's Intensive Care Unit had more requests for admission than any time in the last 5 years which placed extreme demand on its intensive care facilities.<br>*paras 3.1.68 to 3.1.70* |
| The high demand relative to the number of intensive care beds, contributed to one in every 3 critically ill patients not being admitted to the Alfred Hospital's Intensive Care Unit and having to be transferred to other areas for treatment.<br>*paras 3.1.71 to 3.1.78* |
| The Alfred reverted to ambulance bypass on 9 occasions within a 3 month period which could have impacted on optimal patient care due to the delay in receiving emergency treatment.<br>*paras 3.1.55 to 3.1.57* |
| The total waiting list number for the Hospital was 2 200 at 28 February 1990, with 400 patients experiencing waiting times in excess of one year.<br>*paras 3.1.15 to 3.1.21* |
| For 1988-89 there were 248 diagnosis-related illness groups in which the average length of stay per patient was higher than the State average.<br>*paras 3.1.80 to 3.1.90* |
| The treatment in public hospitals of privately insured patients, with higher than basic cover, for illnesses which could be equally treated in a private hospital, reduces the availability of beds for the disadvantaged in the community.<br>*paras 3.1.44 to 3.1.54* |
| Benchmarks in relation to waiting times, critical care and emergency services, were not in place to progressively measure the impact of strategies implemented by the Health Department Victoria and the Alfred and to provide information to assist in periodic decision-making.<br>*paras 2.2.4 to 2.2.8* |

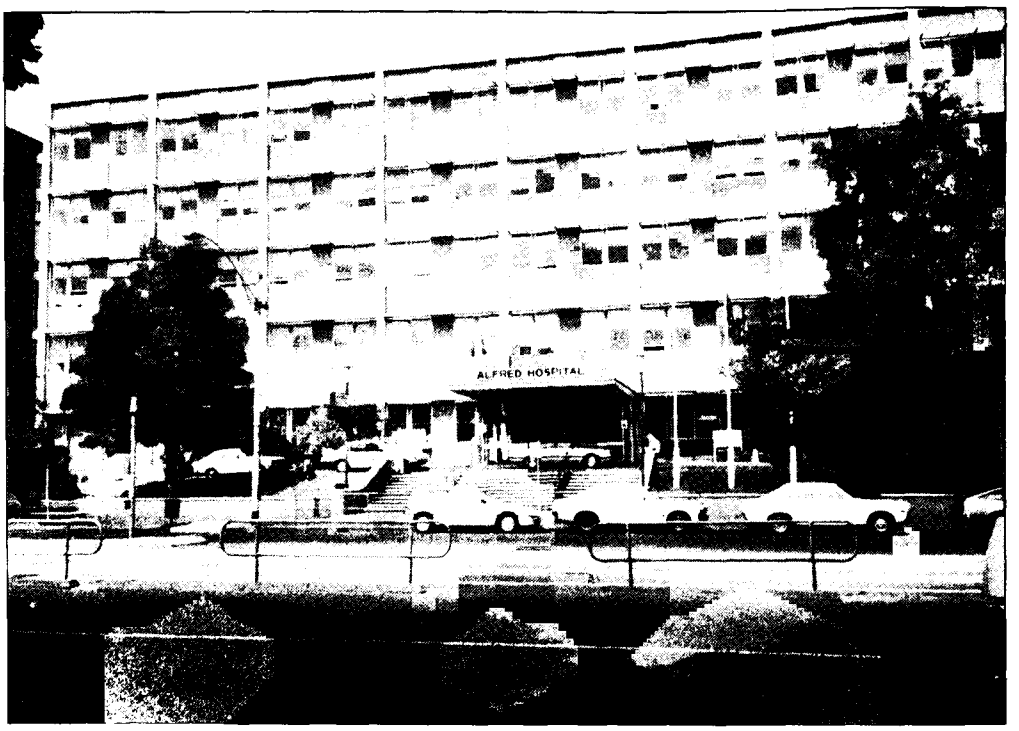
| PROPERTY MANAGEMENT |
|---|
| Properties valued in excess of $29 million, which occupied 25 per cent of the Hospital's land holdings, had predominantly not been used for hospital purposes. These properties include the Chevron Hotel which is owned by the Hospital. *paras 4.1.8 to 4.1.15* |
| Fawkner Mansions (valued at $1.2 million), which previously provided accommodation to 80 nurses and was closed in October 1987, had not provided any financial return to the Hospital since that date. *para 4.1.16* |
| The Alfred did not have a strategic plan for the use of its properties and had not formulated policies for the management of its property holdings. *paras 4.1.5 to 4.1.7* |

| CATERING AND CLEANING |
|---|
| A comparison of meal and cleaning costs at the Alfred with other hospitals revealed that there was potential for annual savings in excess of $1 million to be achieved at the Alfred. *paras 5.19 to 5.24 and 6.14 to 6.18* |
| The level of subsidy for staff meals cost the Hospital approximately $1 million per annum. *paras 5.38 to 5.54* |
| Productivity was not maximised as:<br>♦ the cost of cleaning per square metre was similar for non-hospital areas as for ward areas; and *paras 6.21 to 6.23*<br>♦ the level of cleaning on weekends was the same as during weekdays, even though patient activity was lower. *paras 6.24 to 6.27* |
| Audit was prevented by the threat of industrial action from observing the work practices employed by catering and cleaning staff. *para 2.2.9* |

| MEDICAL AND SURGICAL SUPPLIES |
|---|
| The re-use through re-sterilisation of medical and surgical items, designated as single-use by manufacturers, created potential health risks. *paras 7.8 to 7.15* |

# PART 2

# THE REVIEW




*Alfred Hospital, Commercial Road, Prahran.*

# 2.1

# INTRODUCTION

**2.1.1** Established in 1871, the Alfred Campus of the Alfred Group of Hospitals is one of Victoria's oldest major metropolitan public hospitals. The Alfred was amalgamated with the Caulfield and Royal Southern Memorial Hospitals in November 1987 and now operates under one Board of Management as the Alfred Group of Hospitals. The objective of the amalgamation was for patient services to be undertaken in a more efficient and effective manner.

**2.1.2** As a result of the amalgamation, services are now provided from 2 campuses of the Alfred Group of Hospitals, namely:

- the Alfred Campus; and
- the Caulfield and Royal Southern Memorial Campus.

**2.1.3** The Alfred Campus (the Alfred) is situated in Prahran and has a staff of over 2 600. The Alfred provides super specialist services such as the recently established Heart Transplant Unit for the State of Victoria and has a specialist role, particularly for the South-East Metropolitan Region of Melbourne which extends to outlying areas such a Pakenham, Cranbourne, Phillip Island and Wonthaggi. Services are provided on either an elective or emergency basis through inpatient and outpatient facilities. The Alfred is a major provider of Victoria's emergency services. Its emergency cases represent approximately 45 per cent of its admissions and comprise about 8 per cent of emergency attendances at the major metropolitan teaching hospitals.

**2.1.4** The Alfred has an establishment of 605 registered beds of which 489 were utilised at 28 February 1990. It is a Monash University-affiliated teaching hospital in medicine and carries out various paramedical teaching programs including the training of nurses.

**2.1.5** The audit review focused on the Alfred Campus of the Alfred Group of Hospitals.

**2.1.6** The total budgeted expenditure by the State on public hospitals amounted to $1 900 million for 1989-90. Public hospitals also receive income by way of private appeals, revenue raising activities and the receipt of private patient fees. The Alfred's recurrent expenditure budget for 1989-90 approximates $118 million.

**2.1.7** In 1987-88 the Alfred entered for the first time into a Health Service Agreement with the Health Department Victoria. The Agreement process is designed to set a number of targets to be achieved by the Hospital for a certain level of funding. Hospitals are given sufficient autonomy to manage their affairs in the most economic and efficient manner to achieve the stated targets.

# 2.2

# OBJECTIVES AND SCOPE OF THE REVIEW

**2.2.1** The overall audit objective was to review hospital management practices at the Alfred as well as the central processes of the Health Department Victoria (HDV) to determine whether the procedures in operation enhance the efficient and effective management of the Hospital for the following activities:

- medical and nursing services;
- property management;
- catering;
- cleaning; and
- supply of medical and surgical supplies, and equipment.

**2.2.2** A substantial amount of research was undertaken by members of the audit team prior to reviewing each activity. A bibliography of material examined is presented at the end of this report. Advice was also sought from experts in various fields such as medicine, catering and cleaning. A comprehensive audit questionnaire, covering issues relating to medical and nursing services, was issued to the Hospital to obtain various information relating to the Hospital's policies and practices. In-depth discussions were then held with senior management of the Alfred and various departmental heads to gain further explanations concerning audit issues relating to medical and nursing services.

**2.2.3** At the completion of each segment of the review, an interim audit report was provided to the Alfred and HDV. Comments provided by the Alfred and HDV in response to matters of significance are included in this report.

**2.2.4** As stated previously, one of the difficulties confronting audit in the assessment of the operations of the Alfred was the lack of acceptable benchmarks against which to measure performance particularly in the area of medical and nursing services. Without these benchmarks varying interpretations can be placed on the audit findings outlined in this report.

**2.2.5** Although the audit team had access to expert technical advice provided by the Health Economics Consulting Division of Deloitte Ross Tohmatsu, the absence of such benchmarks posed another level of complexity to the audit task.

**2.2.6 I believe there is an urgent need for HDV, in conjunction with the hospitals and the community, to establish effective and acceptable performance benchmarks in areas such as:**

- **waiting times for elective surgery; and**
- **an acceptable level of emergency services and intensive care facilities.**

**2.2.7 Such action would assist HDV and the Alfred in monitoring the impact of health policies and forming the basis for periodic decision-making.**

**2.2.8** In this context, it is interesting to note that under a national scheme being established by the Australian Council on Health Care Standards, hospitals will be required, through the establishment of clinical indicators, to measure their quality of care in medical disciplines.

**Scope of review restricted by the threat of industrial action**

**2.2.9 Due to the industrial relations climate within the hospital arena, audit was prevented by the threat of industrial action from observing the work practices employed by catering and cleaning staff. At a meeting with a representative of the Hospital Employees Federation, audit was informed that audit observation of work practices would result in a walk-out of union members. The review was therefore restricted to interviews with management, and review and analysis of documentation and financial information. Faced with the prospect of audit involvement precipitating a walk-out of hospital staff which could have jeopardised the standard of patient care, I reluctantly decided not to proceed with this element of the review. I do believe, however, that it is in the public interest that this matter be pursued at some future time.**

# PART 3

# MEDICAL AND NURSING SERVICES

- AUDIT REVIEW
- MANAGEMENT RESPONSES

# 3.1

# MEDICAL AND NURSING SERVICES - AUDIT REVIEW

## KEY FINDINGS

**Budget position**

- At 28 February 1990 the Alfred had exceeded its cash budget by $1.75 million, of which $1.2 million related to its heart transplant program. *paras 3.1.12 to 3.1.13*

**Waiting numbers and times**

- The number of persons awaiting admission to the Hospital totalled 2 200 at 28 February 1990. *paras 3.1.15 to 3.1.16*
- 400 persons on the waiting list (18 per cent) had waiting times in excess of one year. *paras 3.1.18 to 3.1.21*
- 21 per cent of elective cases for February 1990 were not admitted on the scheduled times due to bed unavailability. *para 3.1.22*

**Private patient admissions**

- The treatment in public hospitals of privately insured patients, with higher than basic cover, for illnesses which could be equally treated in a private hospital reduces the availability of beds for the disadvantaged in the community. *paras 3.1.44 to 3.1.54*

**Emergency services and intensive care**

- From December 1989 to February 1990 the Alfred went on ambulance bypass 9 times which could have impacted on optimal patient care due to the delay in receiving emergency treatment. *paras 3.1.55 to 3.1.57*
- Some patients were located on patient trolleys in the Emergency Department for up to 12 hours due to beds not being available in wards. *para 3.1.58*
- Between 10 and 20 patients per day suffering minor ailments did not have a sufficient medical need to be treated by the Alfred's general outpatient clinic attached to the Emergency Department resulting in an inappropriate use of hospital resources. *paras 3.1.65 to 3.1.67*

**Emergency services and intensive care** - *continued*

- During 1989 the Intensive Care Unit had more requests for admission than any time in the last 5 years, which placed extreme demand on the intensive care facilities at the Alfred. *paras 3.1.68 to 3.1.70*

- The high demand relative to the number of intensive care beds contributed to one in every 3 critically ill patients not being admitted to the Alfred's Intensive Care Unit, and having to be placed in other areas of the Alfred or transferred to another hospital. *paras 3.1.71 to 3.1.78*

- Placement of critical patients in general ward areas imposes stress on nurses not trained in intensive care. *para 3.1.76*

- Health Department Victoria has advised that the facilities of the Road Trauma Centre will be available to treat trauma patients and thereby reduce the demand on the Alfred's Emergency Department and Intensive Care Unit. *paras 3.1.63 to 3.1.79*

**Inter-hospital comparisons**

- The average length of stay per patient at the Alfred was higher than the State average for 248 of the diagnostic-related illness groups. *paras 3.1.80 to 3.1.90*

**Visiting medical officers**

- Sessional allocations to visiting medical officers had not been formally reviewed by the Hospital for the last 2 years. *paras 3.1.91 to 3.1.100*

**Discharge policies**

- The practice of discharging patients at short notice places additional pressure on nurses and the resultant short notice for admissions makes it difficult for efficient operating theatre scheduling to occur. *paras 3.1.113 to 3.1.126*

**Outpatients**

- 14 500 or 16 per cent of outpatients failed to attend their appointments resulting in an under-utilisation of hospital resources. *paras 3.1.127 to 3.1.132*

## BACKGROUND

### General information

**3.1.1** The Alfred is a major specialist hospital which provides high technology facilities in a wide variety of services such as adult heart transplants, adult bone marrow transplants, cardiothoracic surgery, burns, road trauma and cancer treatment.

**3.1.2** The major objective of the Alfred is for the Hospital to provide and promote the highest quality of patient care possible within the limits of available resources for both the local community and the people of Victoria. Of the Alfred's operating budget for 1989-90, $89 million relates to inpatient costs and $29 million covers outpatient services.

**3.1.3** The Alfred has 605 registered beds (489 current utilised beds at 28 February 1990) and has more than 50 general and specialist medical and surgical units supported by diagnostic and service departments. In relation to the number of closed beds, 58 have been semi/permanently closed since January 1988 and a further 58 have been closed in the early part of 1990 (the majority in February 1990). It also operates approximately 72 medical and surgical outpatients' clinics. The Alfred admits around 25 000 inpatients each year and about 160 000 people attend as outpatients annually.

**3.1.4** With the introduction of the Medicare Scheme in 1984 all Victorians became eligible for free public hospital accommodation and treatment. A levy of 1.25 per cent of taxable income applies to all Australian residents with the exception of certain groups such as low income earners and war widows. Optional private health insurance is available for private treatment in public and private hospitals. As part of the Medicare program, the Federal Government pays Medicare Compensation Grants to the States and Territories to compensate for the revenue losses associated with the abolition of charges for public patients and other additional costs associated with the introduction of Medicare.

**3.1.5** The proportion of Victorians having basic private health insurance has declined from 72 per cent at September 1983 to 51 per cent at September 1988 (*source:* Private Hospitals' Association of Victoria, *Briefing Paper*, 1989).

### Health strategies

**3.1.6** The Federal Government in the 1989-90 Budget has given emphasis to the needs of disadvantaged young people in order to provide them with access to health services. The particular program developed focuses on homeless young people in metropolitan areas.

**3.1.7** The Victorian State Government Social Justice Strategy, which complements the Federal strategy, is directed towards:

- children in poverty;
- people who are long-term unemployed; and
- human rights.

**3.1.8** Two priorities of the Victorian State Health Plan (1987) are to increase access to acute hospital services and to improve management accountability of health services. Current priorities for the Health Department Victoria's South East Metropolitan Region, the region serviced by the Alfred, include the provision of, and access to acute hospital and primary health care services.

**3.1.9** As referred to in the Health Services Agreement between the Alfred and the Victorian Government all of these priorities are reflected in the services provided by the Alfred. By way of illustration, homeless unemployed youth tend to congregate in the immediate St Kilda area and are frequent attendees at the Alfred's Emergency Department.

## AUDIT OBJECTIVES

**3.1.10** The overall objective of this segment of the review was to determine whether adequate policies, systems and practices existed within the Alfred and HDV to ensure the efficient and effective delivery of medical and nursing services.

**3.1.11** Specific audit objectives were to determine whether:

- Adequate accountability arrangements existed for payments to visiting medical officers in regard to sessional services provided;
- Nursing resource allocations were consistent with patient workloads, and there was adequate co-ordination between nursing and medical administration in this process so as to ensure an optimum utilisation of the available resources;
- Bed allocations to clinical units/wards were based upon patient throughput and available staffing levels, and there was ongoing review of bed occupancy rates in order to optimise bed utilisation;
- Adequate financial accountability arrangements and processes had been established at key levels of service delivery to facilitate the monitoring and evaluation of financial performance;
- Admission practices ensured that:
  - admissions were based on medical need criteria;
  - unnecessary hospitalisation did not occur;
  - patient length of stay was minimised;
  - elective admission scheduling did not jeopardise bed availability for emergency and critical care admissions;
  - bed availability was effectively managed;
- Discharge practices provided for the minimisation of patient length of stay;
- Waiting lists for elective admissions were managed in a manner that ensured the minimisation of patient waiting times prior to admission;
- Operating theatre resources were efficiently and effectively utilised;
- An effective quality assurance program had been developed and implemented to evaluate the standard of patient care; and
- Outpatient services were provided at a level consistent with patient needs and there was ongoing review of service utilisation and requirements.

## AUDIT OBSERVATIONS AND RECOMMENDATIONS

### Budget position - February 1990

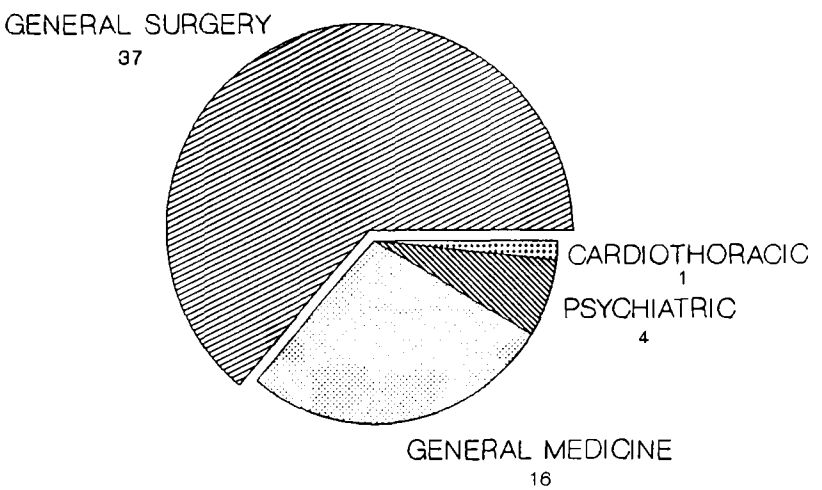
**3.1.12** At 28 February 1990 the Alfred had exceeded its cash budget by $1.75 million ($532 000 if costs associated with the heart transplant program are funded by HDV). The major factors which have led to this situation are:

- expenditure of approximately $1.2 million has been incurred in the Hospital's heart transplant program which has not been funded by HDV (currently under consideration by HDV);
- higher than expected nursing costs associated with student nursing and patient dependency; and
- inpatients treated were 1.7 per cent (291 patients) ahead of target.

**3.1.13** To address the Alfred's budgetary problems, the Hospital implemented the following measures:

- In January 1990 the Hospital submitted a claim to HDV based on 30 heart transplants to be performed per annum, 20 of which have already been undertaken during 1989-90 and funded from hospital funds;
- A revised nursing budget for salaries and wages was prepared in February 1990 for 1989-90 which will result in a reduction of the original budget by $357 000 by the management of nurse staffing; and
- A number of beds were progressively closed (58 at 28 February 1990). Chart 3A shows the specialties where beds have been closed.

**CHART 3A. DETAILS OF BED CLOSURES PER SPECIALTY**



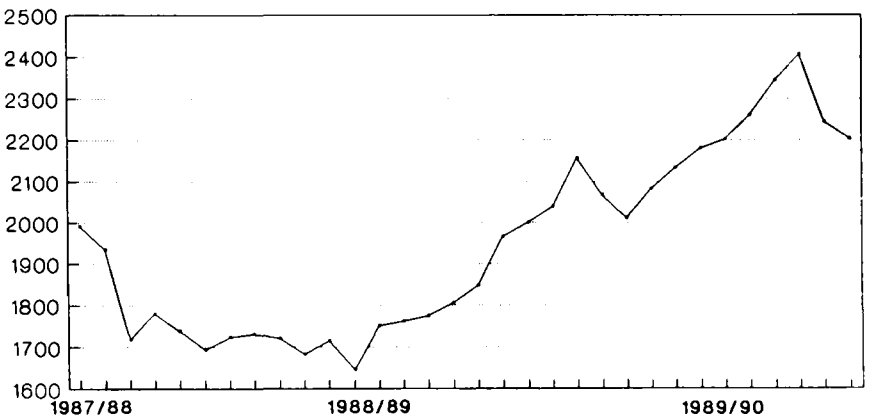
## Waiting list numbers and waiting times

**3.1.14** Waiting lists represent the demand on the Hospital mainly for elective surgical procedures. Management of waiting lists is targeted towards the minimisation of waiting times. A commentary on the trend and composition of waiting list numbers and waiting times for the specialties provided by the Alfred is detailed below.

*Waiting list numbers*

**3.1.15** Throughout 1986 public hospitals experienced industrial unrest and bed closures which culminated in a Statewide nurses' strike for several weeks in the latter part of 1986. At February 1987 the Alfred's waiting list numbered 3 375. Although the Alfred achieved a reduction in this figure in the ensuing months, the information disclosed in Chart 3B highlights an overall increasing trend in waiting list numbers from 1 July 1987. The total waiting list number for the Hospital has increased from 2 038 at 28 February 1989 to 2 204 at 28 February 1990.

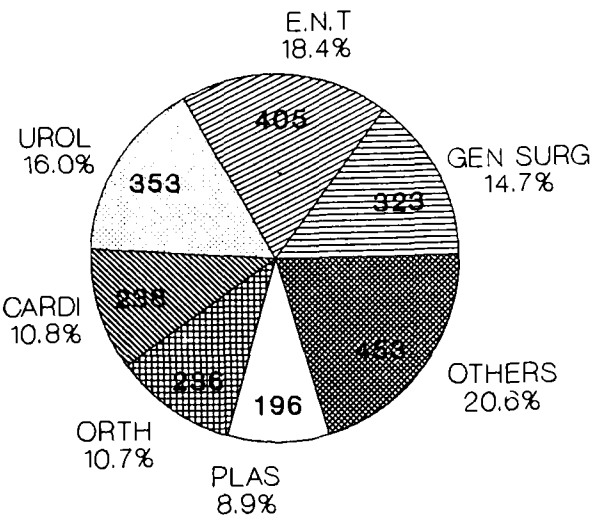
**CHART 3B. TOTAL WAITING LIST NUMBERS, 1 JULY 1987 TO 28 FEBRUARY 1990**




*Note (1):* In the comparable period, patient throughput has increased from 24 776 in 1987-88 to an estimated 26 200 for 1989-90.

*Note (2):* Waiting list data includes patients who for social or medical (i.e. planned repeat surgical procedures) reasons are scheduled for treatment at a predetermined future date. HDV indicated that this group of patients comprises approximately 7 per cent of patients included on the Alfred's waiting list.

**CHART 3C. COMPOSITION OF WAITING LIST AT 28 FEBRUARY 1990, TOTAL NUMBER: 2 204 (2 038 AT 28 FEBRUARY 1989)**




*Note:* Others comprise ophthalmology (64), paediatric surgery (5), gynaecology (40), neurosurgery (45), vascular surgery (71), thoracic surgery (9), medicine (173), other surgery (46).

| LEGEND | | | |
|---|---|---|---|
| ENT | Ear nose throat | GEN | General surgery |
| PLAS | Plastic surgery | GYNO | Gynaecology |
| UROL | Urology | NEUR | Neurosurgery |
| CARDI | Cardiac surgery | THOR | Thoracic surgery |
| OPHT | Ophthalmology | PAED | Paediatric surgery |
| VASC | Vascular surgery | OTH | Other surgery |
| ORTH | Orthopaedic surgery | MED | Medicine |

**3.1.16** The overall reduction in the aggregate number of people recorded on the waiting lists which occurred in January and February 1990, despite a background of bed closures and marginal reduction in operations performed, was due to:

- a 15 per cent increase in admissions in January 1990 (517) compared with December 1989 (451); and
- a substantial increase in cancellations from the waiting list numbers (84 during December 1989, 275 for January 1990 and 305 for February 1990) mainly resulting from the clinical audit undertaken by the Alfred to validate waiting list numbers.

*Waiting times*

**3.1.17** While waiting times in some specialties have reduced (for example gynaecology, vascular surgery and orthopaedic surgery), substantial increases in waiting times have occurred in the specialties of ear nose and throat, urology and other surgery. A comparison of the average waiting times per specialty at 28 February 1989 and 28 February 1990 is contained in the following chart and table.

**CHART 3D. COMPARISON OF AVERAGE WAITING TIMES PER SPECIALTY**
(months)

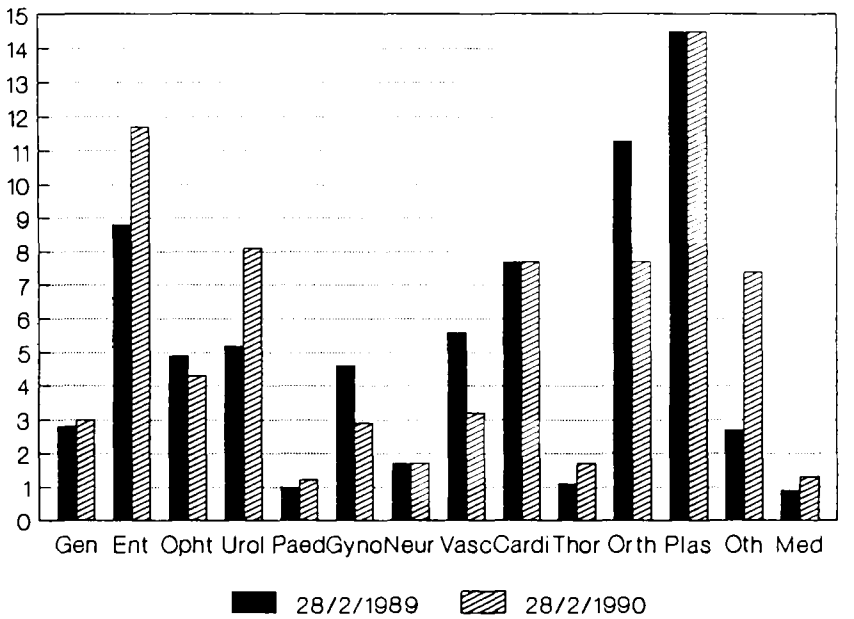


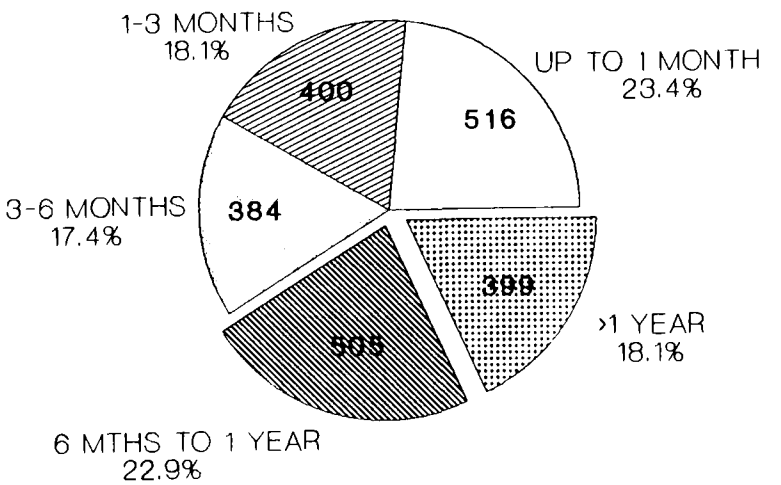
**TABLE 3E. WAITING TIMES**
(months)

| | At 28 February | |
|---|---|---|
| *Specialty* | *1989* | *1990* |
| General surgery | 2.8 | 3.0 |
| Ear nose throat | 8.8 | 11.7 |
| Ophthalmology | 4.9 | 4.3 |
| Urology | 5.2 | 8.1 |
| Paediatric surgery | 1.0 | 1.2 |
| Gynaecology | 4.6 | 2.9 |
| Neurosurgery | 1.7 | 1.7 |
| Vascular surgery | 5.6 | 3.2 |
| Cardiac surgery | 7.7 | 7.7 |
| Thoracic surgery | 1.1 | 1.7 |
| Orthopaedic surgery | 11.3 | 7.7 |
| Plastic surgery | 14.5 | 14.5 |
| Other surgery | 2.7 | 7.4 |
| Medicine | 0.9 | 1.3 |

*Note*: Average waiting times are based on the average of monthly admissions per specialty over the past 12 months. The average waiting times are not an indication of the waiting times for any particular patient.

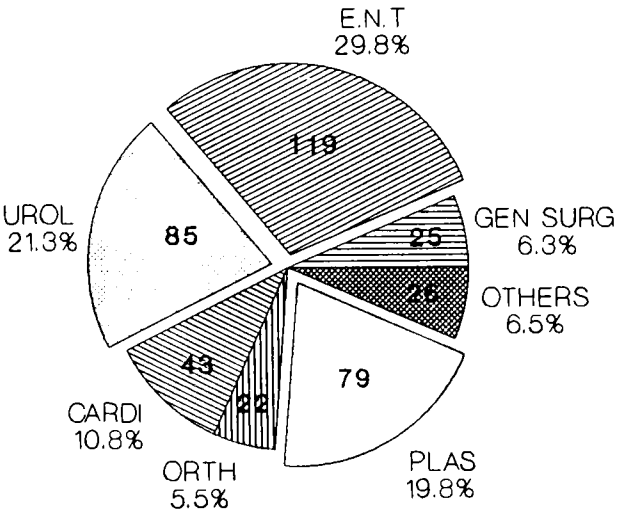
**3.1.18** An analysis by audit of the waiting times at 28 February 1990 revealed that a high proportion of patients on the waiting list (399 or 18 per cent) had waiting times in excess of one year.

**CHART 3F. STRATIFICATION OF TOTAL WAITING TIMES, AT 28 FEBRUARY 1990**



**3.1.19** As indicated in the following chart the majority of patients having to wait for more than one year related to the ear nose and throat, urology and plastic surgery specialties.

**CHART 3G. WAITING LIST GREATER THAN ONE YEAR BY SPECIALTY, AT 28 FEBRUARY 1990**




**3.1.20** In relation to patients listed as having to wait for more than one year, a review of the surgeons' waiting list at 28 February 1990 revealed that certain cases added to the lists between 1983 and 1987 were still awaiting admission. However, the total number of such patients was small. Details of the number of cases that had remained on surgeons' waiting lists for more than 2 years at 28 February 1990 for each specialty are given in the following table:

**TABLE 3H. NUMBER OF PATIENTS THAT HAD REMAINED ON SURGEONS' WAITING LISTS FOR MORE THAN 2 YEARS, AT 28 FEBRUARY 1990**

| *Case* | *1983* | *1984* | *1985* | *1986* | *1987* | *Total* |
|---|---|---|---|---|---|---|
| Ear nose throat | | | | 3 | 15 | 18 |
| Plastic surgery | 1 | 2 | 1 | 1 | 2 | 7 |
| Urology | | 2 | | 2 | 7 | 11 |
| Vascular surgery | | | | 1 | | 1 |
| Cardiac surgery | | | | | 1 | 1 |
| Orthopaedic surgery | | | 1 | 1 | 2 | 4 |
| Other surgery | | | | 2 | | 2 |
| **Total** | **1** | **4** | **2** | **10** | **27** | **44** |

*Note:* At least 9 patients elected to have their operation deferred, while at least 3 patients failed to attend.

**3.1.21** In response to audit inquiries as to the underlying causes of waiting list numbers and waiting times, audit was advised by senior medical staff that these situations were generally due to:

- patient demand exceeding funds available to provide beds and resources;
- bed closures due to lack of funding;
- priority being given to emergency and cancer/trauma cases in preference to non-urgent elective patients;
- lack of specialist surgeons in the highly specialised areas of ophthalmology, neurosurgery, orthopaedics and plastic surgery and difficulties experienced in recruiting specialist nursing staff; and
- insufficient after care placement facilities.

**3.1.22 The closure of beds which occurred mainly in February 1990 resulted in 174 out of 820 scheduled elective cases for admission in February 1990 not being admitted on the scheduled date (21 per cent of scheduled cases). In contrast, only 47 (6 per cent) scheduled cases in January 1990 were not admitted on the scheduled date due to a bed not being available.**

**3.1.23** Audit was advised by senior medical staff of the Hospital that HDV and the Alfred had implemented a number of initiatives to improve the management of waiting lists and reduce waiting lists and waiting times, namely:

- A working party has been established by HDV to examine strategies to reduce the waiting lists in public hospitals;
- HDV has provided waiting list initiative funding of approximately $900 000 to the Alfred in each of the past 3 financial years which has been spent in the medical and surgical specialties of general surgery, ear nose and throat, cardiac, urology, and plastic surgery;
- The Alfred altered the target for its case mix admission ratio (the desired level of emergency and elective admissions) from 60 per cent emergency and 40 per cent elective to 45 per cent emergency and 55 per cent elective;
- To a marginal degree some patients of the Alfred in the generalist area have been re-allocated to surgeons with smaller workloads;
- The Alfred has examined whether there is scope for transferring cases within certain disciplines to the Royal Southern Memorial Campus of the Alfred Group of Hospitals and as a result certain orthopaedic cases were transferred. In addition, the Alfred has agreed with the Government that the Royal Southern Memorial Campus will need to take in more elective surgery and elective medical treatment patients particularly as the Alfred will have a reduced capacity for such patients due to increasing emergency/trauma and other *highly specialised* admissions; and
- The waiting list register is reviewed at least 4 times per year and regular clinical audits are performed to validate the waiting list numbers (286 were recently removed from the waiting list due to the particular operation being performed elsewhere or no longer being required).

**3.1.24 While the above recent commendable initiatives appear to have been successful in containing the position, these strategies have not significantly reduced waiting list numbers and waiting times for surgery at the Alfred in recent times.**

**3.1.25** HDV has since advised that an Advisory Committee on Elective Surgery was established in March 1990 with one of its main terms of reference being the examination of the categorisation of patients waiting for elective surgery.

*Variation of patient numbers on waiting lists between doctors*

**3.1.26** The audit revealed that within certain specialties, there were significant variations in waiting list numbers for individual doctors. Details are provided in the following table:

**TABLE 3I. VARIATIONS IN WAITING LIST NUMBERS**

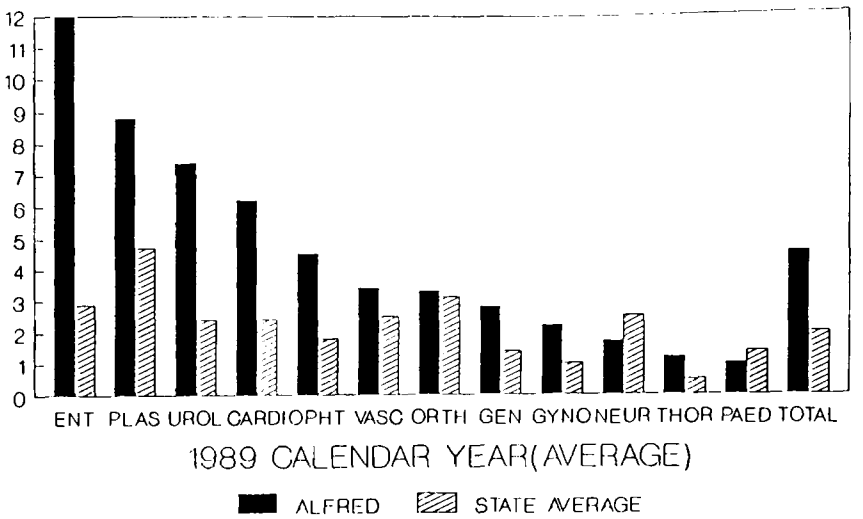
| *Specialty* | *Specialist surgeon* | *Number waiting at 28/2/90* | *Average admissions* | *Estimated waiting time* |
|---|---|---|---|---|
| | | | (per month) | (months) |
| Orthopaedics | A | 151 | 14.66 | 10.30 |
| " " | B | 85 | 15.75 | 5.39 |

**3.1.27 The above table indicates that there is scope for further examining the waiting list numbers for doctors and re-allocating patients to doctors with smaller waiting list numbers in order to reduce the extent of lengthy waiting times for surgery. Audit recognises, however, that due to the doctor/patient relationship patients would have to be consulted and agreement reached concerning any changeover between surgeons.**

*Comparison of waiting times between hospitals*

**3.1.28** As illustrated below from information compiled by HDV, the average waiting times for major specialties at the Alfred are generally higher than the State average.

**CHART 3J. ALFRED COMPARED WITH STATE AVERAGE WAITING TIMES, AT 31 DECEMBER 1989**
(months)




**3.1.29** HDV publishes, on a quarterly basis, the average waiting times for each specialty on a Statewide hospital basis as a guide for medical practitioners. The aim of this document is for medical practitioners to refer their patients to hospitals with a lower waiting time for the particular specialty concerned.

**3.1.30** Despite the publication of this document, it is evident that doctors are still referring patients to ear nose and throat, plastic surgery and urology specialists at the Alfred who have long waiting times relative to specialists at other public hospitals. For example, with the exception of the Monash Medical Centre, Clayton, the average waiting times for surgery at 31 December 1989 in the specialties of ear nose and throat, and plastic surgery were lower in the other 9 teaching and specialist hospitals than at the Alfred. Nevertheless, in January 1990, 34 patients were added to the waiting list of an ear nose and throat specialist at the Alfred who already had 342 patients on his waiting list with an average waiting time of 14 months. Similarly, 25 patients were added to the waiting list of a plastic surgeon in January 1990 who already had 208 patients on his waiting list with an average waiting time of 9 months.

**3.1.31 In an effort to reduce waiting times in certain specialties, HDV needs to introduce improved measures to promote the information contained in the publication on waiting times among doctors in Victoria.**

*Pre-testing of elective patients prior to admission*

**3.1.32** The Alfred advised audit that pre-testing of elective patients for those diagnostic and ancillary services capable of being performed in an outpatient capacity prior to admission had been accepted as a policy, however, implementation was currently not possible due to lack of facilities and resources for such purposes.

**3.1.33** It was estimated by senior medical staff of the Hospital that the length of stay for patients requiring pre-surgical tests such as X-rays could be reduced by at least half a day per patient if these tests were undertaken in an outpatient pre-testing clinic. The absence of such facilities results in patients unnecessarily occupying beds which could alternatively be used for the hospitalisation of other patients on the elective waiting list.

**3.1.34 In order to increase throughput and reduce elective waiting lists, waiting times and length of stay the Alfred should examine the logistics of establishing pre-testing facilities in an outpatient capacity staffed with appropriate personnel.**

*Waiting time between booking date and initial attendance at outpatient clinics*

**3.1.35** The 1989-90 budget for running the Outpatient Department of the Alfred which comprises 72 clinics is $29 million (24 per cent of the total budget for the Hospital). One of the main goals specified in the Alfred's 1987-88 Health Service Agreement was that the waiting time between initial referral and first appointment was not to exceed 5 weeks for specialist clinics. A manual system of information recording is maintained by the Outpatient Department.

**3.1.36** An examination by audit of records in the Outpatient Department revealed a significant delay between the booking date and initial attendance in certain outpatient clinics. Refer to the table below for relevant details.

**TABLE 3K. WAITING TIME BETWEEN THE DATE OF BOOKING AND INITIAL ATTENDANCE**
(weeks)

| *Outpatient clinic* | *Average waiting time* | *Maximum waiting time* |
|---|---|---|
| Ophthalmology | 6.3 | 9.0 |
| Orthopaedic | 7.0 | 10.0 |
| Ear nose throat | 4.5 | 8.5 |
| Urology | 4.7 | 6.5 |

**3.1.37** Approximately 160 000 people attend the Alfred's outpatient clinics annually. In audit opinion, it is essential that the outpatient function of the Hospital operates efficiently to meet the significant community demand for health services in this area.

**3.1.38** Audit inquiries revealed that there was scope for increasing throughput and thereby reducing waiting times by introducing the following changes to the Alfred's outpatient services:

- Developing one procedural outpatient clinic to undertake all procedural activities of a clinical nature such as dressings, rather than the present system of most clinics conducting a mix of procedural tasks in confined areas as well as consultations. Such a strategy would have to preserve the right of continuity of care and enable adequate surveillance by the principal treating doctor;

- Providing weeknight sessions to coincide with the times most people are not at work thereby providing a social benefit to patients; and
- Converting the manual information system dealing with appointments to a computerised system to efficiently handle the large volume of outpatient attendances.

**3.1.39 To improve access by public patients to public hospital outpatient services and reduce waiting times, the Alfred should assess the costs and benefits of opening a central outpatient clinic to undertake all procedural operations presently conducted within individual clinics, implementing weeknight sessions and improving information systems.**

*Waiting time on the day of treatment at outpatient clinics*

**3.1.40** According to an in-house survey of patients and the views of certain hospital staff, the most common cause of complaint from patients attending outpatient clinics at the Alfred was the waiting time which elapsed between arrival at the Hospital and actual treatment in an outpatient clinic.

**3.1.41** One factor contributing to this situation was that wards and the Emergency Department were able to make outpatient appointments for patients when booking clerks were not on duty, for example on weekends and after 5.00 p.m. on weekdays.

**3.1.42** As a consequence the Outpatient Department is not in a position to control the number of patients booked to each clinic as wards and the Emergency Department are able to make appointments without knowing whether the daily patient number limit for a particular clinic has been reached. This practice leads to overbooking and delays in treating outpatients.

**3.1.43 In view of the large volume of patients that are treated by outpatient clinics (some 160 000 per annum) the outpatient appointment/booking system needs to be enhanced to provide wards and the Emergency Department with after hours access to booking information in order to avoid overbooking of outpatient clinics and reduce waiting times for treatment.**

## Admissions of private patients

**3.1.44** A *"private patient"* is defined as a patient who elects to be a private patient at the time of admission to the Hospital. Usually such persons are covered by private health insurance; if not, they must accept direct responsibility for payment of all hospital charges. *Basic* private health insurance cover is designed for those who wish to be treated as a private patient in a public hospital. *Intermediate* and *Top* private health insurance cover is designed to benefit those who wish to be treated in either a public or a private hospital. For the purpose of this report private patients exclude compensable patients whose care is paid for by insurance schemes such as WorkCare and the Transport Accident Scheme, or by statutory authorities such as the Department of Veterans Affairs.

**3.1.45** The review revealed that between 1 July 1989 and 28 February 1990 the Alfred admitted 3 862 elective patients from its waiting lists, of whom 947 (25 per cent) were private patients. As approximately 80 per cent of the general insured population has higher than basic cover (*source: Department of Community Services and Health Annual Report 1987-88*), audit estimates that 750 elective private patient admissions were in this category.

**3.1.46** In a private hospital, patients are generally required to meet the difference between the scheduled hospital fee and the benefit claimed from the private health fund. Private hospital bed day charges are in the order of $280 per day for shared accommodation, $330 for a single room and $350 for intensive care. Benefit payments can leave a gap of up to $30 per day unless there is a preferred provider agreement between the fund and the hospital. There may be additional charges for theatre, drugs, dressings and all allied health staff services. In comparison, public hospital charges of $156 - $200 per day for private patients are comprehensive and therefore much less expensive for the private patient and for the health insurance funds.

**3.1.47** Other factors relevant to the admission of private patients in public hospitals are:

- The resident medical staff are involved in the management of private patients for clerical procedures, assisting at operations and being available for emergency care. This service is welcomed by the patient and is a bonus to lessen the urgent demands on the treating doctor. It is a valuable component of training of registrars seeking Fellowships of the various clinical Royal Colleges. The hospital bears the full cost of this service; and

- Private patients provide revenue to the Hospital not only by way of daily bed charges but also through payment of the Medicare benefit for each diagnostic investigation. The private practice revenue of the full-time salaried specialist medical officers is usually split 60 per cent to general hospital revenue and 40 per cent to the Special Purpose Account/Medical or Private Practice Fund which is used for payment of professional expenses, conference leave and bonus payments to entitled doctors and discretionary payments toward capital equipment for the Hospital. While the most common arrangement is a 60:40 hospital/special purposes fund split, this apportionment can be as high as 84:16 for some radiological specialties. These arrangements are encompassed by the so-called *Dillon Scheme* in operation since the report of Dillon in 1959.

**3.1.48 According to the Health Service Agreement, the average bed cost per inpatient day at the Alfred Hospital approximates $500, whereas public hospital charges for private patients, as stated previously, are only in the order of $156 - $200 per day.**

**3.1.49** There are considerable financial advantages to both the hospital insurance funds and, to a lesser extent, privately insured patients arising from the treatment of such patients at public hospitals under the current Medicare arrangements.

- Private patients are not required to meet the gap of up to $30 a day or to meet any additional charges for ancillary services; and
- As public hospital charges are significantly lower than private hospital charges there are considerable savings for health insurance funds where the insured person has higher than basic cover and is treated in a public hospital. **Audit estimates that savings to health insurance funds could be in the order of $637 000 for elective private admissions to the Alfred during the period 1 July 1989 to 28 February 1990** by virtue of the dual hospital system. Audit acknowledges that without such advantages, the cost of private hospital insurance could increase, which could lead to a decline in the number holding private insurance. Audit also acknowledges the fact that under the budget agreement with the Health Department Victoria, the Alfred is expected to raise in excess of $12 million of its financing from treatment of privately insured patients.

**3.1.50** However, an audit review of the private admission diagnoses for February 1990 showed that some private elective admissions were for the treatment of problems which could have been managed equally as well in a private hospital (for example, cholecystectomy, thyroidectomy, hemicolectomy, cystoscopy and exploration of the common bile duct). The review naturally did not have access to the confidential patient histories and could not determine associated conditions or complexities which may have necessitated the sophisticated specialist services provided by the Alfred.

**3.1.51** There is no priority of access for persons of lower socio-economic groups to receive necessary but elective treatment at a public hospital. They must compete for scarce resources with more affluent members of the community who, by virtue of private health insurance, have the option to exercise free choice of either private or public care in the dual hospital system. Because of the higher level of private hospital charges, those without private insurance, in particular the disadvantaged, have no option but to seek treatment in a public hospital.

**3.1.52** There appears to be an inherent conflict between the State/Federal Medicare arrangements which enable all persons to receive free treatment at public hospitals irrespective of socio-economic status and the general thrust of the Victorian State Government Social Justice Strategy which attempts to cater for the needs of the disadvantaged members of the community by:

- reducing disadvantage caused by unequal access to economic resources and power; and
- increasing access to essential goods and services according to need.

**3.1.53** The health profile of the lower socio-economic groups cited by various authorities suggests that such persons need added support of easy access to care and sickness prevention services.

**3.1.54 If persons with private hospital insurance at higher than basic cover are treated in public hospitals for illnesses which could equally be treated in a private hospital, the result must be a reduction in the availability of beds for the disadvantaged.**

## Emergency Department

*Inpatients*

**3.1.55** The Emergency Department of the Alfred contains 15 cubicles, 3 resuscitation chambers and has space in corridors of the Department to cope with 6 patient trolleys. When this total capacity of the Emergency Department is completely filled the Alfred goes on *"ambulance bypass"* for up to 2 hours which results in ambulances taking critically ill patients to other hospitals. An *"exit block"* is caused when a patient is ready to be transferred from the Emergency Department to a ward but a bed is not immediately available in a ward, resulting in the patient utilising Emergency Department space and resources which would otherwise be available for the treatment of other emergency patients.

**3.1.56 Audit noted that in relation to December 1989, January 1990 and February 1990, the Alfred went on ambulance bypass 4, 2 and 3 times, respectively,** despite the Alfred allocating about 20 ward beds per day to accommodate patients discharged from the Emergency Department. While ambulance bypass can be effective in distributing the emergency load among available hospitals and thereby facilitating access to care by patients, audit was advised that the possible consequences of the Alfred having to revert to ambulance bypass are:

- optimal patient care could be compromised due to the delay in receiving emergency treatment;
- extra strain is placed on the Emergency Departments of other hospitals;
- ambulances are unavailable for other emergencies; and
- the ongoing patient care may be at a hospital remote from the patient's home.

**3.1.57** In audit opinion the number of ambulance bypass situations is attributable, in part, to:

- the Alfred closing 58 beds (at 28 February 1990) in wards since mid-January 1990 due to budget overruns causing a shortage of beds in wards and an *exit block* in the Emergency Department which prevented the transfer of certain patients to wards; and
- the apparent incapacity of the Emergency Department and the Hospital to cope with the emergency workload in Melbourne's south east region.

**3.1.58 From 4 February 1990 to 4 March 1990, 73 patients were situated in the Emergency Department for more than 12 hours (on average about 16 hours). Audit was advised that this occurrence has led to some patients, who should have been in a ward, being located in emergency for up to 12 hours due to an exit block occurring in the Emergency Department.** As a consequence, these patients have not been offered the degree of nursing excellence and treatment planning which they would have received in a ward situation. Such a situation is undesirable also from the viewpoint of the relative discomfort to the patient being located on an emergency trolley rather than being settled in a bed.

**3.1.59** In some cases (generally 3 to 4 patients per week), an *exit block* has also occurred in the Emergency Department in relation to patients who require admission to the Intensive Care Unit due to the current level of intensive care beds (critical care facilities).

**3.1.60** During the period 28 February 1990 to 6 March 1990, Hospital records maintained by nursing staff at the request of audit revealed that for 34 hours out of the 168 hours in the 7 day period (20 per cent) the Emergency Department was completely full which included patients being located on trolleys situated in corridors of the Department. The location of patients on trolleys in corridors compromises the quality of patient care which is necessary under these circumstances.

**3.1.61** A comparison of the Alfred's Emergency Department's facilities with those of the Road Trauma Centre to be funded by the Transport Accident Commission highlights a disparity of resources relative to the number of patients to be treated. Audit was advised that the Road Trauma Centre, equipped with 4 resuscitation cubicles, will handle an estimated one to 2 critical trauma cases per day. Audit was informed that these facilities, due to their location on the floor above the Alfred's Emergency Department located on the ground floor, would not be readily accessible to the Emergency Department which has about 10 out of every 80 cases per day in need of such resuscitation facilities. Such a situation would place extreme pressure on the Alfred's other 3 resuscitation cubicles located in its Emergency Department.

**3.1.62** During 1989 a discussion paper concerning a review of emergency and critical care services in the metropolitan area was prepared by a sub-committee of the Consultative Council on Emergency and Critical Care Services at the request of the then Minister for Health. This discussion paper, referred to as the *Clarebrough Report*, contained the following information:

> *"During 1989 the number of patients requiring admission in emergency circumstances increased beyond expectation due to population growth, population ageing and changes in clinical practice. Health Department Victoria Patient Reporting System shows that between 1987-88 and 1988-89 there was a 10.8 per cent increase in the number of emergency admissions. This increase in demand for emergency admissions occurred against a background of several years emphasis on elective admissions.*
>
> *"Increases in demand for emergency admissions have an impact extending far beyond emergency departments. They require inpatient facilities and may require critical care facilities.*
>
> *"If the importance of emergency exit block and increase in the demand for emergency admissions are to be accommodated 2 courses of action are available. They are:*
>
> - *an alteration in the emergency: elective hospital admission balance in favour of emergency admissions; and/or*
> - *an increase in the total resource available in the acute hospital system."*

**3.1.63** HDV has since advised that as trauma cases currently attending the Alfred's general emergency department will now be cared for in the Road Trauma Centre, pressure on the Emergency Department's resuscitation cubicles will be reduced.

**3.1.64** The Department maintained that *"the facilities of the Road Trauma Centre funded by the Transport Accident Commission are of a substantially higher standard than those now existing in the Emergency Department. This new Centre should be used by the Hospital to provide relief to the Emergency Department. The new Centre is equipped with 4 resuscitation cubicles which should handle the total case load presenting for such services thereby effectively integrating its capacity with the needs of the Emergency Department. Unless such an arrangement is established the capacity of the Trauma Centre and its ability to assist in improving the capacity of the Hospital to handle emergency presentations will not be maximised".*

*General outpatient clinic of the Emergency Department*

**3.1.65** Most patients seeking treatment at the Emergency Department of the Alfred (approximately 80 per cent) do not need admission and are attended to in the general outpatient clinic of the Emergency Department. This clinic, which is staffed by a general practitioner and a junior resident medical officer, attends to some 40 to 50 ambulant patients per day suffering ailments such as minor fractures, cuts and minor respiratory problems. **Audit was informed that about 10 to 20 of these patients per day would not have sufficient medical need to be treated by the Alfred's Emergency Department which constitutes an inappropriate use of hospital resources. However, it was not possible for audit to quantify the associated incremental cost of this situation. To assess the extent of the problem, if any, details of these costs should be maintained and analysed by the Hospital.** In addition, audit observed that at peak times patients had to wait up to 2½ hours to be treated in the general outpatient clinic of the Emergency Department.

**3.1.66** The *Clarebrough Report* also recommended that: *"... in relation to the management of Emergency Department workload, if a hospital decides that general clinical services are not a priority within their emergency services, guidelines be established for the use of Emergency Department medical and nursing staff regarding general clinic type patient reception, assessment, advice and possible redirection to other sources of medical care".*

**3.1.67 In audit opinion a community educational program is needed to encourage primary use of a family doctor and selective use of hospital Emergency Departments for genuine emergencies. Such a program would lead to a better quality of ongoing care and a more efficient use of hospital resources.**

## Intensive Care Unit

**3.1.68** The Alfred's Intensive Care Unit is dedicated to the management of patients with life-threatening illnesses, injuries or complications. At 8 March 1990 the Alfred's Intensive Care Unit had 8 commissioned intensive care beds in operation.

**3.1.69** During 1989 the Intensive Care Unit had more requests for admission than any time in the last 5 years, which placed extreme demand on the intensive care facilities at the Alfred. A senior member of the Alfred's medical staff attributed some of the major reasons for this occurrence to:

- the large number of inpatients treated by the Hospital;
- the increase in surgical operations performed; and
- an increase in serious trauma cases because of the perception that the Road Trauma Centre was open and operating.

**3.1.70** As indicated in the *Clarebrough Report* there was general agreement that:

> *"... intensive care units in the metropolitan area have been operating under considerable demand stress for some time. The pressure on critical care beds is intensified at the major teaching hospitals by competing demands made by elective post operative patients and acutely ill emergency patients. Recognition of this fact is essential if the major teaching hospitals are to be able to offer excellence in care to the most acutely ill".*

**3.1.71** In the light of the number of patients not admitted to the Intensive Care Unit due to the lack of available intensive care beds, senior members of the Hospital's medical staff considered that, based on the size of the Hospital, the type of patients admitted and surgery performed, there was a need for the present number of 8 intensive care beds to be increased to 14.

**3.1.72 The consequences of the high demand level relative to the number of commissioned beds are illustrated by the following examples which occurred between 1 July 1989 and 28 February 1990:**

- **on 120 occasions an intensive care bed was not available and patients could not be admitted to the Intensive Care Unit;**
- **40 of the above patients had to be transferred to other hospitals while 80 patients were treated in other areas of the Alfred despite requiring specialised intensive care treatment;**
- **computer records maintained by the Intensive Care Unit indicated that 14 patients were discharged from the Intensive Care Unit earlier than would otherwise be desirable; and**
- **there were 2 documented cases of elective operations having to be postponed.**

**3.1.73** Table 3L highlights the requests for admission, the number of instances where patients were not admitted to the Intensive Care Unit due to the lack of an available intensive care bed and the number of these patients who had to be transferred to other hospitals or treated within other areas of the Alfred.

**TABLE 3L. INTENSIVE CARE STATISTICS**

| *Financial year ended 30 June* | *Requests for admission* | *Admitted* | **Patients not admitted** | *Transfer to other hospitals* | *Patients treated in other areas of the hospital* |
|---|---|---|---|---|---|
| 1985 | 470 | 340 | **130** (27%) | 1 | 129 |
| 1986 | 438 | 387 | **51** (12%) | 9 | 42 |
| 1987 | 487 | 433 | **54** (11%) | 13 | 41 |
| 1988 | 547 | 464 | **83** (15%) | 18 | 65 |
| 1989 | 585 | 411 | **174** (30%) | 79 | 95 |
| 1.7.89 to 28.2.90 | 345 | 225 | **120** (35%) | 40 | 80 |

**3.1.74** In relation to the number of patients transferred to other hospitals the *Clarebrough Report* contained the following comments:

> *"The higher rate of inter-hospital transfers of acutely ill emergency patients deserves special comment. While recognising that a certain number of inter-hospital transfers are inevitable a major aim of the Council is to develop a critical care network which entails a minimum of such transfers.*
>
> *"To minimise the rate of inter-hospital transfers the following steps need to be taken:*
>
> - *ensure that an adequate number of intensive care beds are available in the State;*
> - *ensure that beds are appropriately located;*
> - *ensure that major intensive care units have access to step down units; and*
> - *ensure that the beds are appropriately used."*

**3.1.75** It is also worth noting, however, that the *Clarebrough Report* indicated that:

> *"According to the Health Department Victoria data the capital costs involved in the creation of a new level 3 intensive care bed can be as high as $160 000 to $180 000 while the fully absorbed recurrent cost generally varies between $1 400 and $1 600 per day."*

**3.1.76 Audit is of the view that the high incidence of critically ill patients not being admitted to the Alfred's Intensive Care Unit (approximately one in every 3 requests for admission) due to an intensive care bed not being available is a less than ideal situation. As illustrated, patients requiring intensive care treatment had to be placed in other areas of the Alfred (one in every 4) or transferred to another hospital (one in every 8). The placement of critical patients in general ward areas could place stress on nurses not trained in intensive care.**

**3.1.77 While audit notes the comments contained in the Clarebrough Report that steps need to be taken to ensure an adequate number of intensive care beds are available in the State, the question of the adequacy or inadequacy of the Alfred facilities in this area could not be determined beyond dispute. However, on the basis of the records maintained by the Hospital, there appears to be a prima facie case justifying an increase in the current number of intensive care beds.**

**3.1.78 Despite the substantial costs involved in expanding the number of critical care beds, there is an urgent need for the Alfred to examine its priorities and improve productivity in other areas of the Hospital and/or HDV to consider giving this area priority for additional funding.**

**3.1.79** Subsequent to the finalisation of the audit review, HDV have advised that the Alfred/TAC Road Trauma Centre has been funded to open 6 intensive care unit beds and 4 intensive care unit stepdown beds. This will considerably reduce or eliminate the need for the general Intensive Care Unit to provide care for trauma patients and enhance its capacity for other categories of patient. As part of the government response to the *Clarebrough Report*, the Alfred has also been funded for 2 stepdown beds in its general Intensive Care Unit.

## Inter-hospital comparisons

*Cost performance data*

**3.1.80** The audit revealed that there was a lack of current comparative data on individual hospital performance. At 16 March 1990, some 8 months after the end of the 1988-89 financial year, HDV had not compiled comparative data on hospital performance for 1988-89 such as the:

- average cost per inpatient bed day and per inpatient treated including Diagnosis Related Group (DRG) adjusted costs; and
- number of patients treated or bed days per unit of labour.

**3.1.81** As a consequence, financial reporting systems were not being effectively utilised by management.

**3.1.82 The absence of timely information of this nature does not enable the medical and nursing costs of hospitals to be analysed at a central and hospital level. Although hospitals have been given more autonomy to manage their affairs to meet targets set in health service agreements within agreed budgets, the lack of timely Statewide information is not conducive to medical and nursing activities being undertaken efficiently.**

*Length of stay*

**3.1.83** Hospital records revealed that the average length of stay at the Alfred has reduced from 8.3 days for 1986-87 to 6.8 days in 1988-89.

**3.1.84** The *Standardised Length of Stay Report* produced by HDV highlights length of stay information for diagnosis related illness groups (DRG) on an individual hospital and Statewide basis.

**3.1.85** On the assumption that information produced by HDV on length of stay was complete and useful for comparative purposes, an analysis by audit of the information contained in the *Standardised Length of Stay Report* for 1988-89 revealed that while the Alfred is to be commended for the 184 DRGs that had an average length of stay lower than the State average, there were nevertheless 248 DRGs in which the average length of stay per patient was higher than the State average.

**3.1.86 An analysis of the DRGs in which the average length of stay at the Alfred exceeded the State average highlighted that, if these DRGs at the Alfred had an average length of stay which equated with the State average, potential existed for a total of 22 180 bed days to be utilised for the hospitalisation of an estimated 3 337 additional patients.**

**3.1.87** A review of the 30 highest DRGs where bed days for the Alfred were above bed days for the State based on the average length of stay disclosed a number of significant variations which are listed in the following table.

**TABLE 3M. AVERAGE LENGTH OF STAY FOR SPECIALTIES AT THE ALFRED WHICH WERE SIGNIFICANTLY GREATER THAN THE STATE AVERAGE FOR THE YEAR ENDED 30 JUNE 1989**

| DRG No. | Specialty (DRG) | Average length of stay at the Alfred (a) (1) | State average length of stay (a) (2) | Bed days foregone (difference between (1) and (2) multiplied by patients discharged at the Alfred) (a) (3) | Additional patients that could have been admitted assuming a State average length of stay could have been achieved at the Alfred (4) |
|---|---|---|---|---|---|
| | | (days) | (days) | | |
| | **MEDICAL** | | | | |
| 473 | Acute Leukemia w/o major O.R. Procedure Age > 17 | 11.6 | 9.6 | 424 | 44 |
| 125 | Circulatory disorders except AMI, w Card Cath w/o complex diag | 3.3 | 2.7 | 305 | 113 |
| 122 | Circulatory disorders w AMI w/o c.u. Comp Disch Alive | 9.7 | 7.9 | 284 | 36 |
| 316 | Renal failure | 12.6 | 7.8 | 254 | 32 |
| 015 | Transient Ischemic Attack and Precerebral Occlusions | 8.8 | 5.8 | 235 | 40 |
| 124 | Circulatory disorders except AMI, w Card Cath and Complex Diag | 8.9 | 6.6 | 203 | 31 |
| 254 | FX, Sprn, Strn, Disl of Uparm, Lowleg ex Foot Age 18-69 w/o CC | 8.0 | 4.5 | 190 | 42 |
| 140 | Angina Pectoris | 5.6 | 4.8 | 168 | 35 |
| 297 | Nutritional and Misc Metabolic Disorders Age 18-69 w/o CC | 9.7 | 6.2 | 164 | 26 |
| 078 | Pulmonary Embolism | 15.9 | 10.3 | 158 | 15 |
| | **SURGICAL** | | | | |
| 468 | Unrelated Operating room procedures | 13.3 | 9.8 | 1 013 | 103 |
| 209 | Major joint and limb re-attachment procedures | 24.3 | 20.8 | 658 | 32 |
| 400 | Lymphoma and Leukemia w major O.R. Procedure | 27.4 | 16.1 | 578 | 36 |
| 075 | Major chest procedures | 19.8 | 13.5 | 509 | 38 |
| 154 | Stomach, Esophageal and Duodenal procedures Age > 69 and/or CC | 15.7 | 12.8 | 469 | 37 |
| 217 | Wnd Debrid & Skin Graft Except Hand, for Muscskelet & Conntiss Dis | 25.0 | 16.0 | 467 | 29 |
| 110 | Major reconstructive vascular proc w/o pump Age > 69 &/or CC | 24.3 | 22.0 | 391 | 18 |
| 263 | Skin Graft and/or Debrid for Skin Ulcer or Cellulitis Age > 69 &/or CC | 56.8 | 35.7 | 381 | 11 |
| 304 | Kidney Ureter and major bladder proc for non-neopl Age 69 &/or CC | 24.2 | 13.5 | 342 | 25 |
| 211 | Hip and Femur Procedures except major joint Age 18-69 w/o Cc | 26.0 | 18.0 | 336 | 19 |

*(a) Source: Standardised Length of Stay Report* produced by HDV for 1988-89.

**3.1.88** Audit was advised by the Alfred that there were numerous factors which rendered audit's conclusions, based on information compiled by HDV, invalid. **If this view is correct, audit questions the purpose of the extensive information being compiled by HDV relating to length of stay.**

**3.1.89** In addition, Hospital records showed that at 16 March 1990 there were 49 inpatients who had a length of stay for over 30 days and that 16 had been in the Hospital for more than 60 days. Some of these patients were in the Hospital awaiting placement in a suitable after-care facility.

**3.1.90 It is acknowledged that the length of stay is dependent on many variables such as the medical condition (sickness) of each patient, the complexity and complications of the treatment required and the social circumstances of each patient. Nevertheless, for certain DRGs at the Alfred with a higher average length of stay than for the State there is a need for the Alfred to analyse this situation with a view to implementing measures to minimise the length of stay, where appropriate, in order to achieve a more efficient use of hospital resources and reduce waiting times for elective patients.**

## Visiting medical officers

*Sessional allocations to visiting medical officers*

**3.1.91** Medical services to patients of the Alfred are provided by the following types of practitioners:

- salaried staff - specialists (53) and resident medical officers (173);
- clinical academics (8);
- honorary visiting medical practitioners (76); and
- visiting medical officers (VMOs) (222).

**3.1.92** Payments to VMOs for 1988-89 amounted to approximately $5 million. The maximum total payments made to an individual VMO during this time amounted to $77 000.

**3.1.93** VMOs are paid on a sessional basis (each session of not more than 3.5 hours excluding travelling time) to provide medical services to a class of patients for which they are appointed. VMOs who are not on-call are paid on a modified fee-for-service basis if they are re-called to duty outside normal sessional hours. If the practitioner is in receipt of an on-call allowance and is re-called to duty the practitioner is paid an hourly rate for re-call.

**3.1.94** Audit was advised that the sessional allocations to units used to be subject to annual review by the Alfred's Sessional Committee and then refined accordingly. This Committee, however, has not met for 2 years and in view of the reorganisation of medical units which took place in October 1989, the Alfred plans to review the sessional allocations to units in March/April 1990. It is therefore reasonable to expect that certain sessional allocations to units may now not be appropriate in terms of patient demand.

**3.1.95 It was noted that records, which were required to be submitted by VMOs to claim payment for normal sessional hours, only recorded the allocated sessions to each VMO. These records did not provide information on services provided.**

**3.1.96** In the New South Wales Public Accounts Committee June 1989 *Report on Payment to Visiting Medical Officers*, it recommended that from an accountability viewpoint sessional payment records submitted by VMOs should contain particulars for each service.

**3.1.97** Despite the lack of detailed information, the records for VMOs engaged at the Alfred were endorsed by the responsible Unit Head and then checked and countersigned by an officer from the Director of Medical Services' Office.

**3.1.98** Audit was advised by a senior medical officer that it was possible for a Unit Head to validate each VMO time sheet as each Unit Head would have been present at the workplace and by observation could determine whether or not a VMO had actually worked for the hours being claimed. Furthermore, audit was informed that it would not be practical for patient details to be recorded on time sheets by VMOs as:

- some VMOs provide services to a large number of patients in a session; and
- specific details concerning ward rounds would be difficult to record.

**3.1.99** In addition, the productivity of VMOs would be difficult to measure from the number of patients treated due to variations in the seriousness of each case and under the sessional basis for engagement, VMOs fulfil their contract by their attendance at the Hospital for the required number of sessions.

**3.1.100 In audit opinion the Hospital should, on an annual basis, assess the adequacy of the sessional allocation to each unit to ensure that the allocations equate with patient demand. In order for such a review to be effectively undertaken there is a need for the specific workload of individual VMOs to be analysed in detail on a selective basis at various times during the year. It should be possible to obtain a complete profile of patients seen by a particular doctor in outpatient clinics, ward rounds and theatre sessions. The administrative responsibilities of medical staff should also be documented including attendance at clinical meetings and quality assurance/peer review activities.**

*On-call allowances to certain visiting medical officers*

**3.1.101** There are often instances, particularly in the case of emergencies, where specialists from medical units are required to attend the Hospital to treat patients outside normal hours. A system of on-call rosters and on-call and re-call payments has evolved to compensate the medical staff for these instances.

**3.1.102** A given specialty unit may be asked to roster staff for either:

- Exclusive on-call : which means the relevant medical practitioner holds him/herself available exclusively to the Hospital.
- Consultative on-call : where the practitioner recognises his/her commitment to the Hospital and, if called, will consider the Hospital's request for assistance against his/her other commitments (e.g. from private practice or another hospital) and will give the Hospital the best priority he/she can.

**3.1.103** Staff participating in the on-call roster are paid an allowance for the inconvenience of being on-call. For full-time staff, this allowance is built in as a regular component of their salary.

**3.1.104** When a VMO, who is actually rostered on-call, is called back to the Hospital, the practitioner is entitled to payment based on the time spent at the Hospital (and one hour travelling time per re-call). These *re-call* payments are at the rate of time and a quarter for re-calls occurring on a weeknight and time and a half for re-calls occurring on a Saturday, Sunday or public holiday. It is recognised that in some cases VMOs are consulted via telephone for which they do not receive a re-call payment.

**3.1.105** As the Alfred's medical administration have discretion in the allocation of funds to on-call rosters, management should monitor expenditure in this area to ensure the coverage is justified in terms of service needs and cost-effectiveness.

**3.1.106 The audit revealed that a management information system disclosing the extent of on-call and re-call hours and associated payments to VMOs for each specialty had not been developed. As a consequence management did not monitor and assess the cost-effectiveness of on-call payments.**

**3.1.107** In the absence of such a system, audit manually collated payroll data relating to the period 25 June to 24 December 1989 (inclusive) for a number of the specialty units which roster VMOs on an on-call basis. The aim of the exercise was to compare the number of hours for which the VMOs in a given specialty were on-call with the number of hours for which they were actually re-called. During this period 64 VMOs were in receipt of on-call allowances of which the maximum allowance paid to an individual VMO amounted to $16 500. Relevant details are recorded in the following table.

**TABLE 3N. ANALYSIS OF ON-CALL AND RE-CALL HOURS AND ASSOCIATED PAYMENTS TO VMOS PER SPECIALTY UNIT, FOR THE PERIOD 25 JUNE 1989 TO 24 DECEMBER 1989**

| *Unit* | *On-call hours* | *On-call payments* | *Re-call hours* | *Re-call payments* | *On-call hours per hour of re-call (a)* |
|---|---|---|---|---|---|
| | | ($) | | ($) | |
| **Consultative on-call** | | | | | |
| Cardiology | 416 | 1 560 | 7.83 | 548 | 53.10 |
| Clinical haematology | 1 292 | 6 171 | 1.00 | 62 | 1 292.00 |
| Endocrinology | 2 928 | 10 984 | Nil | Nil | 2 928.00 |
| Gastroenterology | 1 503 | 5 217 | 29.50 | 1 895 | 50.96 |
| Neurology | 2 330 | 8 318 | 5.75 | 386 | 405.26 |
| Paediatric medicine | 2 899 | 10 215 | 30.50 | 1 871 | 95.04 |
| General medical 1 | 542 | 1 961 | 4.50 | 317 | 120.61 |
| General medical 2 | 409 | 1 652 | 10.50 | 671 | 39.00 |
| General medical 3 | Nil | Nil | Nil | Nil | Nil |
| Facio-maxillary | 1 459 | 5 260 | 22.75 | 1 496 | 64.14 |
| Gynaecology | 2 052 | 7 288 | 31.50 | 1 646 | 65.16 |
| Ophthalmology | 2 717 | 9 447 | 10.50 | 756 | 258.76 |
| Paediatric surgery | 2 639 | 8 960 | 12.50 | 705 | 211.12 |
| Urology | 3 009 | 10 185 | 27.60 | 1 618 | 109.03 |
| Cardiothoracic surgery | 2 171 | 7 532 | 90.50 | 6 401 | 23.93 |
| **Total** | **26 366** | **94 750** | **284.90** | **18 372** | **92.54** |
| **Exclusive on-call** | | | | | |
| Vascular unit | 3 373 | 44 650 | 376.00 | 21 578 | 8.97 |
| Orthopaedics 1 | 1 059 | 14 147 | 20.00 | 1 133 | 52.97 |
| Orthopaedics 2 | 771 | 9 931 | 11.50 | 675 | 67.11 |
| Neurosurgery | 708 | 36 711 | 60.50 | 3 192 | 11.71 |
| General surgery 1 | 201 | 2 797 | 5.50 | 321 | 36.60 |
| General surgery 3 | 537 | 6 969 | 39.00 | 2 243 | 13.78 |
| General surgery 4 | 221 | 3 068 | 11.75 | 674 | 18.80 |
| **Total** | **6 870** | **118 273** | **524.25** | **29 816** | **13.10** |

*(a)* The average number of hours for which VMOs were on-call prior to being re-called for duty.

**3.1.108** Audit noted that on-call sessional allocations had not been reviewed by the Hospital in detail since the last detailed review of normal sessions which took place in November 1987. Of the units participating in consultative on-call rosters, the low incidence of re-call for the endocrinology and clinical haematology units and, to a lesser extent, the neurology, ophthalmology and paediatric units raises the issue as to whether the particular VMOs from these units should, in fact, be receiving on-call payments.

**3.1.109** While staff in the 2 orthopaedic units were rostered on exclusive on-call, they were re-called less frequently than VMOs in several units running consultative on-call rosters. This occurrence raises the question as to whether these specialties needed to engage VMOs on an exclusive on-call basis at higher rates of remuneration than would be payable for consultative on-call.

**3.1.110** In audit opinion cost savings could be achieved by reducing the allocation of on-call hours to certain units. As an illustration, from July to December 1989, $10 984 was outlayed by way of on-call allowances to VMOs from the endocrinology unit while not one VMO was re-called for duty during that time.

**3.1.111** Under the existing situation, it appears some doctors are receiving on-call allowances for very little service or personal inconvenience which gives rise to inequity between VMOs in different specialties.

**3.1.112 While it is appreciated that these amounts may not be considered material in the total context of the Alfred, if a similar situation was widespread across other hospitals, the potential savings would be significant to the State. In this context the Alfred needs to:**

- **Critically review on-call rosters to determine whether the coverage is justified in terms of service needs and cost-effectiveness;**
- **Develop an information system to enable accurate recording, retrieving and analysing of data relating to on-call and re-call payments made to the various units. This system would greatly enhance the future management of on-call rosters; and**
- **Investigate the possibility of networking the Hospital's on-call rosters with other nearby hospitals with a view to developing more cost-effective and efficient on-call services. In this way, a given VMO could receive one payment to be on-call for more than one hospital (he/she would still receive time-based payments from the relevant hospital for any incidence of re-call). It is recognised, however, that this situation may be compromised by some surgeons only working at one hospital as part of a 5 year senior appointment.**

## Discharge practices and allocation of beds to inpatients

**3.1.113** The Alfred has a formal discharge policy which states:

> *"The objective of the policy is to ensure there is adequate and complete planning at the earliest possible time for the appropriate discharge, transfer or placement of patients.*
>
> *"In the interest of patients and staff, notification of discharge will be given at least the day prior to discharge and preferably 24 hours prior to the event. Exceptions where 24 hours notice of discharge will not be required are:*
>
> *(1) where the patient is awaiting placement and a bed becomes available in another facility;*
>
> *(2) where the patient wishes to be discharged earlier than planned; and*
>
> *(3) discharge of day patients."*

**3.1.114** The Alfred's Admission and Discharge Monitoring Group, which meets fortnightly, examines implications and breaches of the Hospital's Admission and Discharge Policy.

**3.1.115** Details of discharges are entered onto the Hospital's computerised Inpatient System which holds a central record of all beds in the Hospital, their status (open or closed) and occupancy details (whether occupied and, if so, what surgical unit the patient is under treatment by).

**3.1.116** Eight wards either have or share a ward terminal with direct on-line access to the System. These wards update data relating to admissions, discharges and inter-ward transfers as they occur.

**3.1.117** The 21 remaining wards (72.5 per cent) do not have access to a ward terminal and must forward the relevant information, written on a *bed-card*, to the inquiries section which then updates the Inpatient System.

**3.1.118** The Medical Admitting Officer is the Director of Emergency or his deputy. This officer liaises with the admitting nurse who identifies available beds. Beds are allocated to emergency patients and elective patients from the waiting list based on medical need.

**3.1.119** Audit inquiries revealed that the requirement for 24 hours notice of discharge was not given in relation to certain discharges from the Cardiology Department and one of the Cardiothoracic Wards (all of which involve patients who did not satisfy the exception criteria detailed above).

**3.1.120 The practice of medical staff discharging patients at short notice places unnecessary pressure on nurses to undertake the discharge process (e.g. arranging the required drugs from pharmacy, outpatient appointments and/or the provision of community services such as district nursing or after-care accommodation in a nursing home). In addition, the sudden availability of beds and resultant short notice for admissions make it difficult for efficient operating theatre scheduling to occur.**

**3.1.121** In some cases discharges were not promptly input through ward terminals to update the Inpatient System and a time lag of up to 6 hours occurred in updating the system in relation to discharges from those wards without a ward terminal. As only 27.5 per cent of wards had terminals installed, the Alfred had not yet achieved the target specified in the 1987-88 Health Service Agreement for 40 per cent of wards to have terminals installed.

**3.1.122** As a consequence, the information provided by the System via the terminal in the Admissions Office is often not an accurate reflection of bed availability. As a result, the Admissions Nurse performs 3 rounds per day (at 7.00 a.m. 11.00 a.m. and 2.00 p.m.) where she physically visits each ward to determine the actual number of beds available for admission purposes. This process, which is consistent with the Hospital's Admission and Discharge Policy, generally takes in excess of 3 hours per day to perform.

**3.1.123** Compliance with the Alfred's Discharge Policy in terms of giving 24 hours notice of discharge and the maintenance of an up-to-date information system would alleviate the need for the Admissions Nurse to conduct ward rounds to determine available beds which would save at least 3 hours per day of her time.

**3.1.124 Audit is of the view that the Alfred's Admissions and Discharge Monitoring Group should investigate the extent of notice of discharge not being given at least the day prior to discharge and the implications thereof, particularly for ward staff and the Admissions Nurse.**

**3.1.125 If deemed necessary, the need to comply with this Policy should be stressed to the Alfred's medical staff in the interests of patients and staff. In addition, the number of ward terminals should be expanded to enhance efficient and effective discharge planning and enable current and accurate information on bed availability to be recorded on the Inpatient System as an aid to the efficient allocation of beds to patients awaiting admission.**

**3.1.126 Audit recommends that the Alfred investigate the practicality of including an additional field in the system to record details of discharges advised in advance. This will assist ward staff in their planning and the Admissions Nurse by allowing her to see not only what beds are currently available, but also those which will become available later in the day. This facility would also assist monitoring of compliance with the 24 hours notice element of the Discharge Policy.**

## Outpatient Department

**3.1.127** Patients attending the Alfred in an outpatient capacity comprise either patients suffering ailments of an emergency nature attending the general outpatients clinic of the Emergency Department or patients attending, by appointment, specialised clinics within the Outpatient Department of the Hospital.

*Outpatients failing to attend*

**3.1.128** As indicated in the 1987-88 Health Service Agreement the Hospital established an Outpatient Action Working Group to review outpatient services. The main goals referred to in the Agreement were:

- to streamline procedures for appointments and to overcome the problems which result from defaulting patients;
- to establish a centralised distribution system for appliances, aids and prostheses; and
- to investigate the feasibility of computerising the appointment system.

**3.1.129** In April 1988 the Outpatient Action Working Group recommended that the outpatient appointment system be computerised to enable the monitoring of patients who did not attend the Hospital when required.

**3.1.130 Between 1 July 1989 and 9 March 1990 the Outpatient Department made approximately 90 600 outpatient appointments of which 14 500 or 16 per cent failed to attend.** While the pattern of non-attendance was generally spread evenly over most of the 72 outpatient clinics operated by the Outpatient Department, Hospital staff advised that the dermatology clinic had an above average rate of non-attendance.

**3.1.131 The high incidence of outpatients failing to attend their respective appointments results in a significant amount of resources in terms of time and effort being wasted** due to:

- the operation of a manual booking system which requires the referrals of prospective outpatients to be manually processed before an appointment is made;
- each patient's medical history having to be manually located and checked on the day prior to the appointment; and
- outpatient clinics being staffed and equipped to a level commensurate with the total number of appointments made.

**3.1.132 The Alfred, when determining future systems to be computerised, should give priority to the booking system in the Outpatient Department in order to enhance the efficient and effective management of the substantial number of appointments to the outpatient clinics. Patients who consistently fail to attend could be highlighted at an early stage and corrective action taken to avoid unnecessary appointments being made.**

*Distribution of medical supplies*

**3.1.133** Where considered necessary medical supplies, aids, appliances and pharmacy items are prescribed for outpatients as part of their treatment. There are 10 different sources of supply for items within the Hospital which include the various outpatient clinics, allied health departments and the pharmacy. Some of these items may be obtained by more than one source of supply which duplicates the storage and distribution process.

**3.1.134** In 1988 the Outpatient Action Working Group concluded that this situation was self-evident in manifesting duplication, fragmentation and the ineffective use of Hospital resources. The Group recommended the establishment of a central appliance distribution centre to enable organised, controlled and co-ordinated functions to be performed in relation to the provision of aids and appliances to patients of the Alfred Hospital. This recommendation has not been implemented.

**3.1.135 Audit supports the establishment of a central appliance distribution centre on the basis of the reasons outlined by the Outpatient Action Working Group.**

# 3.2
# MEDICAL AND NURSING SERVICES
# - MANAGEMENT RESPONSES

## OVERALL COMMENTS BY THE ALFRED HOSPITAL

### Introduction

*Throughout the Reports on these five separate audits there are included various comments by the Hospital on the Audit observations. Some audit comments, while inherently critical, are correct; some are quite wrong. The Hospital's detailed reply has been given in relation to the individual Reports of the Auditor-General and is to be found later in this document.*

*However, for a proper appreciation of the findings of the various audits it is necessary that they be viewed within the context of fundamental issues that have to be addressed before any worthwhile improvement can be achieved in the overall management of the Hospital's resources. The Board has made no secret of the deficiencies that exist within the Hospital's administrative, statistical, accounting and management information areas and a full statement on this will be found of Page 7 of its 1988-89 Annual Report - areas which have been starved of resources for years. The Audit Reports give examples of the consequences of this.*

*For the findings to provide a fair and constructive input to improvement in the situation the Board's overall approach to the management of the Hospital since the amalgamation occurred, and extensive changes in management were made, needs to be understood.*

*The following text reviews what has happened since 1985-86, identifies problems, explains the philosophy which is being followed in addressing the problems and says what has been done to date.*

### History

*1985-86*

*In 1985-86 a new form of financial accountability began to be phased in at the HDV culminating in the introduction of global budgeting in August, 1986. This has resulted in a major change in the way hospitals have to be managed. It meant that hospitals were to be responsible for making their internal financial allocations and had to operate within a finite fixed annual figure.*

*One of the major problems associated with this move, has been that the Hospital's internal systems were inadequate and major changes have been necessary to reflect the new reality.*

*1986-87*

*Health Services Agreements were first introduced in Victoria on a a pilot basis in 1986. In 1987 Alfred Hospital singed its first Agreement. In that year the Hospital recorded a deficit of $2.588 million.*

*In November 1987, the Minister for Health announced the amalgamation of the Alfred, Caulfield and Royal Southern Memorial Hospitals. This created a new Hospital and a new Board of Management.*

*1987-88*

*The amalgamation brought a considerable period of uncertainty and confusion to the Hospital and it was not until May 1988, with the appointment of a new Group Chief Executive that the various problems within the Hospital began to be identified and strategies to address them put in place.*

*1988-89*

*The first priority was to create an organisation structure for the amalgamated Hospital, and this was in place and operational by August/September 1989.*

*The President commented in the 1988-89 Annual Report:*

> *"Since I became President of the Board we have been aware of numerous deficiencies that exist in the Hospital's administrative, statistical, accounting and management information areas. It has taken nearly two years to identify the problems and to set the Hospital on a better course. The Board has made a series of new staff appointments of persons experienced in modern management and business practices. We have begun to change existing management and administrative procedures so that we can use resources more effectively and ensure that the community gets better value for its health dollar."*

*In that report the new Group Chief Executive also commented:*

> *"The Hospital Group is a large complex organisation delivering a wide variety of health services. Currently the organisation's administration and management practices are not of the same high standards as our patient care services. Consequently there is a need for a significant improvement in our management practices."*

*The President reiterated this theme of a need for managerial improvement at the 1989 Annual General Meeting of the Hospital.*

*The Auditor-General began his first efficiency and effectiveness audit of a Victorian hospital at the Alfred in January 1989. The Board had indicated to the Auditor-General that it believed this to be somewhat inappropriate given the considerable changes occurring in the Hospital.*

*The Board established an Audit Committee during 1989 and its first decision was that there was a need for an Internal Auditor. Such an auditor was recruited and commenced work in December 1989. The Audit Committee of the Board began to meet monthly in February 1990.*

## Problems/opportunities

### *Symptoms*

*The organisation can be examined and problems found in many areas - Catering, Purchasing, Cleaning, poor control of Capital projects, ineffective monitoring of expenditure, etc. These are all symptoms of deeper underlying problems.*

*It is important to distinguish between the numerous symptoms, which are only too apparent to people who know the organisation, and the fundamental causes of them.*

*The Hospital does not have the resource to treat each symptom individually. It is essential that the key systemic problems be recognised and that resources be devoted to treating them in logical priority order.*

### *"The Magic Fix"*

*These problems are often compounded by the common believe that if only the Hospital could get the right information, the right consultants or the right policies, then somehow everything could immediately be put right. There is little doubt that new policies and innovations could make significant impact on health service delivery with the Hospital. However, unless the fundamental problems are resolved, new initiatives will never achieve their full worth.*

### *Major problems*

*There is no "magic fix" because organisations must be built and managed if objectives are to be achieved. Organisations do not just happen; they have to be built to carry out their tasks.*

*The underlying cause of many of the Hospital's problems is that the organisation has evolved somewhat haphazardly and has not been built to achieve certain clearly specified objectives. As a result, the organisation is not structured in a way which adequately reflects accountibilities and the available skills are correspondingly inadequate.*

*People who have accountibilities must be given the tools to carry out their tasks.*

## Amalgamation

*Experience with private and public sector amalgamations mergers, acquisitions and takeovers, suggests that many of them do not work. The reason is that even when there is the basic synergy for amalgamation, the actual detailed implementation is poor and the organisation tends to be torn apart.*

*Rather than rush in, in ignorance of the realities, the Hospital sought to obtain a clear understanding of the precise activities, services and resource allocation at the 2 hospital campus sites, on the basis that amalgamation/co-ordination would proceed in 2 stages. Firstly, an amalgamation of Caulfield/Royal Southern Memorial into one entity, and secondly (and, as far as possible, simultaneously), a maximisation of co-operation and co-ordination between the 2 campuses and, where possible, development of unified operations.*

*In other words, the entire complex will be directed to provide an extensive range of complementary services, fulfilling the various requirements of the local community and of the State. This will not just happen, since each of the 3 hospitals had a very different focus, with some of them at different stages of the patient care process.*

*There is no doubt that in this particular set of hospitals, amalgamation offers real opportunities for providing a range of general and specialised services, and it is the role of management to achieve the provision of well integrated, high quality service, functioning in a cost effective manner.*

## Basic philosophy/strategy

### *Core principles*

*It has been decided that six core principles should govern the evolution of The Alfred Group:*

*(1) The Group must be truly patient-driven;*

*(2) The Group must have a clear idea of what services it is delivering, why and at what cost;*

*(3) The Group's policies must be determined by the dual imperatives of quality of patent service and financial reality;*

*(4) The Group must operate through units which can focus on achievable results;*

*(5) The Group must operate to the principle of responsibility and accountability applying at all levels of the organisation; and*

*(6) The person at the activity level must be given the management tools to do the job with most of the buck stopping at the level where the activity occurs.*

### *The basic building block*

*The basic building block in the organisation is the Department - the foundation upon which the Group is built. There are in excess of 200 departments within the Alfred Group.*

*The whole strategic thrust at the moment is to give departmental heads the tools and assistance they need to operate effectively, i.e. to relate outputs to inputs.*

*In part, this requires better communication throughout the organisation, clearly defined missions and management practices at Departmental level and setting of overall priorities and resources allocation by executive management.*

*A fundamental point is that while direction must come from the top, it is essential to create a satisfactory basis for management at each level and have sound information systems. Rational decision-making cannot be expected at a more senior level if there is no clarity at a departmental level.*

*In specific terms, the tools the Hospital is moving to provide are:*

- *clear Group objectives;*
- *clear management/decision making infrastructure;*
- *clear responsibility and accountability;*
- *clear plans and directions (planning process);*
- *clear process of performance planning and resource allocation (budgeting process);*
- *rapid and clear reporting on performances and resources used (accounting system); and*
- *timely correct data (MIS).*

## Action to date

### *Introduction*

*While the hospitals on the Kooyong Road Campus have been brought together under the one management and some integration has occurred, much of management's effort to date has been spent in utilising its limited resources for the basic day-to-day running of the Hospital. It has been only since August/September 1989 that it has been able to work on the fundamental problems. This has been helped by the filling of several senior positions with individuals capable of dealing with the complex problems involved. The Hospital's current actions relate to devolving responsibility to divisions and departments and providing them with appropriate tools for their tasks.*

### *New organisation*

*The development of the new structure of the Group has been a major task and is still continuing. Two important considerations in the format of the new organisation were the need to provide specialist management services and to involve the health professionals more closely in the management of the Hospital.*

*Another major task not yet complete is to improve the existing responsibility structure to provide a clear definition of who is responsible for an activity and its consumption of resources.*

### *Financial management*

*It has been necessary to modernise the financial structure, accounting practices and the accounting system. Basically the Hospital has now been split into 3 accounting areas with clearly defined boundaries, i.e. Operating, Non-Operating and Capital.*

*In theory these classifications existed previously but they were poorly defined and inadequate attention was given to the non-operating area. This was compounded by an inadequate accounting system.*

*A Chart of Accounts was devised to assist departmental heads as well as the Accounting Department. This Chart was drawn up over a period of 6 months in consultation with department heads and is now being used.*

*From 1 July 1989 a new integrated, comprehensive accrual accounting system was introduced to the Group. This was a major task, as only the Royal Southern Memorial Hospital previously had a reasonable system. The computers at the Alfred Hospital and Caulfield were obsolete and poorly functioning.*

*The new accounting system was introduced at the Alfred on borrowed hardware and it was not until mid-November that the hardware facilities enabled adequate functionality. At present the 2 campuses have identical Charts of Accounts and reporting structures which are run on different computer operating systems (hardware) and accounting software packages. Consolidation will remain an objective subject to the long-term strategic hardware direction of the Group.*

*Detailed budgeting by cost centres was introduced for the 1989-90 financial year. This was a new departure since there had not been previously a defined cost centre structure.*

*The establishment of budgets was hampered by inadequacy of available information. With the new Accounting System this is being overcome and it will be possible in future to make a more realistic allocation of resources across the various activities of the Group.*

*As the basic unit within the Group is the department, it is vital that each department head receive a simply, accurate, comprehensive and timely report on resource consumption for the previous month against budget and year to date. In addition, it is essential that an accurate report exists showing the output of the department versus the resources consumed.*

*The balance between resources and output will differ among departments but it will be possible at least to establish departmental norms.*

*The monthly reports that it is now possible to produce with the new Accounting System, have highlighted the substantial problems in arriving at a realistic budget for a given level of output as specified in the Health Service Agreement.*

### *Capital expenditure*

*Considerable effort has been applied to improving the management of capital expenditure. A register of actual and projected capital projects has been compiled to show how they are being financed and managed, and a system for planning and managing capital expenditure has been developed and has just been promulgated to all departmental heads.*

*New planning systems for the future are in the process of development.*

*While improvements in the management of capital expenditure are essential ongoing projects must continue. Currently the Hospital has had to manage simultaneously the Trauma Centre and Services, the introduction of new computer systems and a new PABX/Telecommunications system, cancer services and a host of smaller projects. It is pleasing that reasonable progress has been made, despite the inadequacy of professional resources.*

## The next steps

*To date, some very fundamental changes have been made in the infrastructure of the Hospital to provide a basis for improved management. There is a more structured involvement of health professionals in planning and major decision-making and a business like system for financial management and control has been established. Its benefits will pay off increasingly as people become accustomed to the new disciplines.*

*The appointment of an internal auditor, of a commercially oriented property manager and the assignment of a few talented people to study and analyse some basic aspects of Hospital operations are bringing to notice a host of previously unrecognised problems. As a result of this, and the outcomes of the above, the next stage of development will be a series of important changes at a more micro level in many areas.*

*These will result in improved management practice and a more effective use of resources. This is essential to enable the Hospital to secure into the future, its position as a premier Hospital Group.*

## GENERAL COMMENTS ON REPORT BY ALFRED HOSPITAL

*Late in 1988 and early 1989, the Board of the Alfred Group of Hospitals was informed of the Auditor-General's intention to conduct a far-reaching audit on the Hospital's activities. To date, the Hospital has received several of the auditors' reports. These have included reviews of (i) catering management practices, (ii) property management practices, (iii) practices relating to medical supplies and equipment and (iv) cleaning management practices. The present Report deals with the Hospital's practices in providing a number of major health services, which is an initiative not previously undertaken by the Auditor-General's Office.*

*Many of the comments in the earlier reports dealt with matters that were well within the previous experience of the officers conducting the audit. However, servicing the officers of the Auditor-General's Department with information has taken up substantial management and staff time.*

*Some of the comments of the present report are helpful and constructive. However, there are comments on numerous issues where this is not the case. These include the complex issue of length of stay in hospital in relation to diagnostic-related groupings, the ambulance bypass system for distributing emergencies to other major Melbourne hospitals, the provision of intensive care beds, the visiting medical officers on-call system and several others.*

*To deal with the complex and emotive issues of the health care system requires deeper technical knowledge and understanding of the system, and a greater capacity of obtaining and analysing data. Rightly or wrongly, the Hospital's staff feel that they have been used as a "learning curve" by the Auditor-General and some of the issues raised cast doubt on the officers' "judicial" competence in relation to several of the issues raised.*

*A major concern is that the Report could be read as undermining the confidence which concerned citizens should have in the Hospital. Patients do receive the best attention that is practicable at the time and it is given by dedicated experienced professionals.*

*Many of the Auditor-General's comments reflect incomplete understanding of the issues and sometimes a superficial analysis of the available data. Some of the headline-grabbing material in the various drafts has been totally incorrect and fails to come to grips with the great complexity of the Health Services provided by this Hospital.*

*Specific replies to the Auditor-General's comments on some of the major issues are given below. This has involved a great deal of senior executive time. In some ways, more time might have been allotted, in order to do justice to some of the more complex topics referred to in the Report. However, no more time could be spared. We believe that the Report provides adequate answers to some of the questions raised or indicates why some of the problems cannot readily be answered at the present time.*

*Earlier, the Hospital had discussed with the Auditor-General and his officers the fact that the Board had received competent legal opinion that the audit objectives as proposed by the Auditor-General did not fall within section 56 of the Health Services Act. In those circumstances, the Board was entitled in law to refuse the Auditor-General access, information, assistance and explanations for the purposes contemplated.*

*The Board did not take this course, as it believed in the concept of accountability and hoped that the Report would be useful in assisting it to establish priorities.*

*The Auditor-General was informed of the Hospital's reservations about the nature and timing of the proposed audit in a letter from the President, written on 14 February 1989, which pointed out that a recently amalgamated group of hospitals was not an ideal place to develop philosophies about the broader issues of providing health care.*

> *"You will be aware that the Hospitals were amalgamated in November 1987 and the present Chief Executive took up his appointment in May 1988. From then onwards numerous problems in the way the Hospital has previously been managed have come to light, which we are currently trying to address. I believe that we are heading in the right direction and that management practices and utilisation of resources will be substantially improved in the next 12 - 18 months. Currently, a significant number of Hospital policies and procedures are in the process of undergoing change or are about to do so. From every viewpoint, the type of "efficiency" audit that you have in mind will provide both us and the Victorian community with better feedback, if it were deferred for 12 - 18 months, until 1990.*
>
> *" ... Many senior administrative/management positions in the Amalgamated Hospital are presently unfilled, but we expect to fill them within the next 4 - 8 weeks. There is then likely to be a further gap of 4 - 8 weeks or longer until the person appointed takes up his/her position. They will be occupied very fully. Apart from improving management practices, the Board is in the process of introducing several major new health initiatives during 1988 ...*

*" ... We are, of course, very much in tune with the concept of public accountability. However, it is not fair to appoint what is, in fact, a new Board of Management and examine its performance before it has had time to settle down to its job."*

*Our current view is that the process with all of these reports has involved the Hospital's senior staff in an inordinate amount of effort at a time when we could ill afford to do so.*

*The Hospital makes no secret of the fact that, while the Hospital provides a fine medical service, the administrative and management support systems are inadequate and significant improvements are needed. This was noted by us in the Hospital's last annual report (1988-89). This is an area that has been starved of resources for years. Major improvements are being achieved in financial control systems and are beginning in other areas. But, as financial and skilled staff resources are scarce it is a long-term process and only high priority matters will receive early attention.*

*Lastly, it is important to point out that it is not the Hospital, but the Victorian Health Department that determines the Hospital's annual financial resources and influences how they are to be deployed. The recent introduction of Health Services Agreements has been a major step towards improved planning and accountability. There is a need to further improve longer-term planning (i.e. over periods of longer than a year) and allocation of resources for plant, buildings and equipment.*

*The Board believes that its major priority is to provide first-class health services in the Victorian community's interests within the limitations of the resources available. At present, too much time is diverted to bureaucratic tasks in the interests of "accountability" that is sometimes so broadly defined as to lose meaning.*

## GENERAL COMMENTS ON REPORT BY HEALTH DEPARTMENT VICTORIA

*The audit report is simplistic and focuses on "high technology facilities" rather than presenting the Hospital in an appropriate context of the human and professional skills inherent in the provision of the Hospital's services, and the educative and research environment of a major teaching hospital.*

*This is illustrative of the approach taken throughout the audit report where a number of comments relate to data taken out of context and not reflective of the nature of provision of services in teaching hospitals in general, nor the Alfred Hospital per se. Some of the comments in the audit report relate to assertions which are unsubstantiated or inadequately substantiated.*

*The audit comments also seem to fluctuate between observations aimed properly at reducing the cost of services currently provided at the Alfred and other observations apparently reflecting either individual or Hospital desires for increased funding in specific areas.*

## Budget position - February 1990

### *Management response by Alfred Hospital*

*Summary comments (3.1.12 to 3.1.13)*

*The Hospital could treat more patients if more funds were available.*

*The Hospital is funded to undertake a certain number of treatments. In April 1990 it is still ahead of the agreed number of inpatients.*

*The number of beds staffed should be the number of beds necessary to achieve the agreed number of inpatients. In the Alfred's case, that is 25 700 inpatients.*

*General comments (3.1.12 to 3.1.13)*

- *The situation is much more complex than is represented by this report.*
- *The Alfred is funded to undertake a certain number of admissions.*
- *By December/January, it was apparent that the Alfred would treat more patients than called for in the Health Service Agreement. This would incur a cost overrun.*
- *The subject of the Heart Transplant Program had been under discussion since August 1988 and was not a major factor in any decision-making process. Even though the financing implications are substantial they were recognised.*
- *The Alfred is not paid to treat patients in excess of its Health Service Agreement. The Hospital has reduced the level of staffed beds in order to meet its funding agreement with HDV.*
- *There is obviously a source of tension between the number of patients the Hospital could treat it if had the funds, the number it can treat with the funds available and the number seeking admission. This is perhaps the major source of stress in a hospital.*
- *The revision of the nursing budget in response to changed circumstances is sound management.*
- *The number of beds staffed obviously depends on the required number of admissions.*
- *The Hospital policy on admissions is that admissions will be based on medical need.*
- *The Hospital will treat the number of patients it has agreed with HDV.*
- *Additional funding obviously would enable the Hospital to treat more patients.*

## *Management response by Health Department Victoria*

*The budget position presented in the audit report is in error on 2 grounds.*

*First, cash outlays must be balanced against adjustments for both expenditure and revenue. Revenue for services provided during a particular period may not accrue until a subsequent period of time has elapsed. As well, "other revenue" collected by the Hospital in excess of agreed revenue targets may be retained by the Hospital as an offset against expenditure. Thus, the extent to which the Hospital, in any given period, provides services for which revenue is payable will influence the "apparent" cash position at the end of that period, however, the true position is made clear only when that revenue is received. For example the Hospital, to end March, had collected $450 000 in excess of its revenue target to that point.*

*As well, expenditure adjustments occur throughout the year and are not finalised until the budget wrap-up following the end of the financial year. Such adjustments, which may include part of the effect of award variations, may significantly affect the apparent cash position of the Hospital at a given point in time during the year.*

*Second, a "snapshot" of the budget position at a given point during the year, while valuable for local management decision-making, does not take into account seasonal variations in service provision, nor the fundamental context in which public hospitals operate, namely the meeting of agreed service targets and financial performance on a full year basis. It is inappropriate and totally misleading to use such a "snapshot" as a basis for a public report of the kind that appears to be proposed by audit.*

*It is the prerogative of Hospital management to vary the level of hospital service provision, including the level of available beds, to meet both clinical service and financial performance targets.*

*It is the responsibility of Hospital management to ensure that, in doing so, the legitimate and immediate patient care demands of the Hospital's patients are not unreasonably compromised.*

*It is not the Hospital management's responsibility to provide all services to all "potential" patients in an immediate fashion.*

*Within this context, HDV policy dictates that emergency situations take priority over elective services but equally recognises that there is a balance between these 2 potentially competing demands.*

*Health care providers, particularly doctors, are sometimes reluctant to recognise that variations in hospital service provision are a legitimate management tool in the overall context of Health Service Agreements. Involvement of health care providers in management decision-making is, however, a key strategy of HDV and is, in any case, a normal procedure in hospitals. The process of involvement of providers is evolutionary in the framework of Health Service Agreements. The "ideal" endpoint of this evolutionary process is that providers understand and accept the hospital position in regard to the provision of services at any given point in time and, to the maximum extent possible and without prejudicing legitimate emergency demand, participate in accommodating their own demands on hospital services. Such an ideal set of objectives would clearly be facilitated if hospital management could comprehensively predict, well in advance, the likely patterns of demand and the corresponding management plan appropriate at each point in the forthcoming relevant time period.*

*The environment and nature of hospitals is, in the real world, both extremely complex and dynamic. Demand for particular services can rarely be accurately predicted much in advance. As an example, demand for emergency and critical care services during the winter of 1989 was at an unprecedented level.*

*There will always be tensions between providers and hospital management regarding the allocation of resource for particular areas of health service. These tensions occur for a number of reasons, including:*

- *that providers, legitimately, consider that one of their major roles is to act as "advocates" for their own patients both in terms of timeliness of access and resource availability;*
- *that individual providers are rarely associated with more than one public hospital; rarely have a perspective of Statewide clinical service planning or resource allocation issues; and, in the context of individual patient relationships, rarely accede to the logic of distribution of their own patients to clinical service resources more readily available in other public hospitals; and*
- *that providers, particularly those committed full-time or for a substantial period of their working week to a particular public hospital, correctly perceive that their own and the hospital's interests are best served by seeking the maximum resource allocation to their own particular clinical area in the particular public hospital.*

*Notwithstanding all of the above, the factual situation at the Alfred Hospital is that it is currently exceeding its clinical service targets. In fact, at 28 February 1990, the Hospital was 1.7 per cent, or 291 inpatients treated ahead of its service targets. The Hospital projects its end of year position as 26 200 inpatients treated; 1.9 per cent ahead of the target of 25 700. Further, the audit report acknowledges that the waiting list has declined by almost 200 patients during the period when the level of available beds has altered.*

*A final specific relates to cardiac transplantation.*

*It is stated that the presumptive cash outlay shortfall (disputed as above) of $1.75 million is primarily due to the cardiac transplant program "cost" to date of $1.2 million, not funded by HDV.*

*In fact, the figure of $1.2 million used by audit is part of a draft submission recently lodged by the Hospital which presents a projected cost structure for an ongoing permanently established Transplant Unit.*

*The actual costs incurred by the Program in the initial stages were significantly less than the allocation included in the budget assessment as presented by audit. HDV accepts that the lower marginal costs which relate to a "start-up" unit could not be expected to apply to a fully established unit.*

*For 1989-90, the Hospital's Budget Agreement identified that the part year effect of the 1988-89 program (16 cardiac transplants) would be funded from within the Global Budget. Moreover, a reserve amount of $0.7 million (a share of a total Statewide Transplant allocation of $2 million) was made available for the Hospital in the 1989 State Budget for transplants in excess of the 16 funded within the Global Budget. This additional funding has not been taken into account by audit in its assessment.*

## Waiting numbers and times

### *Management response by Alfred Hospital*

*Comments on 3.1.14 to 3.1.21*

*The Alfred is a high specialty, Acute Teaching Hospital. Even though only 45 per cent of admissions are emergency, in excess of 60 per cent of bed days occur in connection with emergency admissions.*

*Priority of treatment at the Hospital is based on medical need through the spectrum:*

- *Emergency;*
- *Urgent electives;*
- *Semi-urgent electives; and*
- *Other electives*

*The Hospital has finite funding and an agreed level of admissions.*

*Consequently, there will be situations where "other electives" (e.g. tattoo and scar removal) which have been put on the waiting list, will, if present practices continue, never get treated because their medical need is not sufficiently high to warrant treatment in a major hospital.*

*The Hospital attempts to ensure that no patient who meets the criteria for listing on a waiting list should be on a waiting list for more than 18 months.*

*There is a need to develop guidelines as to:*

- *who should be on the waiting list in the first place; and*
- *how does the system treat patients whose low medical need means that higher priority patients will always get priority of access.*

*Because of the interwoven implication for the public and private system, this matter is best handled by the HDV Waiting List Consultative Group.*

*Summary*

*In 1988-89 the Hospital treated 25 164 inpatients and is forecasting in excess of 26 000 for 1989-90. This should be compared with 19 874 in 1986-87.*

*In February 1987, the Hospital's waiting list numbered 3 375 compared with the number waiting as at February 1990 of 2 200 (a reduction of 35 per cent over the period).*

*Comment on 3.1.22*

*January is an atypical month for comparison.*

*Bed closures*

*The true situation on "bed closures" is as follows:*

- *Hospitals enter into a Health Services Agreement and a funding agreement once a year with the Health Department. This basically states that the Hospital will treat a certain number of inpatients and outpatients and for that level of service its funding will be $X.*
- *The Hospital is only funded to undertake a certain number of cases. It is not funded to undertake more than that number.*

  *As at 6 May 1990, the Hospital is in front of its target admissions.*

  *Much as the Hospital may attempt to control admissions it is difficult, if not impossible, to refuse most patients.*
- *In the case of the Alfred, the budgetary systems in place require considerable upgrading, given the complexities of the organisation.*
- *The ability of the Hospital to relate expenditure to workload is not high, especially as each patient is different and will have different resource requirements. Hence, if the severity of patients increases or the mix of diagnoses changes to more complex, demands for resources will increase.*
- *Once a hospital is aware of a forecast budget overrun, it needs to take corrective action.*

  *Its ability to do this is extremely limited as in excess of 70 per cent of expenditure is salary related, and staff numbers cannot be changed in the short-term.*

  *The only area of staff flexibility is nursing, which has a predictable rate of resignation. Hence, the only short to medium-term avenue of cost flexibility is nurse staffing.*

  *One does not actively close beds; one decides not to replace nurses or hire agency nurses.*

  *A consequence of this is that bed closures occur at random throughout the Hospital.*

*Management information*

*The Hospital is working to improve its management information systems and budgeting systems.*

*This will enable the Hospital to relate more accurately the forecast workload to forecast expenditure, and hence, prevent substantial alterations in the number of staffed beds on a monthly basis.*

*There is a need to relate forecast patient admissions to forecast bed days and then to forecast staffing requirements.*

*This is a very complex problem and difficult in a major hospital, but is nevertheless being attempted.*

*Emergency load*

*In excess of 60 per cent of the hospital bed days are connected with emergency admissions. This makes scheduling of elective cases extremely difficult as admission's are based on medical need.*

*If there is a surge in emergency admissions, there will be a reduction in elective admissions.*

*Summary*

*The Hospital could treat more patients if it had more resources.*

*The Hospital is currently above target for admissions.*

*A major determinant of the non-admission of scheduled cases on the day they are first scheduled is the Hospital's emergency caseload.*

*(Both HDV and TAC have recognised the Hospital's special role in Emergency).*

*There is a need for greatly improved management information systems if one is to prevent rapid changes in the Hospital's staffed bed state. These are being developed.*

*Comment on 3.1.24*

*The subject of Waiting Lists is not simple.*

*If more resources were available the Hospital would be able to treat more patients.*

*In February 1987, the Hospital's waiting list numbered 3 375 compared with the number waiting at February 1990 of 2 200 (a reduction of 35 per cent over the period).*

*The Alfred's admissions have increased significantly over the last 4 years as shown below:*

| *Year* | *Admissions* |
|---|---|
| *1986-87* | *19 874* |
| *1987-88* | *24 776* |
| *1988-89* | *25 164* |
| *1989-90* | *(Target) 25 700* |
| | *(Forecast) 26 200* |

*Patients are referred to hospitals known to provide excellent patient care. It is expected that the best teaching hospitals will have the longest waiting lists, when resources are short.*

*Comment on 3.1.27*

*The surgeons often treat totally different problems and there is little possibility of movement between surgeons. It must be recognised that doctors have specialties and patients have specific diagnoses.*

*Given the doctor/patient relationship both doctors and patients would need to be consulted and agree. Given the system wide implications of such a move, the Hospital believes that such a move would be best initiated by HDV.*

*Comment on 3.1.32 to 3.1.34*

*The need to evaluate a project such as pre-testing of elective patients prior to admission is recognised. However, a number of other projects of higher priority currently exist. This project has already been discussed within the Hospital.*

*Comment on 3.1.35 - 3.1.39*

*The need to evaluate a project such as opening a central outpatients clinic to undertake all procedural activities, implementing weeknight sessions and improving information systems is recognised. However, a number of other projects of higher priority currently exist.*

*Comment on 3.1.40 to 3.1.43*

*The Hospital's Outpatient Action Group will be asked to examine methods by which booking information can be provided to wards and the Emergency Department after hours.*

## *Management response by Health Department Victoria*

*Audit notes that the total waiting list number for the Hospital has increased from 2 038 at 28 February 1989 to 2 204 at 28 February 1990.*

*Not presented in the report is that the waiting list number has declined from 3 375 at February 1987, a "reduction" of 34.7 per cent.*

*Not presented in context is that hospital inpatient throughputs for the 1986-87 year were 19 874 and the projected inpatient throughput for the 1989-90 year is 26 200, an expected "increase" of 31.8 per cent.*

*It has previously been stated that the waiting list number has declined from approximately 2 400 at the end of 1989 to the described figure at 28 February 1990.*

*The composition of the waiting list number, proportionally represented in the audit report, is not contentious with one exception.*

*HDV elective surgery waiting list figures do not include "Medicine" as included in the audit report. Exclusion of this group by HDV was undertaken on the basis of advice from eminent experts in the clinical arena on the basis that:*

- *by and large such patients are "booked" admissions, a term which encompasses both provider and consumer preference therefore they are not "delayed" or waiting in the true sense (further discussion ensues); and*
- *the focus of attention of both HDV and providers in the matter of waiting lists is elective surgery.*

*The audit report notes that "cancellations" from the Alfred waiting list (more correctly described as deletions) was due to the clinical audit. Such audits are undertaken on a regular basis and resultant deletions from the waiting list are on the basis that:*

- *the patient no longer requires surgery;*
- *the patient no longer desires surgery; or*
- *the patient has already had the surgery performed, either at the Alfred (no data correlation system is perfect) or elsewhere.*

*Clinical auditing of this nature, in the audit report, should be applauded and encouraged.*

*Audit also comments that the described decline in waiting list numbers is, in part, due to an increase in admissions (the proportion of emergency to elective not specified) in January 1990. As previously stated, this reflects seasonal patterns in hospital service provision, reflecting both sessional illness patterns and provider preference.*

*Waiting times are given special attention in the audit report.*

*Data is presented comparing the average waiting times (months) for a range of specialties, comparing the situation at 28 February 1989 with that of 28 February 1990.*

*On the basis of the data presented, it is stated that increases in waiting times have occurred in certain specialties. The data presented presumably derives from raw data provided by the Alfred.*

*HDV currently publishes, on a quarterly basis, "Estimated Admission Times" for a range of elective surgical specialties. This published data comprehends 11 teaching and specialist hospitals, 11 suburban hospitals and 11 country hospitals. The most recent published document is at the end of December 1989.*

*Estimated admission times, as published, are derived from an algorithm based on the number of patients admitted from the waiting list in a given period (by specialty) and the number of patients on the waiting list (by specialty) during that period.*

*The estimated admission time therefore is not an indication of the waiting time of individual patients. HDV published data, as distinct from data in the audit report, does not include patients ascribed to "Medicine" for reasons as stated above. Audit analysis of average waiting times of all patients on a specific hospital waiting list can be predicted to produce times different from the HDV estimated admission times for sound reasons.*

*Patients truly waiting for elective surgery are admitted on the basis of clinical need. Patients with the least clinical need, as an example purely cosmetic plastic surgery, will wait for the longest periods. This clinical need assessment is inarguably appropriate.*

*Turnover of patients from aggregate waiting lists is substantial. At the end December 1989, the State average waiting time in months for all surgical areas was 2. This dictates a turnover of 6 times in a full year, or 131 454 patients (based on the published waiting number of 21 909 at 31 December 1989), all other things being equal.*

*Analysis of the average waiting time of patients on a specific hospital waiting list, at a given point in time, distorts the realistic expectation of a patient presenting, or referred, to that hospital for elective surgery in a given surgical specialty area because 5 times (the difference based on months waiting of those turned over from the waiting list compared with those remaining on the waiting list) as many patients have been admitted to hospital and removed from the waiting list as remain on it. Since waiting list priority is based on clinical need, this methodology is robust and furthermore mathematically competent.*

*The waiting time data, in months, presented in the audit report is correlated in the following table against published HDV estimated admission time data at 31 December 1989 and HDV estimated admission time data to be published in May 1990, but as of 31 March 1990.*

**ALFRED HOSPITAL WAITING LIST DATA**
(months)

| | | | Expected admission time | |
|---|---|---|---|---|
| | Waiting times (audit report data) | | HDV published data (February 1990) | To be published (May 1990) |
| Specialty | 28/2/89 | 28/2/90 | 31/12/89 | 31/3/90 |
| General surgery | 2.8 | 3.0 | 2.8 | 2.5 |
| ENT | 8.8 | 11.7 | 12.0 | 8.7 |
| Ophthalmology | 4.9 | 4.3 | 4.5 | 4.4 |
| Urology | 5.2 | 8.1 | 7.4 | 6.0 |
| Paediatric surgery | 1.0 | 1.2 | - | - |
| Gynaecology | 4.6 | 2.9 | 2.2 | 2.5 |
| Neurosurgery | 1.7 | 1.7 | 1.7 | 1.5 |
| Vascular surgery | 5.6 | 3.2 | 3.4 | 2.5 |
| Cardiac surgery | 7.7 | 7.7 | 6.2 | 5.8 |
| Thoracic surgery | 1.1 | 1.7 | 1.2 | 2.0 |
| Orthopaedic surgery | 11.3 | 7.7 | 3.3 | 3.0 |
| Plastic surgery | 14.5 | 14.5 | 8.8 | 6.7 |
| Other surgery | 2.7 | 7.4 | (a) | (a) |
| Medicine | 0.9 | 1.3 | (b) | (b) |

(a) The category "other surgery" is a composite which includes all surgery in areas where the given hospital does not have a specialist unit or discipline. It therefore varies markedly from hospital to hospital and is not published as it has no meaningful clinical relevance.

(b) Not included.

*There are differences between HDV and audit data presented above for the Alfred Hospital, both in the quantum and trend of waiting times.*

*While argument as to the basis of figures published by HDV may pertain, HDV data has been calculated on a consistent basis for some years and the value of comparison between measurements of a consistent index is considered by HDV to be completely justifiable. An economic parallel can be drawn between this index series and, for example, the Consumer Price Index, where the basket of goods and services does vary, but the history and consistency of measurements is relevant to inclusion/ exclusion from published serial data.*

*HDV has established (as of March 1990) an Advisory Committee on Elective Surgery. Principal among its terms of reference is an examination of the categorisation of patients waiting for elective surgery.*

*HDV submits that the collection of waiting list data in Victoria is superior to that throughout most of the western world. Nevertheless, there are variations between hospitals and providers as to who is placed on a waiting list, specifically:*

- *the use of the waiting lists as "booking" lists for planned future surgical procedures;*
- *the nature of waiting lists of themselves, i.e. are they a measure of hospital activity in that there is an acceptable interval between identification of the need for a surgical procedure and its reasonable time of occurrence;*
- *how waiting list data might reflect the clinical urgency or priority for surgical procedures; and*
- *how waiting list data might reflect delayed (i.e. postponed beyond an expected period) admission times as opposed to the actual admission experience of most patients on current waiting lists (1.4 months at 31 December 1989).*

*The Advisory Committee on Elective Surgery, chaired by Mr John Clarebrough and comprising eminent experts from the fields of clinical surgery, hospital administration and health policy formulation has already met on several occasions. As stated above, definitional change as a result of it's consideration will need to take into consideration the effect of such change on historical indicator series, as well as the acceptance of such change by the clinical field.*

*The relevance of preceding discussion to the audit report is self evident.*

*The audit report continues by analysing the number of patients (by specialty) on the Alfred waiting list for more than one year. In particular, cases placed on the waiting list between 1983 and 1987 attract special attention.*

*Of those patients waiting more than 2 years (documented in the report as 44) it is stated that "at least" 9 patients elected to have their operation deferred, while "at least" 3 patients failed to attend.*

*In addition to the 30 per cent of prospective patients who chose not to proceed with elective surgery when offered, it must be emphasised that elective surgery admissions are based on medical need. Clearly, given the number of people in the specialties identified who have received treatment in the period, those remaining on the List in excess of 2 years are low medical priority cases.*

*The audit comment on waiting list numbers and waiting times imply a value judgement that is not substantiated. This is inappropriate, for reasons stated earlier. As stated above, waiting list numbers are based on a diverse number of factors, including (perhaps most importantly) provider demands for services at "their" hospital, but as well the nature, accuracy and appropriateness of data collected. Nevertheless, HDV responds to waiting list data as one indicator of hospital service demand.*

*The Issue of priority being given to "emergency and cancer/trauma patients in preference to non-urgent elective patients" has not only been discussed but is explicit HDV policy irrespective of the financial/clinical service performance of any given hospital at any given point in time. Subsequent discussion on this matter ensues.*

*Comment regarding a purported shortage of specialist medical practitioners and specialist nursing staff is reported in the audit report at this point, but is neither previously identified, nor further expanded upon. In so far as the latter is concerned, HDV not only recognises difficulty in recruiting specialist nursing staff, particularly in the area of critical care, but has undertaken elaborate industrial, training, recruiting and retention strategies to address this problem.*

*Insufficient after care placement facilities are also identified by audit. The Alfred Hospital, within the South East Metropolitan Region, is situated in an environment which contains the highest number per capita of nursing home beds of all metropolitan HDV regions. Additionally, the Alfred is amalgamated with Caulfield Hospital, a major geriatric care and rehabilitation centre. Nonetheless, HDV recognises that timely and appropriate placement of patients requiring continuing care or suitable accommodation after acute care needs have been met, is an issue requiring constant attention.*

*Audit goes on to assert that bed closures in February 1990 resulted in 21 per cent of scheduled elective cases not being admitted on the scheduled date in that month, as compared with 6 per cent in January 1990.*

*The quoted figures presumably include waiting list patients.*

*As previously described, variations in bed availability reflect both legitimate immediate clinical demand and the overall context of hospital service provision in meeting full year clinical and financial performance targets.*

*A further variable, not addressed by audit, is the extent to which emergency demand displaced elective capacity in the period in question.*

*Admission deferral, with adequate advance notice, is not necessarily inappropriate for non-urgent elective surgery. The need for planning of hospital service resources variations (if possible) and the involvement and co-operation (to the extent possible) of health care providers in accommodating such variations has been previously discussed.*

*Of the subsequently reported advice by "senior medical staff" to audit regarding initiatives to improve waiting list number and waiting time management, the following deserve comment:*

- *The HDV Advisory Committee on Elective Surgery has previously been discussed. As well, the regional working party on waiting lists has met regularly over several years;*
- *Specific Commonwealth funding for waiting list initiatives supplemented by State funds, have been available since the end of 1987-88;*
- *The Alfred, in conjunction with HDV, did set and meet an objective as of the 1987-88 financial year to admit within its inpatient target 45 per cent emergency and 55 per cent elective admissions. This was, however, in the context of a substantial increase in inpatient admissions (31.8 per cent from 1986-87 to 1989-90). Further, the proportion of bed days consumed by emergency admissions (a separate indicator from inpatient throughputs) exceeds 60 per cent according to hospital data;*
- *The limited ability of Alfred to transfer patients from one doctor to another reflects the inherent difficulty amply discussed earlier, of efficiency improvement by patient transfer of this type;*
- *The Alfred is "amalgamated" with the Royal Southern Memorial Hospital (RSMH). Treatment of elective orthopaedic cases at RSMH has been an outstandingly successful feature of functional amalgamation (including conjoint medical appointments) between the campuses of the Alfred Group of Hospitals. In fact, since 1986 the orthopaedic waiting list number has declined by 60 per cent and the estimated admission time reduced from one year to 3 months; and*
- *As to waiting list audits, in an audit report, as previously stated, these should be applauded and encouraged.*

*Audit comment that these strategies have contained, but not reduced waiting list numbers and waiting times is a further indication of the lack of understanding by audit of the complexity of hospitals and the hazard of using single indicators, in the absence of context, as measures of efficiency and effectiveness.*

*The nature and components of waiting lists, their measurement, comprehensiveness and HDV continuing initiatives in this matter have been amply discussed previously.*

*HDV is confident that its data collection system and response to such data is at least equal to any comparable Australian health care system. HDV will maintain this leadership through the deliberations of the Advisory Committee on Elective Surgery, previously described.*

*Audit goes on to report differences between waiting list numbers and waiting times for procedures to be undertaken by different individual surgeons in the same surgical specialty. This data, and the audit comment, merely reinforces the comment made on this matter previously in this commentary.*

*Pre-testing of elective patients prior to admission is an initiative which, along with adequate discharge planning, HDV would wish to "encourage" as a local management tool, which (where appropriate) may improve the efficiency of the provision of hospital inpatient services.*

*Improving booking systems, including the use of computer systems, where appropriate, is an initiative which HDV would also wish to "encourage" as a local management tool for the efficient and effective provision of hospital outpatient services.*

*As far as single procedural clinics are concerned, HDV believes this to be a local management and clinical issue, as there may be instances where a single procedural clinic may be geographically or clinically inappropriate in terms of the management of patients attending hospitals for outpatient care.*

*As far as weeknight of "out of hours" outpatient clinics are concerned, HDV is surprised that audit should recommend establishment of such clinics, particularly as they would necessarily involve substantial additional cost without any "clinical" benefit. While convenience, for some would be augmented, the beneficiaries (in terms of employers not losing time through employee absence for medical purposes), do not noticeably or uniformly provide such facilities.*

## Private patient admissions

### *Management response by Alfred Hospital*

*Comment on 3.1.44 to 3.1.54*

*The Hospital has no right to discriminate between public and private patients. In fact, under the budget agreement, we are is expected to raise in excess of $12 million of our financing from private and compensable patients.*

*Many private patients can best be treated in public hospitals.*

*The observations made by the Auditor-General in his report have been noted and there is no disagreement as to the number of patients privately insured who have been treated at the Hospital, including the number of privately insured patients who have been taken off the waiting list.*

*The Hospital is not in a position to refuse admission and/or treatment to people because of their insurance status. Quite obviously to do so would be a direct negation of the Australian and State Government's directives in terms of an equity of access for the public.*

*Patients are admitted and treated at public hospitals largely through a referral system. One of the tenets of that referral system is based upon a relationship developed amongst medical staff having regard to the knowledge, perception of skills and established relationships between general practitioners and specialists.*

*The Hospital, in addition to providing high quality patient care, has a commitment to teaching and research. This implies that there is an appropriate mix of diagnoses and consequent treatment in order to maintain not only the professional skills of postgraduate staff, but also as an implicit part of the undergraduate teaching process. The fact that some of those patients presenting may be of privately insured status, cannot influence the Hospital's need to ensure that the widest range (within the agreed level of services) is undertaken. Such patients contribute to skill maintenance, teaching and revenue.*

*The Hospital is a teaching hospital and therefore it must treat a balanced range of patients. It cannot only treat patients in need of sophisticated specialist services.*

*Use of public hospitals to treat privately insured patients is, therefore, an issue which needs to be recognised at a central level. It is not an issue the individual public hospital can address other than within its agreed Health Service Agreement.*

## *Management response by Health Department Victoria*

*Most privately insured patients treated in private hospitals currently face minimal, or no out-of-pocket charges.*

*The involvement of resident medical staff in the care of private patients in public hospitals varies between hospitals, and between patients (dependent on patient and doctor preference) within hospitals. For many, if not most, private patients, the level and nature of resident medical staff services is not different from that provided to hospital (public) patients.*

*Audit notes that, in some instances, there are revenue remittance arrangements between doctors and the hospital. They are currently subject to review and current guidelines are expected to be released shortly.*

*Audit's view of "savings" to Health Insurance Funds is based on a fallacious assumption to vigorously contested by the funds. In fact, people who are privately insured have paid for (and are entitled to receive) public hospital treatment subsidised by Commonwealth Medicare. Commonwealth policy sets the "private" charge in public hospitals and the basic table benefit at a level below full cost specifically to allow private patients in public hospitals to benefit both from their Medicare cover and their private cover. The original purpose of the Medicare compensation grant from the Commonwealth was to meet the resulting cost to the hospital. This element is included in the hospitals' government funding.*

*If there is an anomaly in current Medicare policy it is that patients who use private hospitals receive no benefit from their Medicare cover. This is however a matter for Commonwealth policy.*

*Commonwealth policy (which Victoria is bound to conform to as a result of the Medicare hospital funding agreement) is that public hospital care is universally available independent of financial or insurance status, based on medical need. Audit comment is based on assumptions that "disadvantaged" members of the community (defined as those who do not have private insurance or who do not choose to be admitted as private patients) should have exclusive use of public hospitals and that those who can afford to do so should be required to take out and to use private insurance. These are assumptions which are directly contrary to Medicare policy on hospital services.*

*HDV does not dispute that there are some patients treated as private patients in public hospitals who might equally be treated in private hospitals. Audit appears to suggest that privately insured patients should not have access to care in public hospitals. As stated earlier, this is contrary to State and Commonwealth policy, the Medicare Agreements between the Commonwealth and States, and both provider and consumer preference.*

*Notably, such a viewpiont is quite contrary to the most recent comprehensive study of this matter - the Committee of Inquiry into Rights of Private Practice in Public Hospitals, chaired by Professor David Penington, which was commissioned by the Commonwealth in response to the so-called "section 17 dispute" and which reported in September 1984. This report firmly recommended the retention of rights of private practice in public hospitals on the basis of professional, teaching (exposure to a diversity or patients) and financial grounds.*

*The audit comment that use of public hospitals by private patients impacts adversely on the availability of beds for disadvantaged members of the community is not justifiable. Indeed, even in the context of the preceding comments regarding highly specialised care not available elsewhere, the data Indicates an overwhelming focus on hospital (public) patients (i.e. 75 per cent).*

*Moreover, all patients currently admitted as private patients and thus contributing to the Hospital's revenue, would be entitled to be admitted as public patients and to make no payment.*

## Emergency Department

### *Management response by Alfred Hospital*

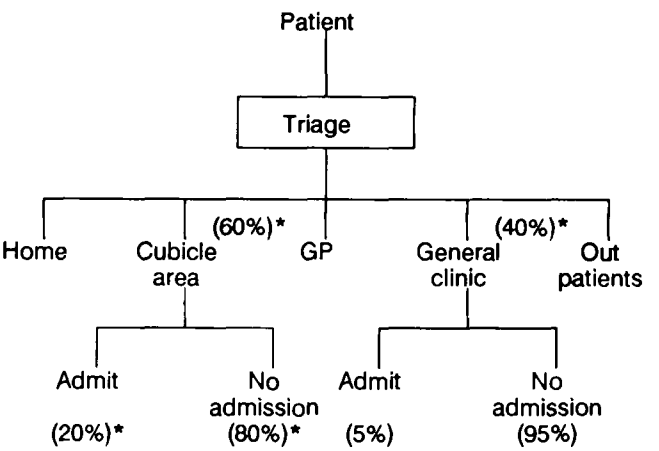
*This section of the Report displays little knowledge of the workings of the Alfred Hospital's Emergency facilities or how they fit into the State's Emergency System.*

*Comment on 3.1 55 to 3.1.57*

- *Bypass is a system management tool to redistribute emergency load within the system.*
- *There are many reasons patients are located within the Emergency Department for up to 12 hours.*

  *Bed availability within the Hospital is only one of many reasons.*
- *The new TAC Trauma Centre should release pressure in this area.*

  *Emergency facilities*
  - *The Emergency facilities provide:*
    - *evaluation;*
    - *investigation;*
    - *treatment; and*
    - *placement.*
  - *They are part of a Statewide Emergency System.*
  - *They are part of the Hospital, yet separate.*




(* the percentages relate to total patients seen by the Alfred's Emergency facilities.)

*Bypass*

- *Bypass is a management tool used by all major hospitals to re-distribute the Emergency load across the system.*
- *The Hospital could have 100 vacant staffed beds and still go on bypass. The Emergency Department goes on bypass when the capacity of the Department to provide care is overloaded at a point in time, i.e. 3 people with gunshot wounds.*

- *Ambulance bypass rules have been laid down by the Health Department Victoria. Ambulance bypass is only permissible when the facilities in the Emergency Department are full. Bed unavailability in wards is not a factor considered in deciding to go on bypass. The Hospital has adhered to this policy meticulously and each bypass has to be authorised.*
- *One does not overload a particular hospital Emergency facility when other facilities in the system may have capacity.*
- *Being on bypass does not mean patients are not brought to the Alfred, e.g.:*
    - *if someone is critically ill and near the Alfred, the patient is received even if the Hospital is on bypass; and*
    - *if the patient has had a long-term association with the Alfred and does not have a life threatening disease or injury they will come to the Alfred even if it is on bypass.*
- *The final decision on destination is the Ambulance Service, who will direct ambulances to the Emergency facilities which are most suitable.*

*Episodic nature*

*Emergency facilities and Trauma Centres have to cope with peak loads. Emergencies do not arrive in a neat order. There may be nothing for 4 hours and then bedlam. This is why one has "bypass procedures".*

*This is the reason why the TAC Trauma Centre will be fully staffed, even if it receives only one to 2 multi-trauma cases a day.*

*Audit comments*

- *"Patient treatment could be compromised due to delay in receiving emergency treatment."*

  *This is unsubstantiated speculation.*

  *Where are the facts?*

  *This is why bypass exists.*
- *"Extra strain is placed on the Emergency Departments of other hospitals."*

  *A circular argument.*

  *No understanding of the system.*

  *The Alfred receives patients who have bypassed other hospitals all the time.*
- *"Ambulances are unavailable for other emergencies."*

  *Unsubstantiated.*
- *"Ongoing patient care may be at a hospital remote from a patient's home."*

  *This would be of minor impact given the number of hospitals in the inner city area.*

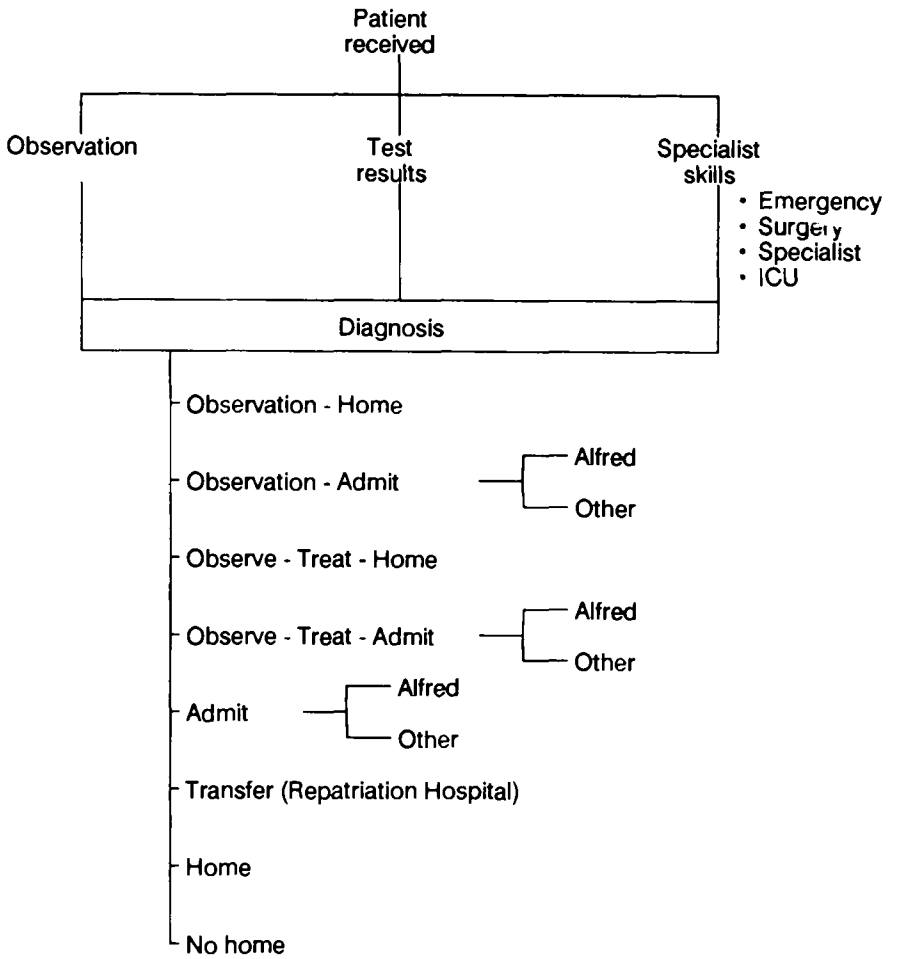
*The report then goes on to comment on the major reasons for bypass.*

*The major reasons for bypass have previously been outlined and no data is presented to enable conclusions to be drawn about the capacity of the Alfred's Emergency Department or that of the region.*

*Comments on 3.1.58 to 3.1.60*

*The audit report shows poor understanding of a complex area. This complexity is not evident in the 2 pages on emergency facilities in this report.*

*The time spent on emergency depends on many factors:*




*Lack of beds is only one possible reason for delay. There may be a considerable period before a diagnosis is even possible.*

*Even when a diagnosis is available there are many reasons a patient may stay in the Emergency area:*

- *Observation;*
- *No home;*
- *Transfer;*
- *No ambulance;*
- *No theatre available;*
- *No beds;*
- *No ICU beds; and*
- *Humane.*

*Transfer to another hospital may not be because of a lack of beds at the Alfred. The patient may need specialist treatment, be actually under the care of that hospital or may carry private insurance and elect to go to a private hospital.*

*The Ambulance Service does not provide transport for patient transfers between 12 midnight and 8.00 a.m. In practice this can mean 11.30 p.m. to 9.00 a.m.*

*The audit report comments on the period 28 February 1990 to 6 March 1990. This information did not come from Hospital records but was recorded incidentally for audit by the busy Emergency Department staff. The methodology of this recording has been reviewed. The review has highlighted a number of serious weaknesses in the count. Patients will be on trolleys for many different reasons. No attempt was made to determine why the patient was actually on that trolley.*

*Summary*

- *People remain in the Emergency Department for some time for a variety of reasons.*
- *The audit report gives no analysis of those reasons.*
- *Seriously ill patients do receive appropriate treatment.*
- *In some circumstances availability of beds is a problem.*
- *There is a need to evaluate the impact of the new Trauma Centre before any further action is taken.*

*Comments on 3.1.65 to 3.1.66*

*(1) Once a patient attends the Hospital the Hospital must examine the patient.*

*(2) The general outpatient clinic is part of the Emergency facility. It operates:*

*9.00 a.m. - 9.00 p.m. (Monday to Friday); and*

*12 Noon - 9.00 p.m. (Weekend).*

*(3) It is part of the Triage system.*

*(4) The following patients are referred to it:*

- *Paediatric (non-trauma);*
- *Eye;*
- *Soft tissue injury;*
- *Simple fractures;*
- *Hand injuries; and*
- *Other minor conditions.*

*(5) The basic split between the 2 main areas in the emergency facilities are:*

- *cubical area - patient needs to lie down or undress; and*
- *general clinic - walking patients.*

*(6) There are 2 trolleys associated with the general clinic.*

*(7) If the patient is walking and does not have an obvious problem they will be sent to the general clinic for assessment.*

*(8) It would appear that the audit report may be discussing the "other" category of patients.*

*Obviously the Hospital must examine a patient before any decision can be made. It is unethical and bad medical practice to do otherwise. How else does the Department decide who needs attention and who does not?*

*(9) The general outpatient clinic was set up so that demand on the specialists facilities of the Emergency Department would be reduced.*

*(10) The audit report states:*

> *"Two prioritles of the Victorian State Health Plan (1987) are to increase access to acute hospital services and to improve management accountabllity of health services. Current priorlties for the Health Department Victoria's South East Metropolitan Region, the region servlced by the Alfred, Include the provislon of, and access to acute hospital and primary health care services.*
>
> *"As referred to in the Health Services Agreement between the Alfred and the Victorian Government all of these priorities are reflected in the services provided by the Alfred. By way of illustration, homeless unemployed youth tend to congregate in the immediate St Kilda area and are frequent attendees at the Alfred's Emergency Department."*

*(11) Transfer of general outpatient clinic activities In the Emergency Department to other providers is supported. However, this process of re-direction requires not only educational programs for the community but a recognition that this is a modification of policy which places emphasis on the Hospital to provide at least initially, care to anyone presenting to the Emergency Department, e.g. homeless young in the St Kilda area.*

*Comment on 3.1.67*

*The Hospital agrees that a community education program is needed to encourage primary use of a family doctor and selective use of hospital Emergency Departments for genuine emergencies but many uninsured patients are reluctant to attend private facilities. If resources are made available, the Hospital would be pleased to undertake such a program.*

## *Management response by Health Department Victoria*

*Audit reports ambulance bypass data for, Alfred for December 1989, January 1990 and February 1990 as 4, 2 and 3 incidents, respectively.*

*The subsequent commentary by audit appears to be based on misunderstanding of the provision of emergency services in the public hospital system and contains a series of unsubstantiated assertions.*

*Patients may present to Emergency Departments of their own volition, be referred by a doctor for assessment or treatment, or be transported In an emergency situation whether referred or not. Any of these categories of patient may contribute to those rare situations where the physical capacity of an Emergency Department is exceeded.*

*Patients requiring ambulance transport are not necessarily unstable nor in life-threatening situations. The system focuses, however, on those who are, and for whom institution of treatment is time-critical.*

*Initial treatment, which may be quite sophisticated, is given to such patients at the scene of accident or emergency. As appropriate, this may involve dispatch of a Mobile Intensive Care Ambulance (MICA) with highly skilled ambulance officers.*

*Following initial treatment, which may include resuscitation, the patient is transported to the nearest available public hospital Emergency Department appropriate to the probable needs of the patient. As detailed in the discussion paper of the Consultative Council on Emergency and Critical Care Services (CCECCS), it is proposed to simplify the stratification of Emergency Departments to "major" or "minor".*

*For the purposes of time-critical emergency patients the inpatient bed state of the concerned hospital is not relevant, only the availability of appropriate emergency (particularly resuscitative) facilities.*

*Once such patients have been resuscitated and stabilised, they will most frequently be admitted to the hospital concerned, however, on some occasions they require transfer to another hospital. This may be for particular specialised care (i.e. neurosurgery) not available at the first hospital, or it may be that a particular resource, such as intensive care is not available at the first hospital at that time, but is available elsewhere. Transfer of stabilised patients is an inevitable consequence of the efficient management of resources and is accepted as such in the CCECCS discussion paper.*

*Commenting on hospital bypass, audit opinion is that its occurrence at the Alfred results in:*

- *possible compromise in patient care due to delay in receiving emergency treatment;*
- *extra strain on other hospital emergency departments;*
- *restriction in availability of ambulances; and*
- *ongoing patient care remote from home.*

*There are 3 major Emergency Departments within 6 kilometres of the Alfred; one within 3 kilometres. Audit appears to misunderstand ambulance bypass. When the Alfred is designated as ambulance bypass, patients are not transported to Alfred at all, but are taken from the primary scene of an accident or emergency to the nearest available appropriate Emergency Department. Given the proximity of 3 other Emergency Departments and the nature of ambulance transport, for audit to offer clinical opinion that care could be compromised is improper as well as erroneous.*

*As an alternative to audit comment regarding extra strain on other hospital Emergency Departments, it could equally be argued that the hospital bypass mechanism acts as a fail-safe mechanism and indeed redistributes patient load for better care and better use of resources.*

*Ambulance availability is essentially unaffected if the Alfred is on ambulance bypass. Ambulances simply take patients directly to another hospital's Emergency Department.*

*Ongoing patient care marginally more remote from home is a possibility, however, does audit seriously believe that only residents of the inner south-east suffer emergencies or accidents resulting in their transport to the Alfred?*

*Audit further opines that the ambulance bypass numbers result in part from:*

- *closure of 58 inpatient beds; and*
- *the insufficient capacity of the Emergency Department and the Hospital to cope with the emergency workload in Melbourne's south-east region.*

*As discussed earlier, ambulance bypass occurs when the physical capacity of an Emergency Department is exceeded. However, so-called "exit block" can influence Emergency Department capacity. Dealing with this issue, in the context of recent unprecedented emergency demand, has been a key priority of HDV for more than 12 months.*

*Audit implies that the described number of ambulance bypass events is unacceptable. It is worth noting that this discussion refers to a maximum of 22 hours in a 3 month time period. HDV submits that the described number is not only acceptable but indicative of the efficiency and effectiveness of the Alfred's Emergency Department and the system in general.*

*Audit opinion regarding the sufficiency of Alfred's capacity is lacking in analysis of the situation.*

*Audit then discusses 73 patients who, over a one month period, stayed longer than 12 hours in the Emergency Department. Audit advice was that some (the number not quantified) were awaiting ward inpatient admission. Subsequent clinical opinion regarding the level of care provided to such patients during this time needs to be more objectively analysed before any conclusions can be drawn. Avoidance of admission delays is a key priority of HDV and, as far as ICU facilities are concerned, additional funding has already been provided to the Alfred to establish 2 ICU step-down beds to promote a more efficient ICU function. As well, 6 ICU beds and 4 intensive care step-down beds are funded and shortly to commence opening as part of the Alfred/TAC Road Trauma Centre Initiative. This will considerably reduce or eliminate the need for the general ICU to provide care for trauma patients and enhance its capacity for other categories of patient.*

*Audit observation of a completely full Emergency Department for 34 hours in a 168 hour period is at odds with ambulance bypass data. Patient location in corridors is generally undertaken only if such patients have low dependency needs. There are many such patients, including those with social problems, who from time-to-time require some Emergency Department observation and care.*

*Audit somehow seems to distinguish the Road Trauma Centre from the Alfred Hospital, of which it is part. Funding has been provided for 6 intensive care beds, 4 intensive care step-down beds, 20 general inpatient beds and a number of intermediate care rehabilitation beds as well as the operation and maintenance of helipad facilities, dedicated operating rooms and investigative facilities.*

*The design, both clinical and physical of the Road Trauma Centre was based on the advice of eminent surgeons, specialist in trauma care, from both Australia and overseas.*

*As trauma cases currently attending the Alfred general Emergency Department will now be cared for in the Road Trauma Centre, pressure on the Emergency Department's resuscitation cubicles will be "reduced". Audit comment in this matter appears to reflect a particular set of clinical (and relative resource allocation) views.*

*The Alfred Road Trauma Centre is the most modern facility of its kind in Australia and will provide tremendous benefit to the entire Victorian health care system and particularly the Alfred Hospital.*

*Audit then selectively quotes from the CCECCS discussion paper. The Government's response to the discussion paper has already occurred and has resulted in an additional $20 million (full year) recurrent funds available in the health budget for emergency and critical care services. Out of this, the Alfred has already been funded for 2 ICU step-down beds.*

*Audit comment regarding general practice-type patients in the Alfred's Emergency Department is largely supported by HDV. The matter of such patients, and mechanisms to assist in redirecting them to other care facilities is, as acknowledged by audit, addressed in the CCECCS discussion paper.*

## Intensive care unit

*Management response by Alfred Hospital*

*Comments on 3.1.68 to 3.1.75*

*The figures presented in Table 3L do not give a complete picture of the complex environment in which the intensive care unit operates.*

*(1) Definitions*

*The following definitions are required if one is to understand the operation of the unit.*

*Requests for admission*

*The requests are from within the Hospital and from other hospitals, and from the Emergency facilities associated with the Hospital.*

*These are requests where the ICU Department believes that the facilities of the ICU Department would be beneficial to the patient.*

*The Table excludes the requests where the ICU Department believes that it would be inappropriate for that patient to have access to the ICU facility at that point in time.*

*Requests for admission are of 2 types:*

- *Planned requests*

  *The treating doctor requests admission for a patient who will be having an elective procedure (this does not include a patient undergoing an elective procedure who has an unplanned requirement for ICU, i.e. an emergency).*

- *Emergency requests*

  *All non-planned requests.*

*Patients not admitted*

*Those patients where a bed could not be made available within 8 hours.*

*(2) Sources of admission*

*Requests for admission may arrive from 3 sources:*

- *External hospital patients*

  *Patients referred from outside the Hospital. They will in general be at another hospital.*

- *Emergency Department at the Alfred Hospital*

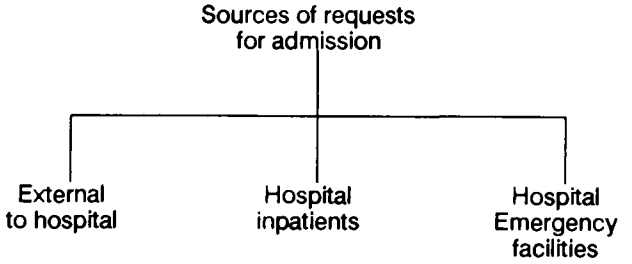
  *The Emergency Department can be regarded as a "stand-alone facility". Patients may be received there, treated and then admitted to another hospital. They may never be admitted as an inpatient at the Alfred.*

  *Just because a patient is treated at an Emergency facility does not imply that the patient was admitted to the associated hospital.*

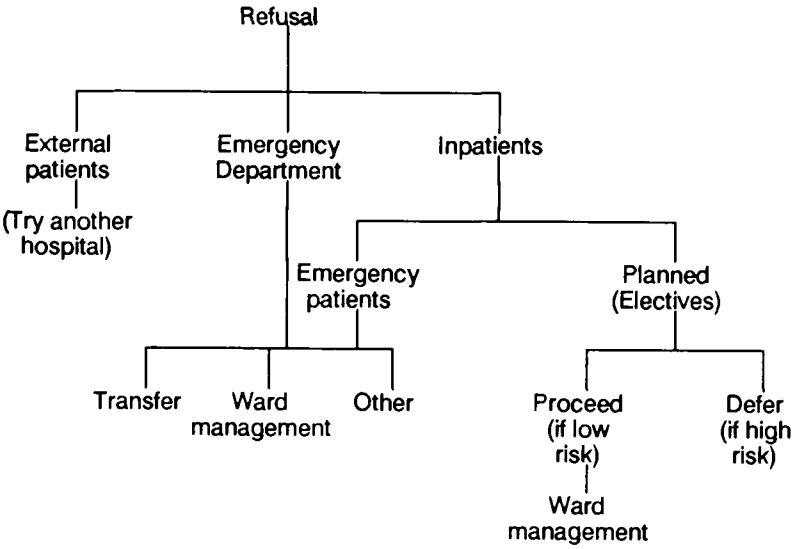
- *Alfred Hospital inpatients*

  *This refers to patients who reached inpatient status. If a patient who has been received in the Emergency facilities requires an operation, that person will be designated as an inpatient. They may then be transferred to another hospital without ever reaching a ward.*

  *This category does not distinguish between a patient who was admitted, operated on and transferred without ever reaching the ward and a patient who may have been in the ward for some time.*




*(3) Analysis of non-admission*




*Notes:*

- *For internal patients, the possibility of staffing another bed or early discharge of a patient from the unit is examined before a definite no is given and the patient included in the "not admitted" figures.*
- *In the case of planned patients a detailed review is conducted of the case to determine precisely the risk. Cases may be deferred to a later date when an ICU bed will be available.*

(4) *Intensive care statistics (Table 3L)*

*A more accurate picture of the situation is given below:*

| | *1988-89* | *1/7/89 to 28/2/90* |
|---|---|---|
| Requests for admission | 585 | 345 |
| Admitted | 411 | 225 |
| Not admitted | 174 | 120 |
| *Patients not admitted-* | | |
| Planned patients | 27 | 19 |
| Emergency patients | 144 | 99 |
| Unknown | 3 | 2 |
| Total - patients not admitted | 174 | 120 |
| *Emergency patients not admitted-* | | |
| External referral | 16 | 11 |
| Internal referral- | | |
| Transferred | 71 | 37 |
| Ward management | 39 | 46 |
| Other outcomes | 18 | 5 |
| Total - Emergency patients not admitted | 144 | 99 |

(5) *Analysis of emergency patients not admitted*

| | *1988-89* | | | | *1/7/89 to 28/2/90* | | | |
|---|---|---|---|---|---|---|---|---|
| | *From Emergency* | *From Inpatients* | *No information* | | *From Emergency* | *From Inpatients* | *No information* | |
| External referral- | .. | .. | .. | 16 | .. | .. | .. | 11 |
| Internal referral- | | | | | | | | |
| Transferred | 46 | 20 | 5 | 71 | 20 | 10 | 7 | 37 |
| Ward management | 16 | 23 | 0 | 39 | 11 | 33 | 2 | 46 |
| Total | 62 | 43 | 5 | 110 | 31 | 43 | 9 | 83 |
| Other outcomes | .. | .. | .. | 18 | .. | .. | .. | 5 |
| Total Emergency patients not admitted | .. | .. | .. | 144 | .. | .. | .. | 99 |

.. Not applicable.

(6) *Transfers*

*If no support requirement mandates ICU the patient will be treated in a ward area. However, if there is a high risk or support requirements mandate ICU (e.g. ventilation, inotrope infusion) then the patient will be transferred to another hospital if appropriate.*

*Since 1984-85 there has been a significant increase in the frequency of this event.*

*The increase in transfers is a source of concern to Hospital staff and it is proposed to conduct a study to examine the problems involving patient care associated with such transfers.*

*It should be noted that inter-hospital transfers are inappropriate for unstable patients.*

*Comments on 3.1.76 to 3.1.78*

*The general intensive care unit is under constant pressure in regard to facilities, staff and the increasing severity of admitted patients.*

*The Health Department Victoria has agreed to fund 2 additional step-down intensive care beds.*

*It is expected that the provision of 6 additional intensive care beds, funded by the TAC will be available later this year for TAC patients.*

## *Management response by Health Department Victoria*

*HDV acknowledges that demand for emergency and critical care services during the winter of 1989 was at unprecedentedly high levels. This matter is amply addressed in the CCECCS discussion paper.*

*Of the major reasons given to audit by Alfred "senior medical staff" for the high level of demand at Alfred per se, HDV notes that trauma cases are highlighted.*

*Audit reports the views of "senior medical staff" that the Alfred Hospital needs 14 rather than the current 8 ICU beds.*

*As previously discussed, the Alfred/TAC Road Trauma Centre has been funded to open 6 ICU beds and 4 ICU step-down beds.*

*A recommendation of the CCECCS discussion paper not included by audit is "that the new intensive care beds at the Alfred Hospital, funded by the Transport Accident Commission, be recognised as part of the Victorian critical care system, in addition to the 92 public general adult intensive beds".*

*As part of the Government response to the discussion paper, the Alfred was also funded for 2 step-down beds in its general ICU.*

*The Alfred Hospital has therefore been funded to provide services at least as high as the level identified as ideal by "senior medical staff".*

*It should also be noted that the Alfred has a further 6 ICU beds dedicated to cardio-thoracic surgical patients and a 6 bed coronary care unit.*

*The decision as to whether a patient requires admission to ICU is a clinical one.*

*The definition of an "intensive care unit", contained in the CCECCS discussion paper is as follows:*

> *"An area specifically staffed and equipped for the continuous care of critically ill, injured or post-operative patients who have a condition compatible with recovery. These units care for patients who require mechanically assisted ventilation and have a high likelihood of requiring systems assistance technologies."*

*The Alfred Hospital has undertaken a detailed analysis of the occasions when an ICU bed was not available. This is detailed in the Alfred Hospital's response.*

*In that analysis, 19 of the patients are identified as "planned" (i.e. planned to undergo an elective procedure for which an ICU period post operative is likely to be required) 2 further patient events are undocumented. The number of emergency requests unable to be accommodated in the Alfred ICU is therefore 99.*

*Of this 99, 12 were requests from other hospitals. Such requests are normal practice, and as discussed earlier, and below, usually arise when a critically ill patient is transported by ambulance from the site of an accident or emergency to the nearest appropriate public hospital Emergency Department. Once resuscitation and/or treatment has been undertaken, such patients, if they have a continuing requirement for ICU, are either admitted to the hospital's own ICU, or, if no bed is available transferred. This reflects both efficient and effective use of resources system-wide, and proper clinical management. Transport to an appropriate Emergency Department from the scene of accident and emergency is time-critical. Once the patient is stabilised, the situation is less time-critical and transfer to an available resource, whether within the given hospital or in another hospital, is clinically appropriate.*

*The level of care provided during such transfer is determined by the referring doctor. In general, patients not requiring ventilatory assistance or infusions of complex drugs can safely be transported by ambulance road vehicles equipped with Advance Life Support (ALS) facilities and staffed by ambulance officers who have undertaken an advanced training program - the Continuing Education Program - seventh version (CEP7). If ventilation or complex drug infusion is required patients are transferred in a Mobile Intensive Care Ambulance (MICA), staffed by ambulance officers who have undertaken a MICA course. If the referring doctor believes that a medical escort is required, then that is accommodated. If additional equipment is required, it is "borrowed" from the referring hospital and returned following transfer.*

*If transfer of a patient requiring an ICU bed is necessary, a doctor in the referring hospital (usually the "admitting officer") contacts nearby hospitals and requests receipt of the patient. If no facility is readily available, there is an Office of the Co-ordinator of Emergency Critical Care Services staffed 24 hours a day. The referring hospital doctor contacts the on-duty co-ordinator who then finds an appropriate bed for the patient concerned. If necessary, transfer to an appropriately equipped private hospital facility is undertaken. This service, and any resultant cost, is funded by HDV.*

*That 12 patients external to the Alfred could not be accommodated at the time requested is neither relevant nor does it in any way reflect on the well-organised and efficient system of co-ordination of the provision of critical care services in Victoria.*

*Of the 87 remaining internal emergency patients not admitted to the Alfred ICU, 47 were able to be managed in other areas of Alfred, or had other outcomes (one patient).*

*Forty patients required transfer from Alfred. On 25 documented occasions, the Office of the Co-ordinator of Emergency Critical Care Services provided assistance in such transfers.*

*According to that office, the great majority of these transfers were from the Emergency Department of the Alfred.*

*As discussed above, the critical care system is designed to accommodate situations where local demand exceeds locally available resource but also to ensure that treatment in the time-critical period commences as soon as possible. Thus the availability of ICU beds at any given hospital "does not influence" ambulance transport of patients to that hospital's Emergency Department.*

*Audit seems to imply that the Alfred ICU should be able to accommodate not only all patients presenting initially to the Alfred Hospital's Emergency Department, but all external patients requiring ICU facilities. Such implication has no place in an audit report, ignores rational health service planning, ignores efficient resource utilisation and ignores the organisation of critical care services Statewide.*

*Audit equally does not recognise that the current development of major hospital services, including ICU facilities, at Monash Medical Centre (Clayton), Dandenong and Frankston can be expected to reduce demand on the Alfred's services both in emergency and elective service areas.*

*No single hospital facility can cope with each and every period of peak demand. For audit to imply that this should be the case indicates that audit believes that the inefficient use of resources (which would occur during periods or normal or low demand) is acceptable solely so that all possible peak demands can be accommodated. Audit may not be aware that staffing an ICU facility is non-elastic. The skills of staff are interdependent and at a high level. Opening additional ICU beds at times of peak demand is not easy because such skilled staff are not readily available on a casual basis. The quantum of the ICU facility in any given hospital is thus determined using long-term demand estimates of average demand. It is also a matter determined largely by the hospital concerned, on the basis of clinical priority.*

*Audit reports senior medical staff advice that a number of patients were discharged from ICU earlier than desirable.*

*The decision as to whether a patient should, or should not be discharged from an ICU is a clinical one.*

*Data reported to HDV by the Alfred and contained in the CCECCS discussion paper indicates that in the 9 month period 1 July 1988 to 31 March 1989, the average length of stay of patients in ICU at the Alfred was 4.86 days. This compares with a statewide average of 3.61 days and with similar hospitals such as the Royal Melbourne (2.9 days), the Austin (2.2 days), St Vincent's (4.4 days) and Prince Henry's (4.75 days). While these figures differ, the average length of stay in the Alfred ICU is longer than any other metropolitan ICU. This may reflect the nature of patients and clinical care patterns, but should be taken into account in this matter.*

*Deferral of elective operations relates to "planned" patients. The Alfred has identified 19 such planned patients for whom an ICU bed was not available at a given time. Presumably the intended surgical procedure was deferred or a clinical judgement made to proceed with post-operative management in a ward environment.*

*Audit then comments that placement of critical patients in general ward areas could place stress on nurses not trained in intensive care.*

*This enters a clinical professional area addressed in the CCECCS Nursing Sub-Committee discussion paper, a separate report from the general CCECCS discussion paper. The gist of the matter is contained in the following:*

> *"The impact of ... (the development of high dependency and step-down units separate from general wards) ... can be a decreasing contact with critically ill patients, by registered nurses in medical/surgical wards. A consequent decrease in the opportunities for registered nurses to develop expertise in the care of critically ill patients then results, the registered nurse at times coming to regard that expertise as the province of critical-care qualified staff."*

*The issue of funding and the additional funding provided to the Alfred by HDV and TAC for critical care facilities has already been discussed.*

## Inter-hospital comparisons

### *Management response by Alfred Hospital*

*Comments on 3.1.83 to 3.1.90*

*Summary*

*The conclusions drawn from the data are wrong.*

*The conclusions are based on a simplistic and selective use of complex data.*

*No mention is made of the fact that the Alfred's total bed days are well within the error limits for total bed days based on State average figures.*

*This result is remarkable given that the Hospital has the highest DRG weight factor in the State. This means it is the most complex hospital in the State with a greater proportion of very sick complex patients. The DRG system is not particularly appropriate in that situation for assessing length of stay.*

*The State's most complex hospital should have many complex patients who should exceed the State LOS.*

*(1) DRG system*

*The DRG system is a complex system which attempts to facilitate comparisons between hospitals and patients.*

*The system is by no means simple or accurate, especially for major teaching hospitals.*

*One must understand the basic assumptions and how the data is derived before any valid conclusions can be drawn.*

*(2) Comments on the basic DRG system*

- *The Alfred currently uses the 4 000+ categories of the ICD-9 code to classify diagnosis. This code does not accurately represent all diagnoses.*
- *These 4 000+ categories are compressed into 469 Diagnostic Related Groups (DRGs).*

  *This compression means that data is lost in its true form and consequently there is a loss of specificity and comparability.*

  *The data is broad banded into very general categories.*
- *For a major acute hospital the coding system has many problems because patients present with a number of diagnoses, e.g. multi-trauma. The principal condition is the primary allocation factor to a DRG.*

  *This is not a precise method as the principal condition is defined as:*

  > *"that which used most resources or best justified the length of stay".*

  *This is hardly precision.*

(3) Comments on State average length of stay

*In any set of figures there are random sample errors, so that for any particular category the true mean (average length of stay) will always be between definable limits - not at a precise point - as is assumed in this report.*

*One needs to know the error limits for a set of data as these set the limits on the reproducability of a given set of data, e.g. a mean of 8+/- 1.2 means that if the measurements are repeated next year, a result within the range 6.8 - 9.2 would not be unexpected in 95 per cent of cases, but the figure would not necessarily be 8 again.*

*One needs to calculate the error limits at the 5 per cent probability level.*

*The table below shows the true situation for just 3 DRGs mentioned in Table 3M of the audit report. Figures for 1987-88 have been used as statistical data for 1988-89 is not yet available. The error limits have been calculated based on the 1987-88 data.*

| | 1988-89 | | 1987-88 | | |
|---|---|---|---|---|---|
| DRG No. | Average LOS Alfred | State LOS | State LOS | Standard error of mean | Error limits at 5% prob. level |
| 122 | 9.7 | 7.9 | 8.6 | +/-0.24 | 8.36 - 8.84 |
| 015 | 8.8 | 5.8 | 7.2 | +/- 0.8 | 6.4 - 8.0 |
| 297 | 9.7 | 6.2 | 7.5 | +/-1.12 | 6.4 - 8.6 |

*These figures suggest that for these categories the Alfred is slightly above the State's overall LOS limits. However, this is to be expected given the complexity of cases treated at the Hospital.*

(4) 30 highest DRGs

*Comment is made on the 30 highest DRGs and a table is given for the 10 medical and surgical DRGs.*

*This would tend to indicate that 762 additional patients could have been admitted if one assumes that all DRGs result in the State average length of stay occurring.*

Comments:

- *If the Hospital brings all DRGs to the State average, then in all probability bed days will be lost in total.*

Example:

*If one uses as a sample the top 10 medical and surgical DRGs where the LOS is greater than or less than the State average, the following situation occurs:*

| | Bed days |
|---|---|
| Top 10 greater that State LOS | 7 529 |
| Top 10 less than State LOS | (12 351) |
| Net gain/(loss) | (4 822) |

- *There are substantial errors implicit in comparing the Alfred with a State average for a DRG. The errors implicit in column 1 and 2 have been highlighted above in Section 2 and 3.*

- *The days in hospital are calculated by subtraction of dates.*

  *To talk about a difference of 0.8 days in this context, when the sampling error limits (DRG 140) above may be +/- 1 day is meaningless.*

(5) *Hospital total*

*The Hospital's total bed days are 170 492. The expected bed days based on the State averages are 168 733. This is well within the error limits for this figure.*

*Analysis of situation*

*The Hospital has analysed the situation in depth.*

*For any meaningful quantitative analysis to be done one needs:*

- *HCS grouping program to be the latest release;*
- *error limits should be calculated for all State and hospital data;*
- *validity of the Trimming algorithm should be examined in detail for hospitals with a high DRG weight; and*
- *resources be made available to conduct a meaningful detailed audit of at least 5 DRG codes at a State level.*

*Summary*

*DRG codes are a useful management tool but they do not have the precision that has been attributed to them in the audit report.*

## *Management response by Health Department Victoria*

*Cost performance data*

*Previously discussed has been the investment by HDV, via the Commonwealth Case-mix Program funds, in computer systems to accurately provide "clinical costing" information. The first continuous series of data arising from this investment will become available in the 1991-92 financial year. Such systems also generate DRG information, such as cost per DRG and length of stay per DRG for internal hospital management purposes.*

*Separately, Health Computing Services (HCS) has developed a new patient data system, the Patient Reporting System - 2nd version (PRS-2). PRS-2 will be implemented during the 1990-91 financial year. PRS-2 utilises data reported by hospitals to HCS as required by statute. This data is reported in a common format for all hospitals utilising common definitions of patient-related events as agreed after extensive consultation.*

*As of implementation, PRS-2 will enable data indicated by audit as desirable to be available on-line or to be down-loaded on a perlodic basis (as required) for analysis. Full costing data requires additional case-mix analysis software systems, of which several are available. This new facility will be Invaluable for management purposes - both centrally and in the hospital field - and for service planning.*

*HDV acknowledges that timeliness of data is an important attribute in determining the usefulness of such data. However, data systems useful for hospital and clinical management purposes, and the nature of the data itself, including DRGs, are in an evolutionary phase. As an example, there are currently approximately 9 different Diagnosis Related Group systems. These differ substantially in the number of categories of diagnosis, the nature such groups, i.e. the balance between individual diagnostic specificity and aggregation into useful grouped diagnostic entities; and the measurement of clinical acuity or complexity within any given diagnostic group.*

*Victoria is more advanced than other Australian States, with the possible exception of South Australia, in developing clinical and management data systems.*

*The timeliness and accuracy of data, however, is dependent above all else on the timeliness with which hospitals provide coded diagnostic data to HCS. Lags occur for a number of reasons, especially the rapidity or otherwise with which medical staff complete discharge summaries following a patient "admission" event. At the current time, coded data completion rates rise above 90 per cent only after an average interval of 3 months, prior to which time data is progressively less complete, therefore less accurate for management purposes.*

*The introduction of PRS-2 (and clinical costing systems internal to hospitals) will have the additional benefit of substantially improving this lag because early collection of data will have a significant benefit to hospitals and clinicians.*

*Length of stay*

*Audit comment on differences in length of stay between certain patient groups at the Alfred, compared with State averages (using current Victorian standard DRGs) is acknowledged.*

*This kind of information is exactly the sort of information which will become available with the implementation of the PRS-2 system.*

*Audit calculations regarding potentially available bed days must be qualified, however, as acknowledged by audit, DRGs are aggregate diagnostic categories and are poor at designating clinical complexity or actuity.*

*Nonetheless, local management analysis, naturally including consultation with relevant providers, is to be encouraged.*

## Visiting medical officers

### *Management response by Alfred Hospital*

*Comments on 3.1.91 to 3.1.100*

*Recording the name of the patient and the service given would be a totally impractical concept and would not be capable of easy validation but more importantly it flies in the face of the definition of sessional payment and the conditions pertaining to it. Such an action would provoke industrial disputation if extra conditions were unilaterally introduced by the Hospital for sessional payment.*

*The audit recommendation for the Hospital, on an annual basis, to assess the adequacy of the sessional allocation to each unit to ensure that the allocations equate with patient demand is what the Hospital has always done, apart from the temporary interruption after 1988 because of amalgamation. Sessional allocation is again formally under review (e.g. Division of Medicine).*

*All aspects of a unit's work including the nature of the patients dealt with, will continue to be considered. It is certain that many members of the visiting staff give more time than they are remunerated for. Quality assurance activities and meetings have either been taken up in existing sessional time, or have been attended without additional remuneration for visiting medical staff.*

*It is the Hospital's opinion that a detailed examination of the sessions currently paid to visiting medical staff balanced against all the activities carried out by visiting medical staff would highlight the fact that the majority of visiting staff are generous in their support of the public health system. This fact should be recognised by all concerned.*

*Comments on 3.1.101 to 3.1.106*

*Management does monitor on-call allocations through the Head of the Unit concerned.*

*The Hospital agrees that there is a need to develop management information systems to monitor the cost-efficiency of numerous services. As has been mentioned previously, this has been recognised by the Board and Management.*

*That is why the Hospital has allocated its money to upgrade the computer. However, there are numerous projects with higher priority.*

*Comments on 3.1.107 to 3.1.111*

*These comments are based on Table 3N. Hence it is necessary to comment on that analysis.*

- *Table 3N only shows what on-call payments were made and what re-call payments were claimed from the Hospital.*

  *It does not show what re-call actually occurred.*

  *This analysis is based on the assumption that all doctors claim for all re-call on the Hospital.*

  *This does not occur.*

- *The regulations regarding the treatment of private patients when on re-call specify that no re-call payment will be sought from the Hospital for the treatment of private patients, only "Hospital" patients can be claimed and the claim sheet must specify the UR number, name and diagnosis of all patients claimed for.*

  *Private patients includes all compensable patients, e.g. TAC, WorkCare, Veterans Affairs etc.*

  *Hence, all re-calls for all car accidents (TAC) will not be claimed. Quite correctly the orthopaedic claims are low.*

- *"Consultative on-call" means precisely that - Consultation and Advice. They are only required to be within telephone availability. The Hospital has registrars who ring and in many cases are told to "consult" the doctor on-call. The Hospital provides access to such on-call advice, which often avoids the necessity for re-call and additional expense.*

- *The majority of units listed under exclusive on-call are associated with Trauma, hence little record in the Hospital's payroll records.*

- *In many cases if a doctor comes in they will not claim especially if they see 2 patients, one of whom is compensable.*

*As has been said previously the great majority of doctors are very generous with their support of the public health system. There is little doubt that if all valid activities were claimed for, the finances required by the Hospital would increase.*

*Comment on 3.1.112*

*The need for the Alfred to review on-call arrangements is unsupported speculation.*

*We assume the report means "on-call sessional allocation" not on-call rosters. What the Hospital has with on-call payments is the "fire brigade situation". If there are no fires then an argument can be made out that the community is wasting money having firemen and expensive equipment sitting around doing nothing.*

*The community expects the Alfred to have access to specialised services.*

*As was stated previously, this examination has always been done, but has not occurred recently as a result of amalgamation and re-organisation of medical units.*

*These have commenced again in the Division of Medicine.*

*Information on payments tells the Hospital little. Information is needed on activity and this will be difficult to obtain without resources.*

*The practice of networking has been examined before. It is not feasible for exclusive on-call and there are many practical difficulties for consultative on-call, e.g. how does the consulting doctor know the level of experience and competence of the phoning registrar.*

## *Management response by Health Department Victoria*

*Audit appears to misunderstand the nature of sessional payments.*

*Sessions are time-based, rather than individual patient service related. It is for the Hospital management structure, ultimately extending to the individual medical, surgical or other unit level, to determine the need for such time periods of medical service.*

*Audit opinion that sessional medical officers should be required to provide detail of each patient seen and for what purpose, during each session of work performed needs further examination. This is for 3 reasons:*

- *A session is time, not individual fee-for-service based. In a surgical operating session, perhaps 2 to 5 patients will be serviced. In an outpatient session, perhaps 10 to 20 patients will be serviced. During a ward round, up to 30 or more patients may be serviced. Documenting each service, other than as currently occurs by annotation in the medical record, would be administratively burdensome and may have little, if any, productive outcome.*
- *Sessional allocations are most commonly allocated on an annual basis, taking account of "average" patient service demands. Marked variability may occur at any given time but, on balance, the payment system is regarded as fair and equitable; and*
- *If hospitals wish to employ doctors on a fee-for-service basis, they can do so, but under entirely different industrial arrangements.*

*HDV understands that the Alfred Hospital "does" review sessional allocations annually, in close consultation with medical staff.*

*Audit comments regarding management monitoring of on-call and re-call payments are noted.*

*It should be pointed out, however, that medical staff at many hospitals frequently provide services which, are strictly speaking, outside of allocated sessional periods, but for which they do not claim additional payment. This flexibility has always been a part of sessional employment arrangements and is generally accepted by all parties as representing a good flexible management approach.*

*Audit recommendations in this area, together with recommendations pertaining to sessional allocations per se, could rigidify the employment of doctors and result in "increased" rather than "decreased" cost and reduce time available for clinical services.*

*Audit comment regarding the appropriateness of on-call payments to Alfred specialist doctors is noted.*

*HDV understands that, as for sessional allocations, Alfred annually reviews on-call arrangements.*

*In general terms, audit comment on on-call/re-call costs are somewhat misdirected. While acknowledging that efficient and effective use of resources is paramount, a major specialist hospital like the Alfred must have a number of specialists virtually immediately available to provide services for a diverse set of possible medical and surgical conditions.*

*This situation is analagous to the staffing of fire brigades or the maintenance of peace time armies.*

*HDV believes that the Alfred is attentive to resource efficiency and does appropriately review all such arrangements. Such review does take account of demand, but also the need to ensure that highly specialised services are available to provide care for virtually all medical and surgical conditions.*

*Audit comment regarding "networking" is noted. This concept could only be considered having regard to the matters discussed in the previous 3 paragraphs of this commentary. In fact the on-call category "exclusive" specifically disallows doctors from working elsewhere during the on-call period so described. This is to ensure immediate availability if necessary.*

## Discharge policies and allocation of beds to inpatients

### *Management response by Alfred Hospital*

*Comments on 3.1.120 to 3.1.124*

*The Hospital is aware that discharging patients at short notice places pressures on the system to undertake the discharge procedures and there is a need to ensure that medical staff comply with the agreed policy.*

*However, it should be pointed out that previously in this Report it has been stressed that the Hospital should be concerned about the length of stay which is currently about 6.8 days. Twenty-four hours notice is equivalent to 15 per cent of the length of stay which is 25 000 bed days.*

*The Hospital concurs that the medical staff should comply with the agreed policy and that the Admissions and Discharge Policy should reflect the Government's concern with length of stay.*

*Comment on 3.1.125*

*The Hospital acknowledges that computer systems have an important role to play within the Hospital. This is why it is currently spending $2.6 million of its own scarce financial resources to replace the existing computer system.*

*The Hospital intends to summarise all of audit's comments on computer systems and seek appropriate funding from HDV.*

*Comment on 3.1.126*

*Once resources are available the Hospital intends to develop a comprehensive bed management system.*

### *Management response by Health Department Victoria*

*Audit comment in this section is generally supported by HDV.*

*These are matters internal to the Hospital. The provision of additional ward computer terminals is a matter for funding priority within the Hospital's capital works program. The Hospital may wish to raise this matter during budget negotiations with the South Eastern Metropolitan Region.*

## Outpatients

### *Management response by Alfred Hospital*

*Comments on 3.1.128 to 3.1.131*

*The Hospital agrees that the failure of certain outpatients to attend is a problem, but it is fundamentally a problem of patients, not of the Hospital.*

*The failure to attend is a problem. No attempt has been made by the audit to show that the costs associated with any unplanned under-utilisation are significant. This is a world-wide problem and a review of current literature has not provided any useful solutions.*

*Comment on 3.1.132*

*A computerised booking system in Outpatients would be of assistance. However, the Hospital must point out that at this stage there is a substantial number of higher priority systems projects in the queue for the scarce resources that are available.*

*Comment on 3.1.133 to 3.1.135*

*The establishment of a central appliance distribution centre remains a priority for reallocation of resources in the immediate future.*

### *Management response by Health Department Victoria*

*Audit comment in this section is generally supported by HDV.*

*Any capital requirements resulting from consideration of these matters is a matter for funding priority within the Hospital's capital works program.*

# PART 4

# PROPERTY MANAGEMENT

- AUDIT REVIEW
- MANAGEMENT RESPONSES

# 4.1

# PROPERTY MANAGEMENT

## - AUDIT REVIEW

### KEY FINDINGS

- The Alfred did not have a strategic plan for the use of its properties and had not formulated policies for the management of its property holdings. *paras 4.1.5 to 4.1.7*

- Properties valued in excess of $29 million, which occupied 25 per cent of the Hospital's land holdings, had predominantly not been used for hospital purposes. As a result, scarce hospital resources had not been utilised effectively. *paras 4.1.8 to 4.1.15*

  In particular:

  - Audit questions whether the ownership of the Chevron Hotel (land value of $23.5 million) assists the Hospital in carrying out its primary objective relating to patient care, teaching and research. *para 4.1.13*

  - Fawkner Mansions, which previously provided accommodation to 80 nurses, was closed in October 1987. This property, which is valued at $1.2 million, had not provided any financial return to the Hospital since that date. *para 4.1.16*

  - Two properties located in Prahran and valued in excess of $350 000 had been occupied by squatters since 1985. If these properties had been refurbished, the potential rental loss over the past 5 years would be in excess of $60 000. *para 4.1.17*

  - Nine vacant lots also located in Prahran, had not been used effectively since their progressive purchase which commenced in 1959. *para 4.1.18*

  - Three properties located in Prahran and valued at approximately $750 000 were let at rates substantially below commercial rates, resulting in the non-collection of at least $45 000 in rental income. *paras 4.1.20 to 4.1.21*

  - Full cost recovery in respect of services provided to external bodies was not occurring in all cases, resulting in annual income foregone of at least $100 000. *paras 4.1.22 to 4.1.26*

## BACKGROUND

**4.1.1** The Alfred Campus comprises a number of different types of facilities. Apart from providing extensive patient care accommodation, a number of other facilities are also located at the Campus, namely:

- residences for nurses and resident medical officers;
- Monash Medical School;
- Baker Medical Research Institute;
- Coonara House Private Hospital; and
- Hamilton Russell House (caters predominantly for private patients).

**4.1.2** In addition, the Hospital owns the Chevron Hotel (including Alfred House) and a portfolio of rental and other properties, 25 of which are located in Prahran and 2 in East Melbourne. These properties are valued at approximately $29 million. For details refer to Appendix 4A.

**4.1.3** The 25 properties located in the block bounded by Punt Road, Commercial Road, Alfred Street and Athol Street, Prahran have been purchased progressively since 1959 with a view to redeveloping this area as a car park to cater for the Hospital's ongoing expansion of facilities (refer to Appendix 4B). At the date of audit, a number of proposals outlining various options for car parking were still under consideration by the Hospital.

## AUDIT OBJECTIVES

**4.1.4** The audit objectives were to review management procedures relating to the management of Hospital property holdings to determine whether policies and procedures had been formulated which promote the efficient and effective management of properties, namely:

- there is measurement, maximisation and prediction of property utilisation;
- alternatives to current property operations are evaluated;
- services provided from Hospital resources (e.g. staffing, engineering, power and lighting) for use by academic, research and other agencies operating on Campus premises are identified, costed and recouped;
- residential facilities are adequately maintained and secured; and
- a comprehensive listing is maintained of all Hospital properties and associated details.

## AUDIT OBSERVATIONS AND RECOMMENDATIONS

### Policies - Hospital property holdings

**4.1.5** In December 1983 the former Health Commission of Victoria issued a central policy for the management of hospital property holdings owned, operated or controlled by publicly-funded institutions. The policy, in requiring institutions to make the most effective and economic use of their property holdings, prescribed a number of principles to be applied by hospitals for managing their property holdings.

**4.1.6** Although a comprehensive central policy document on property management was in place, the Hospital had not developed a strategic plan for the use of its properties and had not formulated policy guidelines for the management of its properties. For example, terms and conditions had not been formally prescribed for the occupancy of Hospital residences by nurses and resident medical officers. In addition, a policy addressing goods and services provided to occupants of hospital properties by the Hospital such as equipment, hotel services, security, maintenance and administrative services had not been formulated. The absence of operational policies at a hospital level has contributed to the Hospital not achieving the most effective and economic use of buildings owned, operated and controlled by the Hospital. Further details are contained in subsequent paragraphs of this report.

**4.1.7 The development of a strategic plan for the economic and effective management of its property portfolio, which takes account of government policy directives of December 1983, is long overdue.**

### Ineffective and uneconomic utilisation of Hospital property holdings

**4.1.8** The main thrust of the circular on hospital property holdings issued by the former Health Commission of Victoria in 1983 was that public hospitals should comply with government policy which required publicly-funded institutions to make the most effective and economic use of buildings owned, operated or controlled by them.

**4.1.9** Instances where Hospital properties were not used in the most effective and economic manner are detailed below:

*Retention of properties in excess of Hospital requirements*

**4.1.10 Properties valued in excess of $29 million, which occupied 25 per cent of the Hospital's land holdings, had predominantly not been used for hospital purposes. These properties comprise:**

- **the Chevron Hotel;**
- **2 properties located in East Melbourne; and**
- **25 properties located in the block bounded by Punt Road, Commercial Road, Alfred Street and Athol Street, Prahran which have been purchased progressively since 1959 with a view to redeveloping this area as a car park.**

(Refer to Appendix 4B for relevant details.)

**4.1.11 As a result, scarce hospital resources had not been utilised effectively with the opportunity cost foregone to the Hospital being in excess of $4 million per annum. This does not take into account capital gains, if any, occurring during the period.**

**4.1.12** Consideration had not been given to the Government's recently implemented policy of selling surplus assets to finance investment in new capital works throughout the State.

**4.1.13** The Hospital purchased the Chevron Hotel in June 1976 for $3.6 million (land value of $23.5 million at March 1989) primarily as a means of providing staff accommodation in the Alfred House quarters of the property. Approximately $687 000 was generated as rental income during 1988-89. **Audit questions whether the ownership of the hotel assists the Alfred in carrying out its primary objectives relating to patient care, teaching and research.**

*Chevron Hotel, owned by the Alfred Hospital since 1976.*

**4.1.14** Two properties located in Vale Street, East Melbourne, valued at $500 000 and $450 000, respectively, were not used for hospital purposes although one property is currently occupied by a senior member of the Alfred for $200 per annum after taking into account a rent subsidy of $10 000 as part of his salary package.

*Property in Vale Street, East Melbourne, valued at approximately $500 000 in October 1988.*

**4.1.15 In view of the intense pressures on the public hospital system due to the rapid growth in the number of inpatients treated, technological advances and growing needs in areas such as transplants and cancer services, it is imperative that resources are managed in the most efficient and effective manner. In this context, it is recommended that the Hospital critically review its property holdings and consider disposing of properties which are in excess of its requirements.**

*Certain properties were either vacant or occupied by squatters*

**4.1.16** Fawkner Mansions (valued at approximately $1.2 million at September 1989), which provided accommodation to 80 nursing staff, was closed in October 1987 as it was operating at a deficit of approximately $90 000 per annum. After 2½ years, the Hospital has still not determined its future use.

*Fawkner Mansions, ceased providing nursing staff accommodation in 1987.*

**4.1.17** Two hospital rental properties located in Alfred Street, Prahran and valued at approximately $351 000 in September 1989, which formed part of the potential car parking development, had been occupied by squatters since at least January 1985. If these properties had been refurbished, the potential rental loss over 5 years would have been in excess of $60 000.

*Hospital property occupied by squatters.*

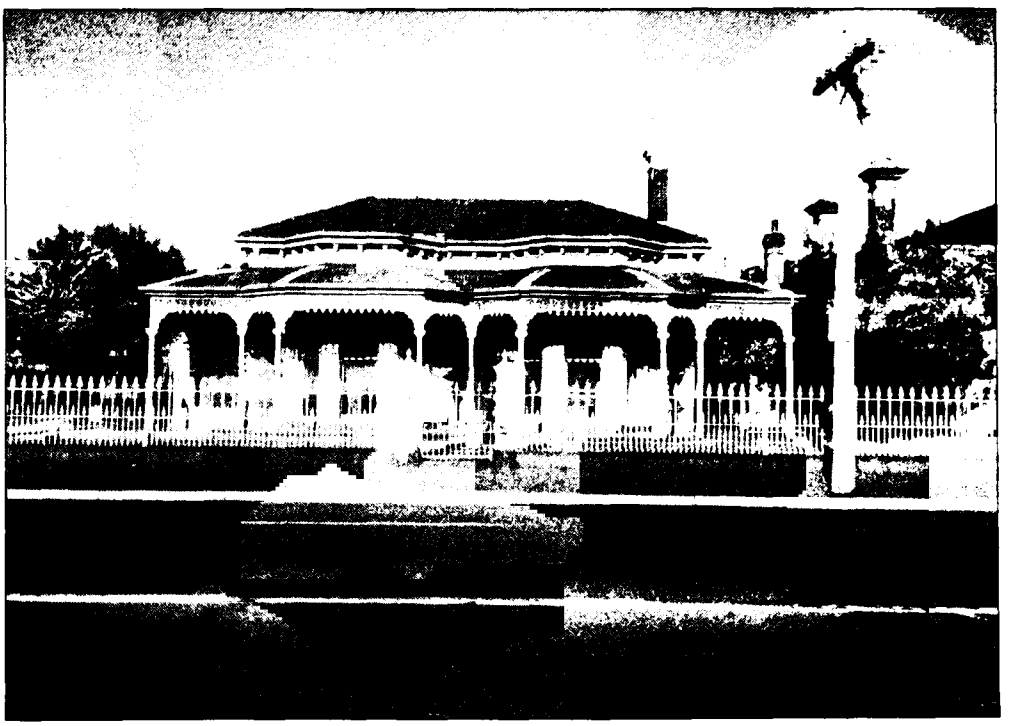
**4.1.18** Since 1959 the Alfred acquired 6 vacant blocks of land in Punt Road, Prahran (total purchase price of $197 000) which were predominantly used for car parking by student nurses at no charge (these properties were not valued due to the Roads Corporation road widening proposal), and 3 vacant blocks of land in Alfred Street, 2 of which are used for car parking.

**4.1.19 In order to achieve economy of operations and enable properties to be utilised in an efficient and effective manner, the Hospital should assess the options for the future use of Fawkner Mansions and the Hospital properties occupied by squatters, and the costs and benefits associated with these options. There is also a need to assess whether charges need to be levied for all car parking.**

*Failure to charge market rates for all rental properties and failure to review rents annually*

**4.1.20** The audit review revealed that, contrary to the former Health Commission policy of 1983, certain properties had not been rented at commercial rates and rents had not been reviewed annually. **As a consequence, the Hospital has failed to collect at least $45 000 in rental income in recent years.** Detailed comments relating to these matters are listed below:

- In July 1982, the Hospital purchased a property located in Punt Road, Prahran for $95 700 (valued at approximately $360 000 at September 1989). At that time, the Hospital informed the previous owner that occupancy of the property could be retained until the site was required for development purposes and subject to determination of an appropriate rental. **Audit noted that the previous owner had not been charged rent for 2 years subsequent to the purchase and had been charged $50 per week in rent since 1984 whereas commercial rental in recent times would be in the order of $170 per week if certain maintenance works were carried out.** Despite the Hospital's real estate agents recommending in July 1987 that the rent be increased, this advice was not acted upon until September 1989 when the rent was increased to $60 per week. In addition, correspondence examined by audit indicated that the previous owner was sub-letting rooms in February 1989, a practice which was apparently in operation at the time of purchase in 1982;



*Property in Prahran valued at $360 000 at September 1989 which has been rented for $50 per week since 1984.*

- The Hospital owns a block of 4 flats in Alfred Street, Prahran. One of the flats is tenanted by an employee of the Alfred. There is no specific requirement for this employee to live in a hospital residence. **Audit inquiries indicated that the hospital employee had been charged $43 per week rent from November 1981 to September 1988 whereas the rent for the other 3 flats reflected market rentals (average rent of $92 at September 1988).** In July 1987 the Hospital's real estate agents informed the Alfred that the rental of the flat occupied by the employee of the Hospital had not been reviewed since April 1982 and the rent needed to be increased to a level commensurate with the other flats. It was not until September 1988 that the Hospital regularly reviewed and adjusted the rent to reflect commercial rates; and

- A property located in Commercial Road, Prahran was purchased by the Hospital in August 1978 for $60 000. The property was valued at about $270 000 in September 1989. According to the September 1988 report on hospital properties prepared by the Hospital's real estate agents, this property was being held vacant for future use by the Office of Psychiatric Services, HDV. Audit inquiries revealed that the services to this property were removed in December 1986 to discourage squatters. As this property had been vacant since that date **the Hospital determined that, as a temporary measure, it would be advisable to rent the property to a relative of a senior member of the Hospital's medical staff in May 1989 as a painting studio for $15 per week, rather than it remaining vacant.**

*Property valued at $270 000 (September 1989) vacant from at least December 1986 to May 1989.*

**4.1.21 If the Hospital regards these properties as not being in excess of its needs the Hospital should review rental levels with a view to bringing rentals into line with commercial rates as soon as is practicable under existing tenancy agreements. In addition, the Hospital should institute a practice whereby all rentals are reviewed on a frequent basis and, where appropriate, adjusted on an annual basis to maintain parity with prevailing commercial rates.**

*Full cost recovery not occurring in all cases*

**4.1.22** Management information systems disclosing timely information in relation to costs incurred by the Hospital for each hospital residence and non-hospital facility such as power and lighting had not been developed. As an illustration the Engineering and Building Services Department did not maintain separate records and costings of maintenance performed on non-hospital facilities. As a consequence management was not in a position to ensure that adequate cost recovery procedures were in place.

**4.1.23** Examples of the Hospital not fully recouping costs in respect of services provided to external bodies are listed below:

*Baker Medical Research Institute*

**4.1.24** Although the Institute was charged an annual fee for the supply of steam, the disposal of refuse and payroll processing by the Alfred, costs were not recovered in relation to the following:

- Rent for occupancy of hospital buildings;
- The provision of 1.5 effective full-time tradespersons to undertake minor maintenance (approximately $34 000 per annum) and the use of 2 cleaners and cleaning materials (about $58 000 per annum). Under the governing lease agreement the Institute is required to repair, maintain and clean the premises rather than the Hospital providing these services; and
- Services supplied by the Engineering and Building Services Department for:
  - major maintenance works such as plumbing and consultancy services involved in the construction of the Risk Evaluation Centre;
  - monitoring of security and mechanical/electrical failure after normal hours; and
  - providing guaranteed standby power for light and power.

*Monash Medical School*

**4.1.25** While the Medical School meets the costs of maintenance works, costs were not recovered by the Alfred in relation to consultancy services provided by its engineers on projects such as alterations to the fourth floor and the use of the Alfred incinerator for the disposal of refuse.

**4.1.26 The Alfred's relationships with the Baker Medical Research Institute and Monash Medical School are both longstanding and of considerable value to the Alfred. Nevertheless, in the interests of identifying the full cost of operating these external bodies and its impact on the Hospital's ability to make sound economic decisions, the Hospital should reassess its practice of not recovering costs incurred in respect of providing services to these organisations. A policy of not fully recovering costs, if considered desirable by the Hospital, should be explicitly addressed in any lease agreement.**

**Lack of comprehensive information on property holdings**

**4.1.27** The Finance Department of the Hospital keeps a listing of properties and their respective purchase prices. Information concerning original purchase details, maintenance, revaluations and tenancy particulars are included in individual property files.

**4.1.28 Audit observed that the Hospital did not maintain comprehensive information of its property holdings. The establishment of a detailed register of property holdings and tenancy information would aid management in its role of making informed decisions on property use.**

**APPENDIX 4A**

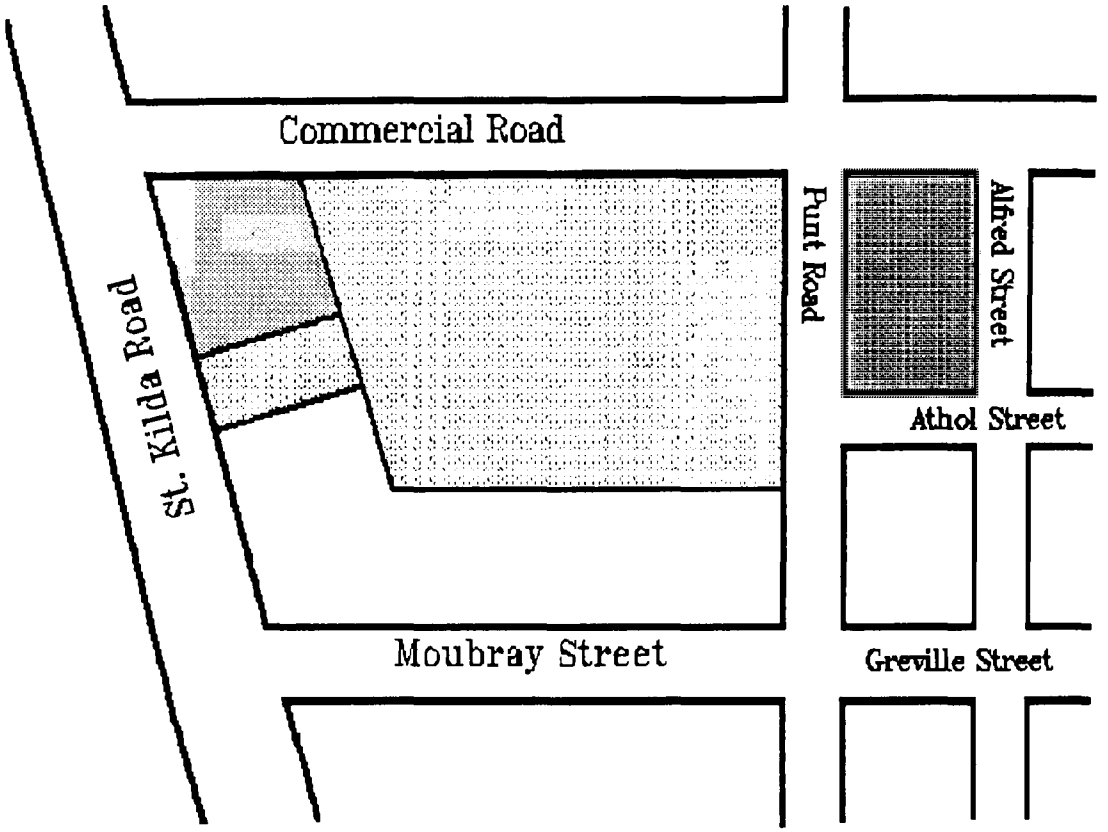
## ALFRED HOSPITAL PROPERTY HOLDINGS, VALUATIONS

| *Address* | *Purchase price* | *Date of independent valuation(a)* | *Valuation* | *Current valuation (9/89)* |
|---|---|---|---|---|
| | ($) | | ($) | ($) |
| Chevron Hotel (land value) | 3 600 000 | 3/1989 | 23 500 000 | *(b)* 23 500 000 |
| Fawkner Mansions - Punt Road Prahran | 219 000 | 4/1987 | 650 000 | *(c)* 1 170 000 |
| ..Vale Street East Melbourne | 34 000 | 10/1988 | 500 000 | *(d)* 500 000 |
| ..Vale Street East Melbourne | | 10/1988 | 450 000 | *(d)* 450 000 |
| ..Punt Road Prahran | 104 000 | 4/1987 | 200 000 | *(c)* 360 000 |
| ..Punt Road Prahran | 16 000 | 4/1987 | 130 000 | *(c)* 234 000 |
| ..Punt Road Prahran | 10 000 | 4/1987 | 80 000 | *(c)* 144 000 |
| ..Punt Road Prahran | 140 000 | 4/1987 | 155 000 | *(c)* 279 000 |
| ..Punt Road Prahran (Vacant land) | | *(e)* | *(e)* | *(e)* |
| ..Punt Road Prahran (Vacant land) | | *(e)* | *(e)* | *(e)* |
| ..Punt Road Prahran (Vacant land) | 97 000 | *(e)* | *(e)* | *(e)* |
| ..Punt Road Prahran (Vacant land) | 8 000 | *(e)* | *(e)* | *(e)* |
| ..Punt Road Prahran (Vacant land) | 5 000 | *(e)* | *(e)* | *(e)* |
| ..Punt Road Prahran (Vacant land) | 7 000 | *(e)* | *(e)* | *(e)* |
| ..Alfred Street Prahran (Vacant land) | 23 000 | *(b)* | *(b)* | *(b)* |
| ..Alfred Street Prahran (Vacant land) | 9 000 | 4/1987 | 80 000 | *(c)* 144 000 |
| ..Alfred Street Prahran | 14 000 | 4/1987 | 75 000 | *(c)* 135 000 |
| ..Alfred Street Prahran | 14 000 | 4/1987 | 75 000 | *(c)* 135 000 |
| ..Alfred Street Prahran | 13 000 | 4/1987 | 75 000 | *(c)* 135 000 |
| ..Alfred Street Prahran | 15 000 | 4/1987 | 75 000 | *(c)* 135 000 |
| ..Alfred Street Prahran (Vacant land) | 13 000 | 4/1987 | 80 000 | *(c)* 144 000 |
| ..Alfred Street Prahran | 9 000 | 4/1987 | 120 000 | *(c)* 216 000 |
| ..Alfred Street Prahran | 32 000 | 4/1987 | 100 000 | *(c)* 180 000 |
| ..Alfred Street Prahran | 45 000 | 4/1987 | 250 000 | *(c)* 450 000 |
| ..Commercial Road Prahran | 60 000 | 4/1987 | 77 000 | *(c)* 138 000 |
| ..Commercial Road Prahran | | 4/1987 | 77 500 | *(c)* 140 000 |
| ..Commercial Road Prahran | 74 000 | 4/1987 | 150 000 | *(c)* 270 000 |
| ..Commercial Road Prahran | 130 000 | 4/1987 | 200 000 | *(c)* 360 000 |
| **Total** | **4 691 000** | | **27 099 500** | **29 219 000** |

*(a)* Valuation of properties provided by real estate agents.
*(b)* No valuation obtained.
*(c)* According to information received from real estate agents the value of properties in Prahran have doubled since the April 1987 valuation. In order to disclose current values for these properties, audit in September 1989, applied an increment of 80 per cent to allow for the poor condition of some of these properties.
*(d)* Audit was advised by a firm of real estate agents located in East Melbourne that over the past year property values in East Melbourne have remained relatively constant.
*(e)* These properties were not valued due to the Roads Corporation (Vic Roads) road widening proposal.

**APPENDIX 4B**

## ALFRED HOSPITAL CAMPUS AND SURROUNDING AREA




Alfred Campus.

North
West
East
South

Chevron Hotel/Alfred House.

Properties predominantly not used for hospital purposes.

Punt Road and Alfred Street properties, the majority of which are owned by the Alfred Hospital.

# 4.2

# PROPERTY MANAGEMENT

## - MANAGEMENT RESPONSES

### Management response by Alfred Hospital

*Policies - Hospital Property Holdings*

*Comments on 4.1.5 - 4.1.7*

Overview

*There is no question that past property management performance at the Hospital has been inadequate.*

*This report, however, did not bring to light any observations which were not known to the Hospital or which are not being acted upon in some manner.*

*We are disappointed that there is no acknowledgement of the positive steps taken by the Hospital.*

*Events have overtaken this section of the report and it highlights the matters raised in the President's letter to the Auditor-General in February, 1989:*

> *"You will be aware that the Hospitals were amalgamated in November 1987 and the present Chief Executive took up his appointment in May 1988. From then onwards numerous problems in the way the Hospital has previously been managed have come to light, which we are currently trying to address. I believe that we are heading in the right direction and that management practices and utilisation of resources will be substantially improved in the next 12 - 18 months. Currently, a significant number of Hospital policies and procedures are in the process of undergoing change or are about to do so. From every viewpoint, the type of "efficiency" audit that you have in mind will provide both us and the Victorian community with better feedback, if it were deferred for 12 - 18 months, till 1990."*

*Action taken*

- *Soon after the new Hospital Group was formed the Board requested that a review of all capital resources and saleable properties be undertaken. This request led to a full financial analysis of all property during late 1988 and early 1989.*
- *It was apparent to the new Board and new Group Chief Executive that whilst the previous organisation had stressed Health Service excellence little attention had been paid to management infrastructure.*

*A new organisation that recognised these deficiencies was proposed to the Board and accepted. This organisation created a new Group Division of Facilities and Supply reporting directly to the Group Chief Executive. Properties very clearly became the responsibility of the Group Director of Facilities and Supply who took up his position in August/September 1989. Since that time the following has occurred:*

- *New financial recording and reporting procedures commenced in October 1989.*
- *A property/commercial manager was appointed in January 1990.*
- *All rents and properties have been reviewed since then.*
- *The Hospital now manages its property portfolio, not an external agent.*

*Properties*

*The Alfred's major non-crown land properties are:*

- *Punt Road Properties;*
- *Chevron Hotel; and*
- *Vale Street Properties.*

*The Punt Road Properties have been associated with a conscious decision to provide adequate car parking facilities at the Hospital where a severe problem exists. The Board minutes show a direct correlation between the acquisition of properties and the provision of car parking.*

*The Health Department Victoria and the Hospitals and Charities Commission before it were also aware of the Board's desire to provide adequate car parking.*

*The Alfred House (residential) section of the Chevron is currently an integral part of the Hospital services to Medical Staff who are required to live in and patients. Patients' relatives from the country who have limited means are also accommodated there. These people could not be located anywhere else on the Hospital Campus at present. It is certainly the intention of the Hospital that the Chevron site be either sold or redeveloped and this will be resolved when an overall strategic site plan has been developed.*

*Vale Street Properties - There is no disagreement that these properties should be sold. The timing of sale will be influenced by the state of the property market.*

*Strategic Plan*

*A decision on how the car parking problem will be resolved is necessary before an overall strategic plan can be developed for properties.*

*The Hospital has been developing a strategic parking plan over the last six - twelve months to help bring to finality a problem which has been under consideration for about 10 years. If the problem were simple it would have been solved. It is expected that this strategic plan will be available in the near future; it should enable a considerable number of property issues to be resolved.*

*As a result of a review of properties in 1988 the Board decided to "defer selling properties to offset deficits as it could be discovered later that they could be used more effectively".*

*The inference was that a strategy was needed to avoid short term gain at long term expense. It was believed that to tackle major issues prematurely would be counter productive to long term effectiveness. The restructuring of the newly amalgamated Hospital was the number one priority at that time.*

*Partially as a result of this decision, a full financial analysis of all properties was done. The report on this highlighted the fact that there was nobody with clear cut responsibility for them. There is no reference to this report in the Auditor-General's Report.*

*The development of an accounting system that would provide accurate information about all properties was a high priority. This would allow the establishment of cost centres to monitor and match all revenues and costs for a particular property and is now in existence. This is of particular relevance to external cost centres such as the Baker Medical Research Institute, Monash Medical School and properties.*

## *Ineffective and Uneconomic Utilisation of Hospital Property Holdings*

*Comments on 4.1.9 to 4.1.10*

- *The properties have been used for Hospital purposes with the exception of the 2 properties in East Melbourne.*
- *The properties with the exception of the East Melbourne properties are not in excess of Hospital requirements. No evidence is presented by Audit to justify this statement.*

*Comments on 4.1.11*

*Opportunity cost represents contributions foregone by rejecting the next best alternative.*

*Audit appears to suggest that the alternative is to sell the properties and invest the money. This is only a viable alternative for one group of properties - the 2 properties in East Melbourne. It is not an alternative for either the Chevron or the Punt Road Properties which were purchased for strategic reasons.*

*To suggest that management should not make strategic decisions is by implication to suggest that management should only focus on the short term. It is not a valid use of the concept of opportunity costing to compare long term strategic decisions with short term investment decisions.*

*The Hospital purchased the Punt Road properties because of the strategic necessity for parking and the Chevron because of the strategic necessity for room to move and the fact that at that time accommodation was needed. The importance of the Chevron will increase with the opening of the new Cancer Centre.*

*Comments on 4.1.12 to 4.1.14*

- *Wrong: The Hospital has considered selling surplus assets.*
- *On current planning, the ownership of the Chevron will definitely assist patient care, teaching and research in the longer term.*
- *We have previously stated that the East Melbourne properties will be sold.*

*Comments on 4.1.15 to 4.1.19*

*See also comments on 4.1.5 - 4.1.7.*

- *The Hospital has considered the future use of Fawkner Mansions in great detail.*
- *With regard to other Punt Road Properties, the then managing Real Estate Agent, in a letter of 19 October, 1988 made specific reference to:*
    - *the poor condition of the dwellings at the date of purchase.*
    - *the cost of bringing them up to an acceptable standard for leasing.*
    - *the significant objections from the Prahran Residents Group.*
    - *why squatters were not evicted.*

*The Hospital decided that any increase in rental revenue would not cover the cost of repairs ($250 000) as estimated by the Agent. In particular, Fawkner Mansions could only be used for Hospital purposes once considerable expense had occurred to renovate the property. Since the building stands on land zoned for future road widening this outlay would seem unwarranted.*

*Charges are not levied for car parking on the vacant sites since we are not in a position to provide any form of security, parking attendants, etc. This concept is being reviewed as part of the overall parking strategy.*

## *Failure to Charge Market Rates for all Rental Properties and Failure to Review Rents Annually*

*Comments on 4.1.20*

- *No details are provided on the statement:*

  *"has failed to collect at least $45 000".*

- *Punt Road Property*
  - *It was a condition of the sale that no rent be charged for 2 years.*
  - *Rent has now been reviewed and the property is currently being vacated. Once vacant it will then be re-let.*
- *Flats*

  *The rent has been reviewed and increased.*
- *Commercial Road Property*
  - *The property is vacant.*
  - *Services have been disconnected and there is no bathroom.*
  - *As a measure to give some presence and reduce vandalism and other problems, portion has been rented out as a painting studio.*

*Comments on 4.1.21*

*A property manager has been appointed to manage this area. It is acknowledged that rentals have been low in the past, but in many cases it has been because of uncertainty concerning future site development and the Hospital's desire not to expend money on improvements until the process was decided.*

*Rents have been increased over the last 12 months and will be reviewed again when plans are agreed. In the meantime it is the opinion of our Property Manager that rents are currently at market levels on those properties that are habitable. Future rent increases would require expenditure first on improvements by the Hospital. Steps will be taken to demolish those that are not habitable, in due course.*

*Comments on 4.1.22 to 4.1.26*

*The work of these bodies (Baker Medical Research Institute and the Monash Medical School) is inter-related with that of the Hospital.*

*The role of the Baker Institute in regard to cardiovascular disease, i.e.*

- *to perform clinical cardiovascular research of the highest level by international standards;*
- *to provide a clinical and consultative service specialising primarily in hypertension, hyperlipidaemia and prevention of cardiovascular disease;*
- *to train graduates in clinical research to doctoral and post-doctoral level.*

*directly supports the Hospital in its routine and super specialist treatment of heart disease and contributes to its high standards of medical practice. Much work is done co-jointly.*

*It should be understood that the Institute is situated in the grounds of the Hospital and, while its building was erected with funds obtained by the Institute, it is owned by the Hospital.*

*Against this background, arrangements have been re-negotiated (effective 29 December 1989), for a sharing of costs. Some items readily lend themselves to direct quantification and are chargeable to the Institute. Others which flow from activities conducted as joint ventures to help improve the Hospital's clinical practice are best shared between the parties on an agreed equitable basis.*

*Audit was informed that this new affiliation agreement had been under discussion since March, 1989.*

*In regard to the matters subject to audit criticism:*

- *The only Hospital buildings (other than the Baker Institute building which did not involve the Hospital in capital outlay), occupied by Institute activities are the Alfred Baker Medical Unit, the associated clinical laboratory and the Biology Research Unit.*

  *These are joint ventures with the Hospital where the absence of any rental charge is part of the quid pro quo for medical benefits obtained by the Hospital from the association and its free access to the Institute expertise;*

- *The Hospital has agreed, as part of the overall joint venture sharing arrangements to carry out minimum maintenance but obtain quotes for more major work for acceptance by the Institute; to monitor its after-hours security and mechanical/electrical failure and provide stand-by power for light and power;*

- *The Institute pays the Hospital for cleaning.*

*With regard to the Monash Medical School audit comments that whilst the School meets (it would be more correct to say "is charged") the cost of maintenance works, the Alfred did not recover costs for consultancy services provided for its engineering or buildings alteration projects. The Medical School was erected by the University in the Hospital's grounds with money provided by Government. It is physically inter-connected with the Hospital which is the common law owner of the building.*

*The Hospital's provision of advice free of charge, to the extent that it is competent and able to do so, on matters relating to the building is not inconsistent with this situation and would be in its longer term interest.*

*It is correct that no charge is made to the Medical School for refuse disposal in the Alfred incinerator. We are currently working with Monash University in drafting a new Affiliation Agreement concerning recognition as a teaching hospital and a subsidiary operating agreement on day to day relationships. In this context, all aspects of the relationship including charging for services is being updated and the matter of refuse disposal will be one of the cost items covered.*

### *Lack of comprehensive information on property holdings*

*Comments on 4.1.27 to 4.1.28*

- *A Property/Commercial Manager has been appointed.*
- *Cost Centres, files and all relevant information has been set up for all properties.*

## Management response by Health Department Victoria

*Health Department Victoria through its regions will initiate discussions with hospitals on the need to develop assets registers and strategic plans for the appropriate use of properties owned, operated or controlled by hospitals.*

# PART 5

# CATERING

# CATERING

## KEY FINDINGS

- Significant variations exist in the cost of catering between a number of similar major hospitals within the State. Based on this analysis, audit is of the view that potential annual savings of at least $1 360 000 could be achieved at the Alfred.

  *paras 5.19 to 5.24*

- Potential existed for additional cost savings to be achieved by combining the purchasing and part of the storage function for foodstuffs with the Hospital's supply function.

  *paras 5.25 to 5.29*

- The utilisation of space and equipment within the kitchen was not maximised.

  *paras 5.30 to 5.33*

- Opportunities existed to update meal preparation technology.

  *paras 5.34 to 5.37*

- There was a need for a policy to be formulated to minimise the level of subsidy for staff meals which cost the Hospital approximately $1 million per annum.

  *paras 5.38 to 5.54*

- Level of wastage of prepared food was approximately $138 000 per annum higher than acceptable standards.

  *paras 5.55 to 5.68*

- A review of patient surveys revealed that satisfaction with meals was below expected levels and management follow-up was ineffective.

  *paras 5.69 to 5.78*

- Pay rises received by food services staff as part of the second tier wage rise did not directly result in any of the promised productivity gains estimated to be $63 000.

  *paras 5.83 to 5.86*

- A current Statewide policy direction for food services had not been developed by Health Department Victoria (HDV). A Statewide policy would enable comparisons by HDV to be made between the catering operations of public hospitals to ensure that scarce resources are employed in an effective manner.

  *paras 5.10 to 5.13 and 5.17*

## BACKGROUND

**5.1** The Catering Department operates as an integral part of the Hospital. It provides daily food and beverages for patients and staff, including catering for those patients on special diets.

**5.2** The Catering Department is responsible for planning, organising and directing all phases of food service delivery which includes:

- the procurement and storage of foodstuffs;
- menu planning;
- food preparation and service;
- visiting ward patients to determine their food preference for meal options;
- budget estimates;
- cost control and administrative record keeping;
- safety and sanitation programs; and
- staff training.

**5.3** The Department's expenditure for 1988-89 was $6.2 million (excluding kiosk expenditure of approximately $861 000) which comprised payroll costs of $4.4 million (71 per cent), food purchases of $1.4 million (23 per cent) and other catering costs of $400 000 (6 per cent). For 1988-89 the Catering Department served, on average, 2 700 meals per day of which hospital staff purchased approximately 850 meals through their staff cafeteria and patients were delivered about 1 850 meals a day (breakfast, lunch, dinner, and morning and afternoon tea).

**5.4** If costs of providing special functions, amounting to $220 000, are excluded from total expenditure, the average cost of preparing a meal in 1988-89 was $6.11 of which the food element amounted to $1.21.

**5.5** To carry out the food and beverage preparation, the Department had 192.75 effective full-time staff (EFT) positions at June 1989. The number of persons employed in full-time, part-time and casual positions totalled 231.

**5.6** The stated mission of the Department is *"to provide a perfect meal to each customer at each meal service"* and its objectives include a requirement for the Department to ensure that:

- nutritious meals are provided to all patients and staff which satisfy their individual dietary requirements; and
- all expenses are within budget allocations.

**5.7** A key goal of the Department is to achieve full client satisfaction within a safe and effective work environment.

## RECENT INITIATIVES

**5.8** Audit is pleased to report on a number of initiatives recently undertaken to improve food service management practices within the Hospital, namely:

- the formulation of a mission statement and departmental objectives which are complementary with those of the Hospital;
- the extent and accessibility of documentation detailing the operations of the Department;
- the installation of a computerised ordering, purchasing and inventory control system;
- a variety of occupational health and safety initiatives including the allocation of a supervisory position for staff training in occupational health and safety, and regular staff training which has contributed to a decline in the number of time lost injuries and an overall decrease in the number of reported accidents; and
- the progressive implementation of a number of indicators to measure the Department's performance in a number of areas including the cafeteria, patient meals and occupational health.

*Health Department Victoria comment*

*Health Department Victoria is currently undertaking a review of its Cost Centre Accounting Manual and associated accounting policies and procedures to provide guidelines for management of financial resources in the public hospital system. A Steering Committee comprising representatives from Treasury, Victorian Hospitals Association, public hospitals and senior departmental finance officers has been established to oversee the review process and the implementation of improved accounting practices and policies.*

*The terms of reference for the review include examination of the existing manual to determine its appropriateness and adequacy in accounting for the financial resources of hospitals, aligning the system with the requirements of the Annual Reporting Act and ensuring that the manual complies with acceptable accounting standards.*

*HDV requires public hospitals to plan for the appropriateness and efficiency of their services, account for their performance, comply with required reporting requirements and exercise financial accountability. HDV therefore recognises the need to maintain up-to-date financial management systems in the public hospitals and to address, within the public hospital system, the need for skilled financial expertise in hospitals.*

## AUDIT OBJECTIVES

**5.9** The audit objectives were to review management procedures involved in the catering function to determine whether policies and procedures had been formulated which provide for the catering function to operate in an efficient and effective manner, namely:

- opportunities exist for achieving cost savings and improvements in productivity;
- the acquisition of foodstuffs is obtained at the most economic price consistent with quality;
- sufficient systems and controls are in place to prevent wastage of food and pilfering;
- adequate management information systems and performance indicators are in place to enable senior management to monitor the efficiency and effectiveness of the catering department;
- the utilisation of resources within the food services area is maximised; and
- pricing and staff meal subsidisation practices are soundly based and approved by senior management.

## AUDIT OBSERVATIONS AND RECOMMENDATIONS

### Food service policies

*Statewide level*

**5.10** In the health arena, the 1989-90 budget seeks to address the increasing health service demands for an accessible and high quality public health service within a constrained economic environment. The objective of the HDV's Health Agency Services Program is to ensure that available resources are effectively and efficiently employed by health agencies and to provide specialised professional advice on a Statewide basis in areas including medical services and industrial relations issues. While Boards of Management of hospitals have a clear responsibility for initiative in planning and effective management, HDV has overall responsibility for ensuring that duplication and waste are avoided and that service delivery is maximised to the State within available resources.

**5.11** However, discussion with senior HDV officers indicated that **an overall current Statewide food service policy for public hospitals covering aspects such as costing and pricing for meals and quality assurance standards had not been developed.**

**5.12** A review of the central policies revealed that the majority of central policies had been written by the former Health Commission in the early to mid-1980s and did not reflect the current views of HDV in relation to staff meal subsidisation and pricing. Food service personnel of the Alfred and hospital management were not aware of the current views of HDV as these changes had not been formally communicated to the Hospital.

**5.13** In order to establish performance bench marks for the catering industry, audit undertook discussions with a large catering department within the hotel industry. These inquiries revealed that the hotel chain had developed extensive central policy documentation to be applied by individual hotels for functional areas.

*Hospital level*

**5.14** In line with the Australian Council of Hospital Standards, the Catering Department at the Alfred documented a wide range of policies specific to its operations. The major policies include:

- a departmental plan comprising a mission statement, objectives, key goal, performance indicators and a strategy plan;
- a catering manual containing instructions on use of specific equipment, safety, kitchen hygiene and incident reporting;
- staff appraisal procedures for senior staff; and
- job specifications.

**5.15** Currently, documented policy items are accessible from various locations within the Department. However, audit observed that **a comprehensive operational policy document, that responsible staff could readily access within their work station, did not exist.** Such a situation contrasts with audit inquiries within the catering department of a major hotel where each of the food service operational areas kept a policy operation manual on site.

**5.16** In addition, **policies had not been developed in relation to quality assurance programs, standards of meal preparation and acceptable levels of wastage.** Audit was advised that in other organisations there are a number of mechanisms to ensure quality such as photographs of standard presentation, a requirement for cooks to undertake regular tastings of patient meals and management supervision of cooks' adherence to standard recipes. With regard to matters relating to industrial relations, the Hospital had not established a policy outlining the issues which can be negotiated with a union.

**5.17 There is a need for HDV to develop Statewide policies on food services in order to give direction on standard practices to be applied throughout the public hospital system, enhance the quality of the public health service and ensure that resources are employed in an effective manner. Such a policy document would enhance comparability between hospitals and should include:**

- **costing and pricing principles for patient and staff meals; and**
- **quality assurance standards which include a summary of the present nutritional requirements.**

**5.18 The catering function of the Alfred would benefit by expanding its policies and combining them into a comprehensive document in order to provide ongoing guidance to the catering staff.**

- *Management response by Alfred Hospital*

  *Subsequent to the audit report comprehensive departmental manuals have been completed and placed in all areas of the Department to allow easy access to the responsible members of staff.*

  *The Hospital undertakes regular quality assurance activities in accordance with the Hospital's 103 page overall Quality Assurance Plan.*

  *The Hospital has recently successfully undergone re-accreditation. The Catering Department was commended for its activities.*

  *The Hospital believes that comprehensive policy guidelines should be available to all staff, however, it believes that documentation of every detail while ideal is not practical.*

  *Policies provide useful guidelines, but at this stage, it is believed that improvements in basic systems and information is the Hospital's most urgent need.*

- *Management response by Health Department Victoria*

  *HDV has financial and management systems to monitor and control the performance of hospitals to ensure they comply with required reporting arrangements and exercise appropriate financial accountability. The Cost Centre Accounting Manual is currently being reviewed and costing principles for food services will be considered as part of this review. An analysis of staff meal pricing in public hospitals is being undertaken and pricing and costing principles for meal prices are being developed as a 1989-90 budget initiative. These principles will need to be endorsed by the Industrial Relations Task Force.*

  *Quality assurance standards in hospitals are generally based on the Australian Dietary Guidelines established by the Commonwealth Department of Health in 1979. Where necessary these guidelines are refined by hospitals to meet the needs of particular patient groups and the standards of care policies of each hospital.*

  *HDV believes that the existing arrangements adequately address the concerns raised by audit. Statewide standards/guidelines cover the specific areas.*

## Central monitoring of catering costs

**5.19** While HDV collected costs in the past across a number of hospitals, audit noted that hospital catering costs had not been compiled and analysed at a central level. In recent years hospitals have been given more autonomy to manage their affairs to meet targets set in Health Service Agreements within agreed budgets.

**5.20** Integral to HDV's central direction role, audit is of the view that HDV should monitor and analyse hospital costs across a wide spectrum of hospitals throughout the State in order to ensure that hospitals are operating efficiently within budget. Audit was advised that HDV is currently working through a program of developing cost indicators.

**5.21** A preliminary analysis undertaken by audit in the catering arena disclosed the following variations for 1988-89:

**TABLE 5A. ANALYSIS OF CATERING ACTIVITIES, 1988-89**

| *Item* | | *The Alfred Group of Hospitals (Alfred Campus)* | *St Vincent's Hospital* | *Monash Medical Centre (Clayton Campus)* |
|---|---|---|---|---|
| Annual catering costs | ($) | 6 025 000 | 6 071 000 | 4 121 000 |
| Number of meals prepared per annum | | 985 000 | 1 283 000 | 791 700 |
| Average cost per meal | ($) | 6.11 | 4.73 | 5.21 |

*Source:* The above information in relation to St Vincent's Hospital and Monash Medical Centre was supplied by the respective hospitals.

**5.22** An analysis of this information disclosed that the average cost per meal at the Alfred was $1.38 (29 per cent) higher than at St Vincent's. Factors which could contribute to the variances in the average cost per meal include:

- differences in services provided;
- purchase cost of foodstuffs;
- labour costs;
- productivity of labour;
- level of waste;
- level of pilfering;
- utilisation of staff cafeteria;
- method of food preparation and delivery;
- differences in definitions (for example meal definition); and
- patient type.

**5.23 An application of the average cost per meal at St Vincent's to the number of meals prepared at the Alfred per annum highlights potential annual savings of $1 360 000.**

**5.24 Although it is recognised that there are differences between each hospital's activities, audit considers that HDV should investigate the causes for material variations. Standard costing policies and definition of terms would need to be developed by HDV prior to undertaking such an investigation. In addition, the distribution of this information to hospitals would also enable meaningful comparisons to be made.**

- *Management response by Alfred Hospital*

  *Inter-hospital comparisons were attempted in 1983 but because of different definitions within the system, meaningful comparisons were difficult.*

  *However, from experience it must be stated that 3 initial steps are required:*

  *(1) the development of precise definitions;*

  *(2) agreement on costing policies; and*

  *(3) development of performance indicators.*

  *It is only after this has been done, that a meaningful and useful comparison can be made.*

  *The Hospital has commenced the process of providing concise, accurate definitions in many areas within the Hospital, and to permit future inter-campus comparison.*

  *The Hospital recommends that an organisation with experience in inter-firm comparisons be sub-contracted to undertake the task of developing and running a series of inter-hospital comparisons. These trials should not be "one-off", but should build, over a period of time, on consistent definitions and accounting policies.*

  *Given the comments in paragraph 5.22, the Hospital fails to see how audit can justify the insinuation that there are potential annual savings of $1 360 000 at the Alfred.*

  *The prior section made the point that one cannot do meaningful comparisons without a lot of basic work.*

  *The Hospital acknowledges that there is a real need to establish sound inter-hospital comparisons.*

- *Management response by Health Department Victoria*

  *Hospitals have the responsibility to manage and plan the appropriateness and efficiency of their services and to monitor and control operations to ensure effective performance. Regions have the responsibility under Health Service Agreements of investigating variances in performance and follow-up with hospitals.*

  *Agreement has been reached between the HEF 1 and HDV under the structural efficiency principle to establish a joint Working Party to develop human resources utilisation and allocation standards for application across the public health sector.*

  *The Department will give consideration to the development of appropriate cost indicators to enable functional activities to be monitored by hospitals and compared with the appropriate standards. It must be emphasised, however, that HDV will use comparative data to determine variances in the cost of hospital outputs (e.g. costs per patient treated). In seeking to explain such variances, hospitals will need to compare functional cost differences in detail.*

## Purchasing and storage function of the Catering Department

**5.25** Purchasing and storage of perishable and dry foods, crockery and related paper goods is the responsibility of the Catering Department. Approximately 4.25 food service department personnel are deployed in the ordering, purchasing, receipt and storage of these items. The cost of these personnel is about $94 000 per annum.

**5.26** Audit observed that similar functions were undertaken by the Supply Department of the Hospital which specialised in the ordering, purchasing and storage of hospital goods such as medical and general supplies.

**5.27** In addition, audit inquiries with the catering management of a large hotel chain indicated that the purchasing of all foodstuffs was undertaken by the hotel's Purchasing Department which was separate to the Catering Department. This arrangement enabled the hotel's Catering Department to focus on the management of food preparation and service delivery while the purchase of foodstuffs was undertaken by the area specialising in purchasing.

**5.28 The duplication involved in the purchasing and storage function of foodstuffs and medical and general supplies at the Alfred has led to additional costs being incurred in the operation of the Catering Department.** Although it may be necessary for practical reasons for the Catering Department to retain the storage of perishable goods, it could be more cost-effective for the purchasing of all goods and storage of non-perishable and paper goods to be absorbed by the existing specialist Supply Department.

**5.29 In order for the Hospital to ensure that its purchasing and storage activities are undertaken in the most cost-effective manner, management should assess the costs and benefits of integrating the purchase function for all food service goods and the storage function for non-perishable foodstuffs with the supply function of the Hospital.**

*Management response by Alfred Hospital*

*As previously indicated, this has been considered. However, it was believed that such a move would not improve the cost-effectiveness of the Hospital at this time.*

## Utilisation of kitchen facility

**5.30 There has been a significant under-utilisation of the Hospital's kitchen facilities since 1978.**

**5.31** Audit was advised by the Director of Food Services that the original intention of the design and fit-out of the kitchen area was for it to be utilised in the preparation of meals for not only its staff and patients but for additional health facilities such as metropolitan nursing homes. On completion of the building in 1978 the kitchen had the physical capacity to produce 8 000 meals a day.

**5.32** Audit noted that meals had not been supplied to external facilities and the maximum number of meals produced for Alfred staff and patients was in the vicinity of only 4 000 meals a day. In recent times the kitchen produced an average of only 2 700 meals a day (1 850 for patients and 850 for hospital staff).

**5.33 Audit acknowledges that the physical capacity of the kitchen has eroded over time. Nevertheless, in the interests of economic and efficient resource utilisation, it is recommended that the Hospital undertake a cost-benefit analysis of fully utilising the kitchen capacity taking into account various options such as the supply of meals to other facilities (for example, the amalgamated hospital and nursing homes). Expanding the use of the kitchen's capacity to prepare meals for the other campuses would be consistent with:**

- **the Minister's direction outlined in the 1988-89 Health Service Agreement that the amalgamation should lead to rationalisation of services across campuses; and**
- **the tenets of the Health Services Act 1988 which requires efficiency and economy of operations.**

*Management response by Alfred Hospital*

*It is acknowledged that in terms of available space and equipment, the catering facility is under-utilised. However, the decision to build a kitchen with capacity for 8 000 meals a day was made 15 years ago to allow for expansion on the Alfred site. The catering service will continue to consolidate and make maximum use of available space.*

*At the same time, it is considered important that before any major upgrade of the kitchens at the Kooyong Campus or indeed other hospitals within close proximity to the Alfred be undertaken that the potential (in terms of capacity) at the Alfred be considered.*

*Any such move would involve substantial capital investment and it is believed that such capital is scarce at present.*

*In addition, it must be pointed out that the Hospital's staff resources are needed for the analysis and management of higher priority projects.*

## Alternative food preparation method

**5.34** At the Alfred, meals are centrally bulk prepared, plated for each meal and then delivered to ward areas. The technique used to ensure the delivery of hot meals is as follows:

- plates are warmed in a carousal system; and
- the meals are covered with an insulated lid to maintain temperature.

**5.35** This method contrasts with that of other Victorian and interstate hospitals and commercial outlets where food is prepared in advance by various methods of chilling and heating and reconstituted when required.

**5.36** The chilling and heating method facilitates bulk preparation and plating over one core period of the day, thereby reducing labour costs and enabling additional revenue to be raised by selling some of the bulk meals to other entities such as associated health facilities.

**5.37 As part of the cost-benefit analysis of fully utilising the kitchen capacity, the various methods of supply and delivery of meals currently available through other hospitals and commercial outlets should form part of this analysis.**

- *Management response by Alfred Hospital*

  *It is acknowledged that with progress there are systems which have been developed which may have advantages over the current system in use at the Alfred.*

  *Nevertheless, the decision to build a fresh cook and serve kitchen was, at the time of commissioning, considered to be the best option available. A body of opinion is that it is still considered the best system, provided meals can be delivered quickly to patients from the kitchen.*

  *The Hospital is well aware of the cook and chill system but the capital investment required has meant that the Hospital has not committed its scarce personnel resources to an in-depth investigation of this particular technology.*

- *Management response by Health Department Victoria*

  *The Department accepts the cook and chill method of food preparation as an alternative for the supply and delivery of meals and it has been installed in a number of institutions. A joint review of the nutritional and operational benefits of the system is to be undertaken in conjunction with relevant unions.*

## Hospital subsidisation of staff meals

**5.38** To offset the costs of introducing the 38 hour week in June 1983, the former Victorian Health Commission advised public hospitals to increase staff cafeteria meal prices to a level where all direct labour and ingredient costs were recovered.

**5.39** Following industrial protests against increased staff cafeteria charges, the Victorian Health Commission in October 1983 advised public hospitals of a range of prices to be charged for typical staff menu items, specifying that prices for individual items were not to exceed the maximum price range and staff who were entitled to receive free meals would continue to do so.

**5.40** The advised price range was considerably below the prices regarded by the Hospital as necessary to recover all direct labour and ingredient costs on staff meals.

**5.41** At the time of audit HDV policy had not formally changed from that of October 1983.

**5.42** The Hospital's Food Service Department followed the HDV specified price list and adjusted prices when instructed by HDV of a national wage rise.

**5.43** A review of cafeteria operations indicated the following levels of staff meal subsidisation (costs of cafeteria - salaries of cafeteria staff, proportion of the cost of food inputs, proportion of meal preparation costs less revenue):

TABLE 5B. STAFF MEAL SUBSIDISATION

| Period | Level of subsidisation(a) | Subsidy at 1985-86 values | Percentage change in real terms |
|---|---|---|---|
| | ($'000) | ($'000) | (per cent) |
| 1985-86 | 1 147 | 1 147 | Nil |
| 1986-87 | 1 072 | 981 | (14.46) |
| 1987-88 | 931 | 800 | (18.04) |
| 1988-89 | 997 | 806 | 0.65 |

*(a) Source:* Figures supplied by the Catering Department.

**5.44 For 1988-89 the level of subsidisation was equivalent to each hospital staff member receiving a meal subsidy of approximately $380 per annum or about $7.30 a week.**

**5.45** Included in this level of subsidisation is the provision of free tea and coffee. This privilege is not generally afforded to government employees. Audit was advised that the cost in 1988-89 for supply of staff tea and coffee was in the vicinity of $140 000 ($100 000 for labour and $40 000 for tea and coffee supplies).

**5.46** As illustrated above the level of subsidy has in real terms decreased by about 32 per cent since 1985.

**5.47** Audit was advised by senior hospital management that a current hospital policy on meal subsidisation did not exist and the rationale of staff meal subsidisation had arisen from a combination of factors including the threat of industrial disputes, commonality of conditions with other hospitals, morale and historical factors.

**5.48** A comparison of the prices charged for meals at the staff cafeteria with those if there was full cost recovery is detailed below:

TABLE 5C. ANALYSIS OF STAFF MEAL PRICES
($)

| Meal type | Alfred staff caf. approx price | Full cost recovery (as calculated by audit) |
|---|---|---|
| Bacon & eggs (with toast) | 1.70 | 2.59 |
| Chicken parmigiana *(a)* | 4.20 | 6.40 |
| Lasagna *(a)* | 3.05 | 4.65 |
| Lamb cutlets *(a)* | 3.40 | 5.18 |
| Roast beef *(a)* | 4.40 | 6.71 |
| Pavlova | 1.10 | 1.67 |
| Sandwiches | 1.05 | (from) 1.60 |

*(a)* Served with 4 vegetables.

**5.49 The prices charged for staff meals were on average 52.5 per cent lower than the cost of providing the meals.**

**5.50** Audit also noted that the revenue collected from the cafeteria was applied towards meeting the general expenditure of the Hospital. This practice of the Catering Department not retaining its revenue did not provide an incentive for the Department to increase its revenue collection and hence reduce the level of subsidisation. In addition, such an arrangement is not consistent with the objectives of the Health Services Agreement which states that a HDV objective is to create more effective financial incentives.

**5.51** Audit analysis of cafeteria revenue over a 3 year period indicated in real terms a steady decline of revenue being collected. Refer to Table 5D below for details:

**TABLE 5D. DECLINE IN CAFETERIA REVENUE**

| *Period* | *CPI (Vic.)* | *Actual revenue (a)* | *Revenue at 1985-86 values* (a) | *Percentage change in real terms* |
|---|---|---|---|---|
| | | ($'000) | ($'000) | (per cent) |
| 1985-86 | | 569 | 569 | Nil |
| 1986-87 | 9.3 | 664 | 607 | 6.70 |
| 1987-88 | 7.0 | 667 | 573 | (5.60) |
| 1988-89 | 7.4 | 672 | 543 | (5.27) |

*(a) Source:* Figures supplied by the Catering Department.

**5.52** Similarly, an analysis of the number of meals being consumed by staff indicated a steady decline. Refer to details below:

**TABLE 5E. DECLINE IN THE CONSUMPTION OF STAFF MEALS**

| *Period* | *Number of effective full-time staff (a)* | *Meals per staff per annum* |
|---|---|---|
| 1986-87 | 2 624 | 139 |
| 1987-88 | 2 709 | 124 |
| 1988-89 | 2 647 | 118 |

*(a) Source:* Figures supplied by Human Resources Department.

**5.53** Discussions with senior HDV management indicated that while government policy on staff meal subsidisation had not formally altered since 1983, a government decision had recently been made recommending full cost recovery. At the date of audit this recommendation was yet to be implemented.

**5.54 Action needs to be taken regarding the framing of a policy to cover the practice of hospitals subsidising staff meals and revenue collection in line with government policy.**

- *Management response by Alfred Hospital*

  *The charges for staff meals are in accordance with HDV advice.*

  *Prior to 1983 each hospital established its own prices. Our surveys show that Alfred charges to staff were, and are, above average in relation to other hospitals.*

  *The HDV directed hospitals (Circular 62/1983) to increase staff cafeteria meal prices to a level where all direct labour and ingredient costs were to be recovered. As a result of subsequent Statewide industrial action the directive was changed (Circular 64/1983) to increase prices by 60 per cent and subsequently in line with national wage case decisions.*

  *As the audit report indicates, staff usage of the cafeteria has fallen off since the new pricing arrangement was introduced in 1983.*

  *The Hospital believes that, ideally, meal costs for staff of all hospitals should be determined centrally as are wage rates, so that the same staff conditions apply to all like-hospitals.*

- *Management response by Health Department Victoria*

  *Health Department Victoria is currently undertaking an analysis of meal pricing in public hospital staff cafeterias to establish a level of meal pricing and cost recovery which reduces meal subsidisation.*

## Food wastage

**5.55** Due to the nature of a hospital service a certain amount of food wastage is unavoidable. For example, patients may be too ill to eat prior to the delivery of a meal, or for medical reasons they may have to be taken out of the ward for an urgent procedure thereby missing their pre-arranged meal.

**5.56** Nevertheless, the extent of food wastage is generally accepted as an important indicator, within a hospital environment, of resource utilisation and consumer perception of food service.

**5.57** In order to measure food consumption and patient satisfaction with the size and quality of meals, food waste audits are undertaken by hospital management. These audits provide management of hospitals with the following information:

- the extent of food which is not consumed;
- a breakdown of foods not being consumed and by whom; and
- the appropriateness of portion size.

**5.58** Such information is necessary for management to evaluate the efficiency and economy of operations and to avoid waste and extravagance.

**5.59** In reviewing the management practices in place at the Alfred concerning the conduct of food wastage audits, it appeared that hospital staff had for some time been concerned about the level of unconsumed meals returned to the kitchen as waste. Only 2 trial and one complete food waste audit had ever been undertaken at the Alfred.

**5.60** The 2 trial food waste audits were undertaken in 1988. The results of the audit were not adequately documented and management had not implemented any corrective measures to reduce wastage after the completion of these audits.

**5.61 Due to the expressed hospital concerns about food wastage and the limited documentation concerning the 1988 food wastage audits, this Office as part of its audit, planned to undertake an independent food waste audit. However, the current industrial relations climate in the hospital arena did not permit this activity to proceed.**

**5.62** Despite the above restriction, it was pleasing to note that during the audit visit the Catering Department decided to undertake an audit of prepared food wastage which occurred after the mid-day meal on 11 July 1989.

**5.63** The Department provided the audit team with the following information on the type and extent of prepared meal wastage. Of the 241 patients sampled:

- vegetables, salads and sandwiches showed the highest level of wastage with 48 per cent, 47 per cent and 42 per cent, respectively, being returned as waste;
- fresh fruit and sweets recorded the lowest wastage, 23 per cent and 27 per cent, respectively, for the grouped items; and
- stewed fruit was the single item with the lowest wastage of 20 per cent.

**5.64** A breakdown of the percentage of waste for each menu component is given below:

TABLE 5F. FOOD WASTAGE

| *Menu item* | *% wastage* | *Menu item* | *% wastage* |
|---|---|---|---|
| Entree | 35 | Salads | 47 |
| Vegetables | 48 | Fruit | 23 |
| Bread | 33 | Sandwiches | 42 |
| Sweets | 27 | Other | 42 |
| Drinks | 32 | | |
| Main meat dish | 37 | **Average** | **37** |

**5.65 When the average wastage for this meal of 37 per cent was extrapolated, the cost of this level of food wastage excluding labour and special functions amounted to $301 000 for a year. According to an acknowledged expert on food services this amount exceeds acceptable standards by about $138 000 (17 per cent).**

**5.66** Although audit recognises that a portion of this cost was unavoidable, the level of wastage appears excessive when compared with acceptable standards of wastage levels which generally should not exceed 20 per cent.

**5.67** Audit observed that food service management had not established acceptable levels of wastage to measure the extent of patient consumption of meals.

**5.68 In view of the results of the current wastage audit, the Hospital should consider, as a priority, the implementation of frequent wastage audits in order to identify areas for improvement in resource usage and quality of food and beverage service. As an illustration, management should assess whether food portions are too large, food is not being delivered at the right temperature or the menu is not consistent with the season in question. It is also recommended that performance indicators be developed to measure the level of food wastage against acceptable levels.**

*Management response by Alfred Hospital*

*The Hospital is aware of the need to monitor food wastage.*

*This is why it has commenced building up a database of information relating to the subject.*

*The Hospital has been unable to obtain any information on complete food wastage audits in similar hospitals, consequently the Hospital undertook the survey described in 5.62 and 5.64.*

*The results given here relate to an analysis of less than 50 per cent of patients for one meal. Since that time further surveys have been done.*

*Such complete audits are extremely labour intensive and can involve up to 20 people. This is why few hospitals undertake them.*

*The Hospital believes the Catering Department is to be congratulated for such a comprehensive survey rather than the indifferent approach evident in 5.59 and 5.60.*

*As previously mentioned, the Hospital has been unable to find any published data on total food wastage for comparable hospitals.*

*Audit should quantify the source of acceptable wastage standards referred to in the report.*

*As the food service management of the Hospital had not established acceptable levels of food wastage that is why the Hospital has undertaken the initiative begun in 1988 to determine what total food wastage levels are.*

## Patient food service survey

**5.69** Patient surveys are a method of measuring patient satisfaction with the food and beverage service.

**5.70** The survey directed to inpatients of the Alfred on a monthly basis takes the form of a short questionnaire (8 to 12 questions) in which comments are sought concerning the meal service provided by the Hospital.

**5.71** In summary, the survey requires information concerning the:

- accuracy of the meal received compared with the meal ordered;
- appearance of the meal;
- meal temperature;
- enjoyment of the meal;
- quantity of the meal; and
- level of staff service.

**5.72** Information is analysed by the Department and included in the monthly report to senior management.

*Consistent poor satisfaction with patient food service and lack of follow-up action by management*

**5.73** Audit analysis of the results of the survey over a 2 year period up to July 1989 indicated that the average level of satisfaction with the food service statistically ranged between 70 - 80 per cent (20-30 per cent of patients, on average, rated the service as less than good).

**5.74** An analysis of the most common complaints concerning food preparation and delivery were as follows:

- vegetables not cooked properly;
- meat was tough;
- no flavour in soup;
- poor presentation; and
- dryness of food.

**5.75** Discussions with food service managers from several other public hospitals indicated that from a similar survey the hospital expected to receive a 90-95 per cent level of satisfaction.

**5.76** Audit observed a lack of follow-up action by management to summarise responses received from the meal surveys and take corrective measures to resolve recurring issues. Audit inquiries at another hospital revealed that the patient survey was used only on limited numbers of patients but each person was individually followed-up to ascertain their clinical condition and reasons for responses. Such a method enabled an indepth analysis to be made of results. Similarly, discussions with management of the Food Service Department of a major hotel indicated individual follow-up of all complaints.

**5.77** The 1988-89 performance indicator outlined in the Hospital's Departmental Plan is that patient satisfaction should average 90 per cent (90 per cent of patients should rate satisfaction of the service between fair and excellent). Results of the survey for that period indicate that as the average rate for 1988-89 was 88.5 per cent, the Department failed to reach its set performance standard.

**5.78 Corrective action should be implemented, where practical, to resolve the recurring issues raised in complaints received from patients to improve the efficiency and effectiveness of meal preparation and delivery.**

*Insufficient detail collected from survey*

**5.79** The current meal survey format did not cover the following areas:

- reasons for poor consumption;
- patient appetite;
- appropriateness of meal times; and
- menu variety.

**5.80 The inclusion of such information would assist the interpretation of the survey results by providing more meaningful information for analysis.**

*Inadequate format of survey form*

**5.81** The patient survey form is written exclusively in the English language and is presented in standard size typeface. To complete the survey the patient needs to be able to read written English and have good eyesight.

**5.82 To ensure that accurate and meaningful responses are obtained, the Department should consider extending the format to include other languages and the use of graphics to enhance understanding.**

*Management response by Alfred Hospital*

*The actual rating scale and results are:*

- *Excellent;*
- *Good;*
- *Fair;*
- *Passable; and*
- *Appalling.*

*During the period for January - March 1990, 90 per cent of the patients rated the food as fair to excellent.*

*The Hospital is very mindful of the need to improve on these figures within its budgets.*

*The Hospital regards the audit statement in paragraph 5.75 to be meaningless unless the same survey has been administered under the same conditions in other hospitals. The Hospital Catering Department, as yet another initiative, is examining the possibility of doing precisely that.*

*In the period January - March 1990 the patient satisfaction figure was 90 per cent.*

*The Hospital agrees that corrective action should be implemented to resolve the recurring issues raised in complaints received from patients.*

*The meal survey formats have now been enhanced.*

## Four per cent second tier agreement

**5.83** As part of the October 1987, 4 per cent second tier wage agreement, hospitals agreed to make 1.5 per cent labour utilisation savings in return for a 4 per cent wage increase.

**5.84** To identify and achieve these savings, a committee was established by the Alfred in April 1988. **In 6 months, the cost of operating the Committee (including a food service representative) amounted to $36 000 while pursuing savings which totalled $1 000.**

**5.85** The Committee was abolished by the Hospital in November 1988 subsequent to the abolition of the Central Co-ordinating Committee by the Industrial Relations Commission because the costs of operation outweighed the benefits being pursued.

**5.86** Audit observed that food service staff gained $170 000 through the second tier agreement. Staff, in return, were expected to identify and achieve cost savings of 1.5 per cent ($63 000) through amendments to existing work practices. **The above mechanisms failed to achieve any of the productivity savings agreed to by HDV and relevant unions as part of the second tier wage agreement.**

- *Management response by Alfred Hospital*

  *The agreement between the HDV and relevant unions in relation to productivity savings as part of the second tier wage agreement was, in fact, an agreement that productivity savings would be made at a future date. On the basis of this agreement the wage increase was passed on to Hospital staff by the HDV, i.e. "in advance".*

  *Because the increase was paid before areas for specific savings were identified, negotiated and agreed, little incentive was given to people to co-operate in the identification and introduction of any productivity improvements.*

  *Specific ideas for productivity improvements were to be identified, negotiated and agreed at local level and thereafter passed to the central body (which was chaired jointly by the Minister and the Secretary of the ANF) for final approval before implementation could proceed.*

  *As a separate exercise, hospitals inputted to the development of a listing of general conditions (e.g. award changes) which the HDV was to negotiate centrally. "Absenteeism" was one such area where it was believed savings would result without creating industrial disharmony. However, while negotiations commenced between HDV and the health unions it is understood that they did not proceed beyond the initial stages.*

  *In commenting on the review of the work practices aspect (RWH model) the statement of the Industrial Relations Commission of Victoria in Full Session re: the Health Industry, Victoria, Public Sector 10th October, 1988 said:*

  > *"Because of these problems, the Health Department Victoria (the HDV) supported by the VHA and the Minister for Labour, has submitted that the Commission should find that the RWH review process has failed and should be abandoned. Indeed, it was submitted by Mr Herrington (for the HDV) that the costs of pursuing this course are greater than the benefits which it is producing".*

  *Virtually all award matters are handled outside the Hospital.*

- *Management response by Health Department Victoria*

  *The Industrial Relations Committee (IRC) decision of 20 October 1987 stated that the cost of second tier increases was to be fully offset by productivity increases or cost savings achieved progressively by June 1989.*

  *These offsets (review of admission and discharge procedures, absenteeism, and changes to work practices etc.) have been implemented in a number of areas and have achieved useful results. However, the IRC later directed that all reviews were to be completed by 15 November 1988 and changes to work practices and award modernisation have since been sought under the new Structural Efficiency Principal (SEP). On 22 December 1989, the IRC endorsed the agreement between the HEF 1 and HDV for a first structural efficiency adjustment. This agreement includes provision for broadbanding of positions, development of certain utilisation standards, job redesign and work practice reviews in appropriate circumstances.*

# PART 6

# CLEANING

# CLEANING

## KEY FINDINGS

- Significant variations exist in the cost of cleaning between a number of similar major hospitals within the State. Such variances should be analysed to determine potential cost savings.

  *paras 6.14 to 6.18*

- Furthermore, there was scope for additional savings by improving productivity as:

  - the cost of cleaning per square metre was similar for non-hospital areas as for ward areas; and

    *paras 6.21 to 6.23*

  - the level of cleaning on weekends was the same as during week days, even though patient activity was lower on weekends.

    *paras 6.24 to 6.27*

- A high level of sick leave was taken by cleaners with the average for 1988-89 being 13.5 days.

  *paras 6.28 to 6.32*

- There is a need to develop Statewide cleaning standards together with standard costing procedures and performance indicators to enable HDV to evaluate the efficiency of cleaning operations between hospitals and to ensure that scarce resources are employed in an effective manner.

  *paras 6.6 to 6.9*

- The non-development of Statewide cleaning standards for the hospital sector does not enable uniformity to be achieved in maintaining the required standards of disinfection, general cleanliness and appearance at a minimum cost.

  *paras 6.10 to 6.11*

## BACKGROUND

**6.1** The objective of the Cleaning Section of the Hospital Services Department is to ensure that hygienic surroundings are maintained in order to minimise the direct and indirect transmission of infection from environmental sources. Achievement of this objective is essential for the safe and effective operation of the Hospital.

**6.2** The responsibilities of the Cleaning Section include:

- routine and special-purpose cleaning;
- collection and disposal of general and contaminated waste;
- the measurement, labelling, storage and proper use of cleaning chemicals and supplies;
- the use, cleaning and care of cleaning equipment; and
- evaluation of cleaning effectiveness.

**6.3** At 30 June 1989 the Cleaning Section had 181 effective full-time positions and cleaning costs for 1988-89 amounted to $4.2 million.

**6.4** Cleaners are employed in various facilities of the Hospital which include general wards, isolation areas, theatres and residential accommodation.

## AUDIT OBJECTIVES

**6.5** The audit objectives were to review hospital management procedures involved in the cleaning function to determine whether policies and procedures had been formulated which provide for the cleaning function to operate in an efficient and effective manner, namely:

- sound cleaning requirement methodologies have been developed to assess the type and frequency of cleaning required;
- cleaning services are regularly inspected to measure the quality of service delivery against cleaning standards;
- management information systems and performance indicators provide useful information to senior management to evaluate whether cleaners are being efficiently utilised and to assess whether productivity improvements and cost savings may be achieved; and
- sufficient records are in place to substantiate overtime and penalty payments.

## AUDIT OBSERVATIONS AND RECOMMENDATIONS

### Cleaning policies

*Statewide level*

**6.6** As referred to previously in this report the 1989-90 budget, in the health arena, seeks to address the increasing health service demands for an accessible and high quality public health service within a constrained economic environment. The objective of the Health Agency Services Program of HDV is to ensure that available resources are effectively and efficiently employed by health agencies and to provide specialised professional advice on a Statewide basis in areas including medical services and industrial relations issues. While Boards of Management of hospitals have a clear responsibility for initiative in planning and effective management, HDV has the overall responsibility for ensuring that duplication and waste are avoided and that service delivery is maximised to the State within available resources.

**6.7** However, discussions with senior HDV officers indicated that **an overall central cleaning policy for hospitals had not been developed** relating to:

- standard costing procedures;
- definition of terms;
- employment of part-time and casual staff; and
- the types of performance indicators to be developed.

**6.8** In addition, **cleaning standards, addressing the method and frequency of cleaning, had not been established at a central level.**

**6.9** Audit was advised that a structural efficiency agreement between the Hospital Employees Federation and HDV covering issues such as job design and work practices for employees employed under the provisions of the Hospital and Benevolent Homes Award was in the process of being finalised. Aspects of the agreement include the need to:

- improve service delivery and efficiency in the public health sector;
- identify and implement improved work practices flowing from award restructuring; and
- develop human resource utilisation and allocation standards for application across the public health sector.

**6.10 Cleaning standards need to be applied throughout the hospital sector to achieve uniformity in maintaining the required standards of disinfection, general cleanliness and appearance at a minimum cost, taking into account patients' needs and local conditions.**

**6.11** In examining this issue in other States, audit noted that the New South Wales Department of Health issued Standards for Cleaning Services in June 1989.

- *Management response by Alfred Hospital*

  *The development of such standards would be useful and this Hospital is prepared to assist in their development.*

  *It must be noted, however, that there are vast differences between hospital construction, use and environment. Consequently, the standards would need to be defined in terms of outputs rather than inputs or process.*

- *Management response by Health Department Victoria*

  *HDV proposes to develop guidelines for cleaning services for general Issue to hospitals. This will need to be done with regard to the development of human resource utilisation and allocation standards under the structural efficiency principle.*

  *HDV recognises that cleaning requirements vary between hospitals and that the level required can best be determined by individual hospitals.*

*Hospital level*

**6.12** While audit noted that certain documentation was available within the Cleaning Section of the Alfred to support cleaning activities, **the Hospital had not formalised a policy and procedures statement for the cleaning function.** Although a policy and procedures statement for cleaning had been prepared in draft form by the Hospital Services Manager, policies had not been ratified by senior management. Audit noted that the draft policy did not address the following issues:

- justifying the provision of cleaning services at night, weekends and public holidays in residential areas;
- monitoring and reporting practices to be used in the management of the cleaning function; and
- the requirements of a quality assurance program.

**6.13 The finalisation and ratification of cleaning practices would provide for consistency of cleaning procedures and form a basis for the Hospital to carry out its cleaning function in an efficient and effective manner.**

*Management response by Alfred Hospital*

*Subsequent to this report, policies and procedures relevant to the cleaning function of the Hospital have now been finalised.*

*There is ongoing assessment of these policies and procedures based on standards and procedures determined for the Department of Health NSW.*

## Central monitoring of cleaning costs

**6.14** While HDV collected certain costs in the past across a number of hospitals, audit noted that **hospital cleaning costs had not been compiled and analysed at a central level.** In recent years, hospitals have been given more autonomy to manage their affairs to meet targets set in Health Service Agreements within agreed budgets.

**6.15** Integral to HDV's central direction role, audit is of the view that HDV should monitor and analyse hospital costs across a wide spectrum of hospitals throughout the State in order to ensure that hospitals are operating efficiently. Audit was advised that HDV is currently working through a program of developing cost indicators.

**6.16** A preliminary analysis undertaken by audit in the cleaning arena disclosed the following variations for 1988-89:

**TABLE 6A. ANALYSES OF CLEANING ACTIVITIES, 1988-89**

| *Item* | | *The Alfred Group of Hospitals (Alfred Campus)* | *Monash Medical Centre (Clayton Campus)* | *Amalgamated Melbourne and Essendon Hospitals (Royal Melb. Campus)* |
|---|---|---|---|---|
| Annual cleaning costs- | | | | |
| Salaries and wages | ($) | 3 930 000 | 1 986 000 | 4 371 000 |
| Cleaning materials | ($) | 321 000 | 214 000 | 114 000 |
| Total | ($) | 4 251 000 | 2 200 000 | 4 485 000 |
| Labour input (effective full-time employees) | | 181 | 85 | 202.5 |
| Area cleaned | ($m^2$) | 99 500 | 54 282 | 100 240 |
| Average cleaning cost per $m^2$ (labour and materials) | ($) | 42.70 | 40.53 | 44.70 |
| Average cost of cleaning materials per square metre | ($) | 3.22 | 3.94 | 1.13 |
| Average area cleaned per cleaner | ($m^2$) | 549 | 638 | 495 |

*Source:* Information provided by hospitals.

**6.17** The review disclosed that:

- The comparison of the Alfred with the Clayton Campus of the Monash Medical Centre revealed that the average cleaning cost per square metre was $2.17 higher at the Alfred than at the Clayton Campus. An application of the average cleaning cost per square metre for the Clayton Campus to the area subject to cleaning at the Alfred highlights potential annual savings of approximately $216 000.
- The total cost of cleaning the Alfred and the Royal Melbourne Campus was similar. However, despite the Alfred and the Royal Melbourne Campus having a similar cleaning requirement, the cost of cleaning materials per square metre at the Alfred was 285 per cent higher than at the Royal Melbourne Campus.

Factors which may have contributed to the above variations are differences in:

- the bases for determining the cost of cleaning;
- the cost-effectiveness of purchasing practices;
- the cleaning requirement of individual hospitals;
- cleaning methods; and
- the frequency of cleaning.

**6.18 Although it is recognised that there are differences between each hospital's physical facilities and activities, it is considered that HDV should analyse the cost of cleaning each hospital in the State, determine the causes for material variations and ensure corrective action is taken where inefficiencies are highlighted. Standard costing policies and definition of terms would need to be developed by HDV prior to undertaking such an investigation.**

- *Management response by Alfred Hospital*

  *The Hospital agrees with inter-hospital comparison and would be prepared to assist in its development.*

  *Inter-hospital comparisons require a dedicated professional team, clear definitions, clear costing policies and agreed performance indicators.*

  *This will require considerable resources and there must be agreement on a strategic plan for developing inter-hospital comparisons rather than an ad-hoc approach.*

  *Table 6A highlights these problems.*

  *At the Alfred, the cleaning cost centre takes into account all items the Cleaning Department is responsible for as well as those items used in cleaning. The cost centre includes, besides basic cleaning materials, the following:*

  - *All paper products*
    - *towels; and*
    - *toilet rolls.*
  - *Soap*
    - *antiseptic; and*
    - *ordinary*

  *as well as cleaning contracts for windows and pest control.*

  *It is believed that this is not the case at the Royal Melbourne or Monash. Hence, the cost of actual cleaning material is significantly less than the figure quoted for the Alfred.*

  *It should be noted that the Hospital has achieved savings in excess of $200 000 compared to Royal Melbourne.*

  *The Clayton Campus is a new hospital designed for a much higher usage of mechanical cleaning. The figures given here do not reflect the benefits of that high level of mechanisation and on the evidence presented here it is doubtful if the Alfred could justify the investment in such equipment.*

- *Management response by Health Department Victoria*

  *As previously indicated, HDV has in place appropriate financial and management systems to monitor and control performance of hospitals to ensure that they comply with required reporting arrangements and exercise appropriate financial accountability.*

  *Agreement has been reached with HEF 1 for a joint Working Party to develop human resources utilisation and allocation standards under the structural efficiency principle. HDV will also consider the development of appropriate cost indicators to enable functional activities to be monitored by hospitals and compared with the appropriate standards.*

## Staffing

### *Staff establishment*

**6.19** To carry out the cleaning function the Cleaning Section had 181 effective full-time (EFT) positions at 30 June 1989 (180 at 30 June 1988).

**6.20** The number of staff required for cleaning has traditionally been based on past cleaning practices and perceived cleaning requirements. **A comprehensive survey of campus cleaning requirements had not been performed by the Hospital in recent times.** Presently, detailed surveys of cleaning requirements are performed only when changes in the nature or use of a particular area occur. A comprehensive survey of campus-wide cleaning requirements would allow an informed assessment of the adequacy of existing staffing levels.

*Management response by Alfred Hospital*

*A comprehensive survey of cleaning requirements has commenced.*

### *Staffing of departmental areas compared with wards*

**6.21** In 1984 a hospital in South Australia engaged a firm of consultants to review the hospital's cleaning activities. The consultants' report stated that larger areas should be cleaned per hour in departmental areas such as residential areas and administration, compared with that achieved in wards as cleaning requirements in non-hospital areas are less intensive. In audit opinion this principle would be universally applicable to all hospitals.

**6.22** However, an analysis undertaken by audit at the Alfred disclosed that **the productivity rate in the Nurses' Home was less than that of the main ward block of the Hospital on weekdays.** Refer to Table 6B for details:

**TABLE 6B. CLEANING PRODUCTIVITY RATES**

| *Location* | *Area ($m^2$)* | *Average daily hours (Mon. to Fri.)* | *Average productivity rate (a)* |
|---|---|---|---|
| Nurses' Home | 4 975 | 85 | 58.46 |
| Main Ward Block (4th and 5th floors) | 3 212 | 48 | 66.92 |

*(a)* The average productivity rate is the average square meters cleaned per hour by cleaner.

**6.23** There are currently 12 cleaners employed in the Nurses' Home for a total of 85.1 hours per day (Monday to Friday). As the cleaning task of the Nurses' Home is less complex than a ward it would be reasonable to assume that a cleaner in the Nurses' Home would cover a greater area per hour than a cleaner in a ward. The Hospital advised that cleaners in the Nurses' Home performed additional duties such as cleaning stairs, curtains, pantries and refrigerators. **Even though these additional duties would lessen the productivity rate for cleaners of the Nurses' Home, it is nevertheless considered that, after taking into account the less complex nature of cleaning duties, there is scope for reducing the number of cleaners employed in the cleaning function of the Nurses' Home.**

*Management response by Alfred Hospital*

*As the Main Nurses' Home is open and occupied 7 days per week, the workload is therefore generated and carried over the 7 day period and not 5 days as calculated in the audit report, albeit that the level of cleaning and staffing is reduced considerably on the weekend. On this basis, the daily average labour hours for the Main Nurses' Home should be 65 hours which indicates a productivity rate over the 7 day period of 76.53 $m^2$/cleaner/hour. However, the Hospital acknowledges audit opinion that a greater proportion of cleaning is undertaken during weekdays, and therefore it is not inappropriate for comparison of productivity rates to be based upon labour components for the Monday to Friday period.*

*Rostering of staff - Weekdays compared with weekends*

**6.24** The following charts illustrate that average daily inpatient admissions decline on weekends and the average bed occupancy is at its lowest level during weekends.

**CHART 6C. AVERAGE DAILY INPATIENT ADMISSIONS, SEPTEMBER 1989**

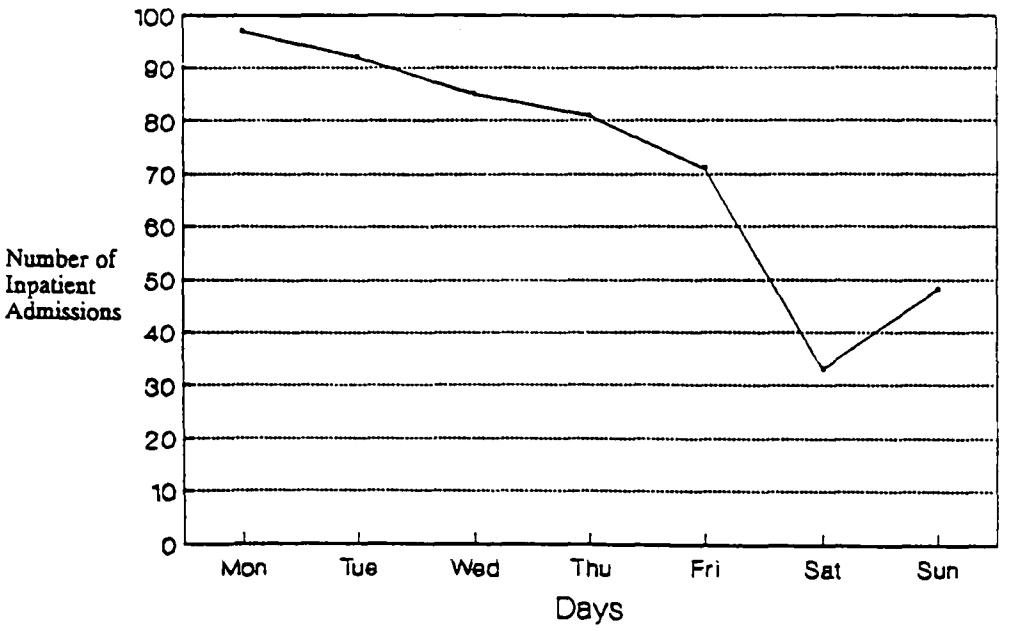
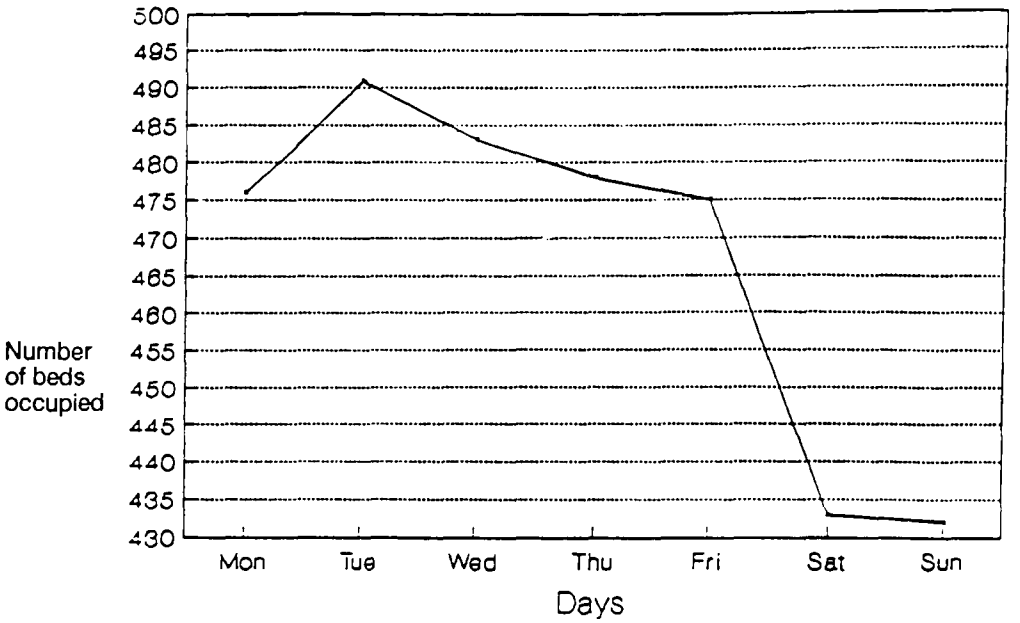


**CHART 6D. AVERAGE BED OCCUPANCY, SEPTEMBER AND OCTOBER 1989**




**6.25** Audit noted that the hours allocated to wards for cleaning on Saturday and Sunday were the same as the hours allocated on Monday to Friday, despite less hospital activity on weekends. The report by consultants in the domestic services area of a hospital in South Australia also suggested that hours allocated to cleaning wards on Saturday and Sunday should be lower than the weekday hours.

**6.26** Although audit recognises that the level of cleaning is more directly related to area requirements than the number of inpatients, in audit opinion occupancy levels should nevertheless be a contributing factor in determining the cleaning requirements of the Hospital on weekends. **As a consequence of improving rostering arrangements, productivity in the cleaning function could be further maximised.**

**6.27 The Hospital needs to undertake a comprehensive evaluation of the cleaning requirements of the Hospital and formalise standard areas to be covered per hour for various surfaces, in order to determine whether the current staffing levels are justified. As part of this process, particular attention should be given to the complexity of various areas of the Hospital and reducing the level of cleaning during periods when patient throughput is traditionally low.**

*Management response by Alfred Hospital*

*Although admission and bed occupancy figures indicate a reduction in patient activity at weekends, this is not necessarily across all patient areas; the cleaning workload is related directly to the area and items to be cleaned rather than to the overall reduction of patient numbers throughout the Hospital. In addition, some areas of the Hospital which are not accessible or suitable for cleaning on weekdays are also serviced on weekends.*

*Nonetheless, the Hospital Services Department is keenly aware of the need to constantly improve its cost-effectiveness. Indeed, a comprehensive re-evaluation of the cleaning requirements of the Hospital and associated areas has already commenced.*

## Sick leave

**6.28** Under the Hospital and Benevolent Homes Award cleaners are entitled to 12 days sick leave in the first year of employment, 14 days per year during the second, third and fourth years and 21 days per year thereafter. Cleaners are entitled to 12 days sick leave in any year without a medical certificate.

**6.29** In August 1988 the Alfred finalised a departmental plan with one of its objectives being to *minimise absenteeism and allowance time. To encourage a conscientious approach to sick leave every supervisor is required to afford personal contact with the staff member on his/her return from sick leave to ensure the well-being of that staff member.*

**6.30 Notwithstanding the introduction of this policy audit examination revealed that the incidence of sick leave remained at a significantly high level. The average number of sick leave days taken per cleaner from 1 July 1988 to 30 June 1989 at the Alfred amounted to 13.5 days compared with 9.8 days for cleaners of government buildings. Audit also noted that 31 per cent of cleaners used their full entitlement for 1989.**

**6.31** As a consequence of the excessive levels of sick leave additional overtime is incurred. Audit was advised that in circumstances where cleaners are absent through sickness, cleaning tasks are rescheduled to enable these tasks to be performed by the cleaners on duty. In periods of high sick leave, however, additional overtime is incurred to achieve the desired level of cleaning. In addition, staffing levels have evolved in such a way so as to accommodate the present level of sick leave.

**6.32 The Alfred should endeavour to reduce the level of sick leave by requiring the more frequent production of medical certificates, consistent with other areas of the public sector, to substantiate sick leave taken.**

*Management response by Alfred Hospital*

*It is understandable that concern would be expressed at some staff being able to take up to twelve (12) days per annum sick leave without the production of a medical certificate.*

*However, the terms of the Hospital and Benevolent Homes Award provide for:*

- *up to 3 single days per annum without the production of any evidence of illness; and*
- *up to a further 3 instances of up to 3 days at a time where a Statutory Declaration is accepted as evidence of illness.*

*An Award change would be necessary before the Hospital could require the production of medical certificates for such absences.*

*Awards also provide a high quantum of sick leave for Hospital staff whlch is fully cumulative from year-to-year. Some staff have credits of over 6 months, and even 12 months, and do not take sick leave unless illness makes it essential to do so.*

*Both the Hospital and the HDV have raised the possibility of an adjustment to certification requirements as a cost off-set at times of investigation or productivity increases.*

*The Hospital is conscientious in ensuring Award provisions are met, both in relation to prior notification of absences and also in certification of illness.*

*Further, the Hospital's Human Resources Department analyses absence patterns and monitors staff with high absence records with a view to managing this area within Award conditions. Actions include counselling to see if assistance can be given to the staff member to assist him/her in any problems which may exist, e.g. work relationships, substance abuse, personal problems. When it is necessary the Hospital utilises the Discipline Procedure in relation to excessive absenteeism.*

*In addition, work has been undertaken to improve, where necessary, and maintain, high levels of morale. The success of the Hospital's Staff Accident Prevention/WorkCare Costs Management Programs are an indication of the success of such efforts (Alfred consistently achieves a WorkCare "bonus").*

# PART 7

- MEDICAL AND SURGICAL SUPPLIES
- EQUIPMENT

# SUPPLY OF MEDICAL AND SURGICAL SUPPLIES, AND EQUIPMENT

## KEY FINDINGS

**Medical and surgical supplies**

- The re-use through resterilisation of medical and surgical items, designated as single-use by manufacturers, created potential health risks.

*paras 7.8 to 7.15*

- Over-ordering occurred due to inadequate quantity estimating and insufficient review of requirements.

*paras 7.22 to 7.25*

- The year end stocktake disclosed an unsatisfactory level of discrepancies (66 per cent of items).

*paras 7.30 to 7.33*

- The quantity of supplies, issued free of charge to patients on discharge (estimated value of $60 000), varied between wards and scope for the introduction of cost recovery practices had not been addressed.

*paras 7.34 to 7.38*

**Equipment**

- Instances were noted of equipment being retained beyond its economic or useful life.

*paras 7.40 to 7.42*

- Information systems to record equipment costs and usage had not been developed.

*paras 7.43 to 7.44*

**Policies and procedures**

- There is a need to establish performance indicators and reporting mechanisms to enable senior management to assess the efficiency and effectiveness of stores operations.

*paras 7.55 to 7.56*

## BACKGROUND

**7.1** At 30 June 1989 the Alfred utilised equipment costing $28.7 million and held stores, including medical supplies, to the value of about $1.3 million.

**7.2** With the exception of pharmaceuticals and foodstuffs, all purchasing within the Alfred is undertaken by the Hospital's Supply Department. Major acquisitions cover consumable medical supplies including surgical supplies and appliances, and medical and non-medical plant and equipment requirements arising from the Hospital's equipment and capital works programs.

**7.3** Separate stores areas, independent of the Supply Department's control and the Supply Store, have been established within the Alfred to handle the following items:

- pharmaceuticals;
- foodstuffs;
- sterile medical and surgical supplies and equipment (Central Sterile Supply Department);
- engineering supplies; and
- cleaning materials.

**7.4** Linen, while also stored separately from the Supply Store, is under the control of the Supply Department.

**7.5** Various end users, located throughout the wards and departments of the hospital, hold stores issued from these central storage areas pending consumption.

**7.6** The Supply Department is staffed by 24 officers. Annual operating costs in 1988-89 were $1.1 million. Audit estimates the value of purchases of medical supplies and equipment transacted by the Department in 1988-89 to be $16 million. The Department maintains an inventory covering 649 stock lines of medical and general supplies.

*Management comment by Alfred Hospital*

*The timing of this review of the Supply Department would appear to be unfortunate since the Supply computer system had just failed and was being replaced. Also, a new financial reporting system was being implemented across the Hospital, which would, in time, have a significant impact.*

*A number of the findings arose because of these factors.*

## AUDIT OBJECTIVES

**7.7** The audit objectives were to review management procedures involved in the supply function for medical supplies and equipment to determine whether policies and procedures had been formulated which provide for the supply function to operate in an efficient and effective manner, namely:

- purchasing of both medical supplies and equipment is undertaken in an economical manner;
- inventory management procedures ensure that there is proper security and accountability for stock held within the Supply Department and various sub-stores;
- imprest systems for the distribution of medical supplies and appliances operate efficiently;
- medical supplies and appliances are used solely for hospital purposes; and
- systems and procedures are employed to achieve the economic and efficient utilisation and disposal of equipment.

## AUDIT OBSERVATIONS AND RECOMMENDATIONS

### Re-sterilisation of single-use disposable medical and surgical items

**7.8** In December 1983 the former Health Commission of Victoria issued a policy stating that unless an institution could comply with all requirements of the Code of Good Manufacturing Practice issued by the Commonwealth Department of Health's National Biological Standards Laboratory, it should not attempt to resterilise any article which has been labelled by the manufacturer as single-use or disposable. The policy indicated that institutions, when reprocessing used items for re-use, may not adhere to the quality assurance controls required by the Code of Good Manufacturing Practice and, if so, should consider the possible legal implications of such actions. The policy also required that the reprocessing unit must ensure that the product is physically capable of safe use after having been submitted to the sterilising process and that all costs including plant, equipment, maintenance and consumables such as steam be taken into account in calculating cost savings associated with reprocessing sterile disposable items.

**7.9 Concern was expressed by the Alfred's Central Sterile Supply Department on the application of this policy as early as January 1984 that:**

- **a large number of disposable or single-use items were reprocessed and the costs of implementing the Health Commission's policy would be very high;**
- **a complete list of all single-use items which are reprocessed or resterilised should be prepared and costed; and**
- **a hospital policy needed to be formulated concerning the balance between expensive and traditionally reprocessed items, notably those from Radiology and Cardiology, versus the risk that these items may not be properly sterilised resulting in the guarantee of sterility being rather low.**

**7.10** Audit noted that it was not until May 1987 that the hospital policy on the re-use of disposable single-use items was considered by the Hospital's Product Evaluation Committee. A list of items currently re-used was submitted by the Central Sterile Supply Department. The Committee agreed that a number of areas required clarification between existing hospital procedures and the Commission circular, but that the approach taken within the Hospital of sterilising and repackaging items opened in error would continue. The matter was again considered by the Committee in September 1987, and it was resolved to forward a discussion paper to the appropriate user departments for further scrutiny. The minutes of the Committee meeting in March 1988 indicated that the matter was still under consideration by the medical staff of the Hospital. No further policy pronouncement has been formally made by the Hospital to date.

**7.11** Audit was advised that the re-use of disposable items had declined since consideration of the matter by the Product Evaluation Committee in May 1987. **However, some items labelled as "single-use" continued to be re-used after sterilisation.** Selected examples are as follows:

**TABLE 7A. RE-USE OF SINGLE-USE MEDICAL AND SURGICAL ITEMS AFTER STERILISATION**

| *Product description* | *Department* | *Annual usage* | *Cost per item* | *Number of times re-used* |
|---|---|---|---|---|
| | | | ($) | |
| Electrode catheters (Various) | Cardiology | 2 600 | 671.00 | Continuous re-use |
| Arterial perfusion cannula | Cardiac Theatre | 400 | 13.50 | 2 |
| Bulb irrigation syringe | Theatres | 200 | 2.52 | 2 |
| Codman surgical markers | Theatres | 196 | 2.53 | 3 |
| Angiographic catheters | Radiology | 1 200 | 23.50 | *(a)*1 - 3 |
| Blood vessel dilators | Radiology | 990 | 4.00 | *(a)*1 - 3 |

*(a)* On average 80 per cent of items were used up to 3 times.

**7.12** Audit was advised by the Cardiology Department that electrode catheters had been designated as single-use items by the manufacturers only within the past 12 months. Prior to this, the equipment was available for re-sterilisation.

**7.13** In discussions with Hospital staff on the issue of re-using disposable medical appliances, 2 viewpoints were presented to audit. One view stressed the economic benefits to the Hospital through reduced expenditure on medical supplies through the re-use of disposable items. As illustrated in the example cited by audit from the Cardiology Department, the single-use of electrode catheters (costing on average, $671) would have an adverse impact on the Department's budget. The other view referred to the potential risk of patient well-being through infection arising from the re-use of disposable items which may not be 100 per cent sterile following cleaning, particularly medical appliances used in intrusive medical procedures and those involving contact with blood. By way of example, of the first view, reference was made to a report published in an overseas journal on hospital infection control which demonstrated that no difference was shown regarding infectious and non-infectious side effects in patients, regardless of whether disposable or resterilised disposable catheters had been used. However, another overseas report outlined a number of issues relating to safety, ethics and legality involved in the re-use of disposable items. In this regard, the report included the following comments: "**the widespread re-use of disposables coupled with any probability of human suffering and death requires a serious evaluation of this activity by all concerned, including professional microbiologists**". Discussions with senior officers from the Alfred's medical administration suggested the issue may best be resolved by a committee of experts working under the auspices of HDV.

**7.14** Additionally, inquiries suggest that varying practices on the re-sterilisation of single-use disposable items may exist in other public hospitals.

**7.15 HDV should initiate a review of existing policies on the use of disposable medical and surgical items in the light of medical and current economic developments. Pending the outcome of this review, the Hospital should comply with the existing HDV policy on the re-use of disposable or single-use items. Additionally, management should regularly review and monitor re-sterilisation practices within the Hospital.**

- *Management response by Alfred Hospital*

  *This section of the report has been discussed on a number of occasions with the audit team.*

  *The Hospital's position is:*

  - *The situation is not as dramatic as pictured here.*
  - *The Product Evaluation Committee is only one Committee of many.*
  - *The Infection Control Committee's terms of reference includes reviewing and monitoring sterilisation and re-sterilisation practices within the Hospital.*
  - *The Hospital does monitor the situation.*

  *The Chairman of the Hospital's Infection Control Committee states:*

  > *"The use of such re-used items has been monitored in this Hospital, particularly the cardiac catheters, and there is no evidence of any actual 'risk to patient well-being through infection arising from the re-use'."*

- *Management response by Health Department Victoria*

  *HDV has considered its current policy on re-use of disposable or single-use items and considers that the policy should remain at this stage. HDV notes the recommendation of audit for a committee of experts to consider the matter. Prior to establishing such a committee, HDV would seek to undertake an analysis of current practices and procedures involved in the resterilisation and re-use of disposable or single-use items and to provide appropriate recommendations for consideration by a committee.*

## Purchasing of medical and surgical stock

**7.16** Supply of medical and surgical stock lines are purchased through either the Victorian Hospitals' Association (VHA) under its various annual Combined Hospital Purchasing programs (CHP) or directly from commercial sources. In relation to purchases through VHA, prices are negotiated for a 12 month period, estimates of supply requirements are advised annually to the VHA, while ordering is on an *as required* basis with orders placed on a weekly basis. Contracts with commercial suppliers of stock items are generally arranged for 6 monthly periods with varying arrangements for delivery of the goods. In determining supply requirements, purchasing officers within the Supply Department are assisted by a computer report which details monthly stock usage.

**7.17** Audit reviewed purchasing procedures associated with the acquisition of medical and surgical supplies and appliances. The review focused on the purchasing of stock lines which comprise a major portion of the Supply Department's inventory.

*Purchase of medical and surgical stock lines from commercial suppliers*

**7.18** Current policies regarding purchasing provide that:

- competitive quotations are to be obtained whenever possible;
- sole source procurement is to be used when there are supporting reasons to limit the source of supply; and
- unless good reasons exist to the contrary, the lowest quotation is to be accepted.

**7.19** The audit review found that policies regarding competitive quotations did not cover issues such as:

- the type and number of quotations to be sought relative to the value of the proposed order;
- guidelines for the approved use of restrictive purchasing;
- guidelines for sole source procurement; and
- when a tendering process should be undertaken rather than reliance on selective quotations.

**7.20 Audit examination of major orders for 20 medical and surgical stock lines held in the Department's inventory revealed that 75 per cent of these orders totalling in excess of $400 000 were raised without obtaining quotations.** However, a check of prices by audit contracted with successful suppliers against prices available through a major medical buying agency disclosed no price disadvantage to the Hospital.

**7.21 Hospital policies should embrace competitive purchasing which constitutes a fundamental tenet of acquiring goods and services in an economical manner, although it is recognised that market circumstances may arise when either restrictive purchasing or sole source procurement is justified.**

- *Management response by Alfred Hospital*

  *The recommendations regarding competitive purchasing and full documentation of action have been accepted in general and are being implemented in general.*

  *Wherever possible, competitive quotations are obtained and evidence and filing Is being maintained to provide records of competitive prices.*

  *There is no denying that there needs to be a substantial improvement in this area, but the emphasis must be on cost-effective purchasing and supply rather than 100 per cent attention to process and little attention to outcome. The resources available in this area are finite, and in many cases the time periods are finite. Hence, the main priority for documentation must be that it be adequate.*

  *The Hospital was aware of the ruling market prices for all 20 Medical and Surgical stock lines via the VHA tender system. Hospital personnel were aware of both VHA cost and sell prices hence they had an excellent idea of movements in the market.*

  *The audit report statement that they could find no price disadvantage to the Hospital would confirm the above view.*

  *The Hospital does embrace competitive purchasing.*

- *Management response by Health Department Victoria*

  *A Materials Management Review for the Victorian public hospital system has been completed (August 1989) to consider critical strategies and operational materials management issues with the objective of reducing the cost of inventory and supplies to hospitals through greater co-ordination of hospital buying power, improved inventory control and standardisation of supply policies.*

  *The recommendations of the Review have been endorsed by the Victorian Hospitals Association (VHA) and are being implemented by VHA Trading (VHAT) in conjunction with major teaching hospitals including the Alfred Hospital. It is expected that significant savings will be made available for redeployment to agreed services within hospitals.*

*Over-ordering*

**7.22** Stock replenishment practice provides for the Supply Department to generally carry, on average, 5-6 weeks' supply of stock lines. The review disclosed that in most cases purchasing officers did not document calculations to determine order quantities and delivery schedules for contracted suppliers prior to seeking approval by the Supply Manager of purchase orders. Furthermore, the economic order quantity facility of the Department's computer inventory system was not utilised as the re-order settings within the system were higher than the maximum level of stock set within the Department.

**7.23 The audit examination of inventory levels at 30 June 1989 disclosed incidences of stockholdings in excess of established levels.** Significant holdings were as follows:

**TABLE 7B. EXCESSIVE STOCK HOLDINGS**

| *Item* | *Quantity on hand* | *Average monthly issue* | **No. of months stock on hand** | *Value of quantity* |
|---|---|---|---|---|
| | | | | ($) |
| Surgical sponges *(a)* | 16 800 | 695 | **24** | 78 960 |
| Surgical sponges *(a)* | 1 700 | 102 | **17** | 8 500 |
| Tubing connector | 879 | 39 | **22** | 1 178 |
| Crepe bandage | 266 | 11 | **24** | 723 |
| Gauze dressing | 241 | 12 | **20** | 2 190 |
| Blood collection tube | 54 | 5 | **11** | 1 093 |
| Intravenous catheter | 27 | 3 | **9** | 1 161 |
| Surgical tubing | 113 | 14 | **8** | 1 803 |
| Dry battery | 1 634 | 336 | **5** | 4 052 |

*(a)* Audit was advised that the overstocking of 2 types of surgical sponges which were stored at the supplier's premises was due to the need for these items to be imported in large quantities.

**7.24** The Department's former computerised inventory system, introduced in 1983, was replaced by a new computerised system in the latter part of 1989.

**7.25 The Hospital should develop procedures for determining optimum levels of inventory, including proper estimation of forward requirements.**

*Management response by Alfred Hospital*

*The current computer system which has been implemented since this review calculates optimum re-order levels and provides past usage, stock on hand and stock-on-order details.*

*The new system also highlights slow moving stock and the situation presented in the audit report regarding excessive stockholding of such items is now capable of being monitored.*

## Stocktaking of inventory

*Stockholdings not included in inventory*

**7.26 Audit examination disclosed that stock items to the value of $121 000 (24 per cent of total stock), consisting of surgical sponges of various types, were neither recorded in the Supply Department's inventory nor subject to verification and review at 30 June 1989.**

**7.27** Audit inquiries revealed that stock was held at the supplier's premises because of space restrictions within the Supply Department. Stock was brought to account only when draw-downs were requisitioned and received in the Department to replenish stockholdings.

**7.28** Audit considers that effective inventory management practices should ensure all stock is brought to account once ownership is vested in the Hospital, regardless of the site of storage, and all items of stock should be included in the annual stocktake.

**7.29 Inventory recording procedures should be amended to ensure all stock acquired by the Hospital is brought to account and stock items located at non-hospital premises are included in the annual stocktake.**

*Management response by Alfred Hospital*

*Comprehensive guidelines for the conduct of the annual stocktake are being developed. These guidelines will provide reference on such matters as:*

- *the accounting and verification of stock;*
- *identification of surplus and obsolete items;*
- *review and adjustment of discrepancies; and*
- *reporting of results.*

*Stocktake discrepancies, 1988-89*

**7.30** The value of stock on hand at 30 June 1989 amounted to $384 000. The end of year stocktake undertaken by the Hospital of the 649 lines of inventory held at the Supply Department Store revealed that **in 66 per cent of cases** (approximately 50 per cent at 30 June 1988) **the actual stock on hand differed from the balance according to the Stores ledger.**

**7.31** The discrepancies in 66 per cent of stock items comprised 156 (36 per cent) surpluses and 274 (64 per cent) deficiencies.

**7.32** Audit was advised by management that due to a number of computer system problems it was not possible to satisfactorily explain the high level of discrepancies highlighted by the stocktake. As a result, management was not in a position to review and analyse the reasons for the discrepancies and report to senior management outlining the result of the stocktake. In addition, authority to amend the stock ledger had not been sought by Supply Department personnel.

**7.33 At the date of audit, it was noted that the Supply Department was implementing a new computer system designed to alleviate a number of the current deficiencies.**

*Management response by Alfred Hospital*

*As stated previously, the new computer system should overcome a number of problems raised in this area.*

*The new System provides the input documentation for stockpicking slips and this eliminates errors of interpretation that occurred previously between the requisitioner, the storeperson and the inventory clerk.*

*Stocktakes are now conducted with each stock reorder report (generated twice weekly).*

*A number of practices and procedures are currently being initiated in the accounts/financing area. Control and management of all stocktakes to ensure accuracy will be an essential part of the controllership function of the Finance Department.*

*Part of this role will be to ensure that there is a reconciliation between the stock value figures in the General Ledger and the actual stock held.*

*While it is a desirable goal to aim for few quantity variances between the physical and perpetual inventory figures, experience has shown that this variance will only reduce as other systems and disciplines are introduced into the Supply Department.*

## Medical and surgical supplies issued free of charge to patients on discharge

**7.34** The Hospital policy provides for the issue of patient medications on discharge. While quotas have been set in regard to the issue of pharmaceuticals on discharge, guidelines had not been formulated for the amount of medical and surgical supplies to be issued from utility stores at ward levels and the Central Sterile Supply Department to patients on discharge and associated cost recovery practices. Inquiries at 7 wards indicated different practices in regard to the issue of medical and surgical supplies on discharge. Details are as follows:

**TABLE 7C. SUPPLIES ISSUED FREE OF CHARGE ON PATIENT DISCHARGE**

| *Issue practices* | *Number of wards* |
|---|---|
| Nil | 1 |
| 1 week supply | 3 |
| 2 weeks' supply | 1 |
| Various (1-4 weeks) | 2 |
| | 7 |

**7.35** Furthermore, internal guidelines were sought in 1984 on the amount of stock to be supplied to patients on discharge. However, no action has been taken on this issue.

**7.36 Audit estimated that the value of medical and surgical supplies issued to patients on discharge at no cost was approximately $60 000 during 1988-89.**

**7.37** In addition, audit understands that in some other hospitals patients are not issued with medication on discharge while in other cases patients are charged for such issues.

**7.38 To ensure consistency in the issue of medical and surgical supplies to patients on discharge, guidelines on patient entitlements and cost recovery procedures should be formally developed by HDV.**

- *Management response by Alfred Hospital*

  *HDV is currently developing general guidelines and the Alfred Hospital Chief Executive, has been asked to develop appropriate guidelines for the Alfred.*

- *Management response by Health Department Victoria*

  *HDV will develop guidelines for the issue of medical supplies and equipment to patients on discharge.*

## Forward planning for the replacement of equipment

**7.39** At the date of preparation of this report the Hospital had not developed policies and procedures for the identification, forward planning and financial programming of equipment replacement needs.

*Management response by Alfred Hospital*

- *The Hospital currently has a firm undertaking an Asset Stocktake for the Group.*

  *The first stage in planning is to know where you are.*

- *A comprehensive chart of accounts has been established which will facilitate the examination of maintenance costs.*
- *All maintenance contracts are being found, listed and examined.*
- *A Capital Expenditure System has been implemented.*
- *A 3 year capital plan is being drawn up as part of the 1990-91 Capital Budget.*

### *Retention of assets beyond their economic or useful lives*

**7.40** The economic or useful life of each item of equipment is dependent on its nature, utilisation level and technological advances. For taxation purposes, the Australian Commissioner of Taxation prepares a schedule of depreciation rates for various categories of assets based on an estimate of the effective life of the item assuming it is maintained in good order and condition. This schedule allows for a replacement cycle of between 10 and 13 years, depending on the type of medical plant concerned. In the absence of standards across the public sector, these rates were chosen as a benchmark to assess the age profile of equipment.

**7.41 The audit review disclosed that:**

- **some items were either approaching the end of their useful life-span or had been retained beyond their economic life; and**
- **the Hospital had not developed equipment replacement programs.**

**7.42** A summary of these items and the consequences of non-replacement are as follows:

**TABLE 7D. COSTS ASSOCIATED WITH NON-REPLACEMENT OF EQUIPMENT**

| *Department* | *Item* | *Age* | *Estimated replacement cost* | *Consequences of non-replacement* |
|---|---|---|---|---|
| | | (years) | ($) | |
| Haematology | Sample handler | 7 | 60 000 | Service costs for last 6 months totalled approx $20 000. |
| Anatomical pathology | Microtome | 15 | 20 000 | Obsolete. Have been using equipment at a college in recent years. |
| Nuclear medicine | ECG monitoring system | 15 | 15 000 | Frequent mechanical failures. The $10 000 spent annually on continuous paper could be substantially reduced by the introduction of a new system. |
| " " | Gamma camera | 10 | 400 000 | Technically obsolete; foregone revenue of approx $80 000 per annum. |
| Cardio thoracic | Monitoring equipment | 9 | 143 000 | Weekly breakdowns. |
| " " | 6 respirators | 15 | 240 000 | Weekly breakdowns. |

**7.43** Audit noted that maintenance, repairs and associated costs such as downtime were not identifiable against individual items or categories of equipment. As a result of inadequate information systems, management was not in a position to readily monitor and measure equipment costs and usage. Also it was not possible to assess the costs and benefits of maintaining an item of equipment compared with replacing it.

**7.44 In order to avoid excessive maintenance costs, reduced operational efficiency and the retention of surplus assets, the Hospital needs to assess the extent of equipment retained beyond its economic or useful lives, identify future requirements and formulate complementary equipment replacement programs, taking into account the magnitude of associated maintenance and repairs. As part of this process, consideration will need to be given to the development of suitable management information systems and disposal programs.**

*Management response by Alfred Hospital*

*The Hospital is extremely concerned about the run down in its capital infrastructure. This is seen as a long term strategic problem. Departmental requests for capital for the Group in 1990-91 exceed $25 000 000 and it is unlikely that the Hospital's Capital Budget from HDV (excluding special projects) will exceed $1.5 million.*

*Given this scarcity of capital, equipment must be utilised beyond its economic life.*

## Purchase of medical equipment

*Prioritisation of equipment needs*

**7.45** Policies set out in the Hospital's Supply and Equipment Instruction provide for the listing and prioritisation of all capital requirements for review by the Senior Executive Group. These arrangements, however, have been superseded by a directive issued in April 1989 by the Group Manager - Facilities and Supply. This directive refers to the absence of procedures for the co-ordination and prioritisation of requests for capital equipment and building works, and provides for the establishment of a Capital Priorities Committee responsible for prioritising requests for equipment in excess of $5 000 and building works in excess of $10 000.

**7.46** Audit noted that equipment requirements funded under the Capital Works, Major and Minor Works and Equipment programs were generally identified by departments and prioritised by divisions with overall co-ordination of programs being provided by senior management. However, **replacement equipment requirements to be funded from hospital sources were not always identified.** In some cases, bulk allocations were made available to the Medical, Nursing and Administrative Divisions for this purpose.

**7.47** At the date of the audit review, requests for capital equipment and building works were not being forwarded to the Capital Priorities Committee for prioritisation. As a result some of the more important equipment needs of the Hospital may have been overlooked in the process of purchasing equipment for individual departments.

**7.48 Given the importance of utilising scarce hospital capital funds efficiently, audit recommends that urgent attention be given to ensuring all departments are aware of the requirements to forward requests for equipment purchases to the Capital Priorities Committee for review and prioritisation.**

*Management response by Alfred Hospital*

*The prioritisation of equipment needs by the Senior Executive Group was superseded in April 1989 by the instruction of the Group Director - Facilities and Supply.*

*These instructions have since been superseded by the Group's Capital Expenditure System implemented in April 1990.*

*Selection of equipment and suppliers*

**7.49** Prior to April 1989, hospital policy for the supply of equipment and services stated that: "... *the requisition may nominate a preferred supplier; however, the Purchasing Officer may select an alternative supplier, but is to advise the requisitioner of the change and that competitive quotations are to be obtained wherever practicable. Sole source procurement is to be used when there are supporting reasons to limit the source of supply".*

**7.50** An analysis of purchases under these arrangements highlighted that departments were consistently recommending a supplier to the Supply Department without submitting detailed specifications. Furthermore, there was a tendency of departments to supply only one or 2 quotations favouring the preferred supplier. In cases where one quote only was supplied, audit sought explanations for sole source procurement. Although these explanations were accepted, in many cases there was a lack of evidence to substantiate that the Supply Department scrutinised the department's recommendations, sought alternative quotes or queried the originating department.

**7.51 The Hospital is commended by audit for the revision in April 1989 of procedures regarding the requisitioning of equipment and selection of suppliers.** New arrangements require that quotations for major items of equipment will not be sought by the Supply Department without a proper specification having been prepared by the end user, and quotations for equipment will only be sought by the Supply Manager. However, at the date of audit, these requirements had not been implemented throughout the Hospital.

**7.52 As it is considered that the revised arrangements will lead to more effective purchasing of equipment, senior management should take action to ensure departments comply with the requirements of the directive issued in April 1989 for the requisitioning and selection of suppliers.**

*Management response by Alfred Hospital*

*As mentioned previously, all directives have been superseded by the Group's Capital Expenditure System.*

*Senior management is taking action to increase compliance with this system.*

## Management review of Supply Department activities

**7.53** The charter of the Hospital's Product Evaluation Committee promulgated in April 1981, includes a mandate to make recommendations on standardisation, economic ordering, stock holding levels and distribution and disposal methods; recommend or endorse changes to ordering arrangements; and initiate proposals to increase the effectiveness and/or efficiency in the use of equipment and supplies.

**7.54** Following discussions with the Chairman of the Committee and a review of its minutes, audit concluded that while the Committee regularly reviewed proposals for the introduction of new medical and surgical products, the Committee had not made any recommendations or initiated any proposals in relation to the Supply Department's supply and inventory management procedures.

*Management response by Alfred Hospital*

*We totally disagree with this concept. It is not the role of the Product Evaluation Committee to review Management practices in the Supply Department. They may wish to comment on certain aspects and their comments will be welcomed. However, the Group Director - Facilities and Supply is responsible for all procedures and management within Facilities and Supply. It is his role to ensure that the Management Procedures are adequate for the needs of the Hospital.*

*A Committee cannot be held responsible for the functioning of a Department. There needs to be clear responsibility and accountability. This has been placed with the Group Director - Facilities and Supply.*

**7.55** Audit also noted that performance indicators had not been set for the Supply Department, and there was no requirement for the formal reporting on departmental activities to senior management.

**7.56 It is considered that a program of periodic review of the Supply Department management procedures over time, in the manner set out in the Product Evaluation Committee's charter, would contribute to a more effective hospital supply function in the long run. There is a need to establish performance indicators and reporting mechanisms to enable senior management to assess the efficiency and effectiveness of stores operations. Performance measures could include:**

- **turnover rate of individual stock items;**
- **cost of operations relative to value of holdings and value of issues;**
- **number of out of stock items; and**
- **aged analysis of outstanding purchase orders.**

*Management response by Alfred Hospital*

*The Hospital agrees with audit's comments.*

*However, it will take some time to achieve this level of sophistication given the position the Hospital is starting from.*

## Inadequate supply policies

**7.57** While policies for capital equipment were revised in April 1989, audit noted that the existing supply policies and procedures of the Hospital had not been reviewed since 1986 and needed to be updated to cover the following activities:

- period contracting for medical and surgical stock lines;
- participation and purchasing in the Victorian Hospitals Association's annual buying programs;
- the need for purchase officers to refer to the Code of Good Manufacturing Practice for Sterile Therapeutic Devices when purchasing prospective surgical products, both from local and overseas suppliers, as prescribed by HDV in September 1988;
- standardisation of medical items, where appropriate;
- a need to review the economic impact on costs (for example, recurring maintenance costs) of the introduction of new product lines and equipment;

- forward planning of capital replacement needs;
- certain tendering arrangements;
- annual stocktaking of inventory; and
- management review of medical and surgical imprest items.

**7.58** The absence of a formal policy on tendering has resulted in varying practices being employed in the purchase of expensive items of equipment. For example, tenders were called for the acquisition of medical linear accelerators ($1.5 million) and a medical gamma camera ($350 000) while only quotations were called for the purchase of intensive care monitoring equipment at a cost of $517 000. In audit opinion the protracted negotiations which occurred over 17 months in the process of acquiring the intensive care monitoring equipment may have been avoided if tenders had been called.

*Management response by Alfred Hospital*

*A Capital Expenditure System for the Group was introduced in April 1990.*

*A formalised General Delegation of Board authority in many areas was issued in May 1990. This included capital and recurrent expenditure.*

*Supply policies in other areas will be introduced in the coming months.*

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