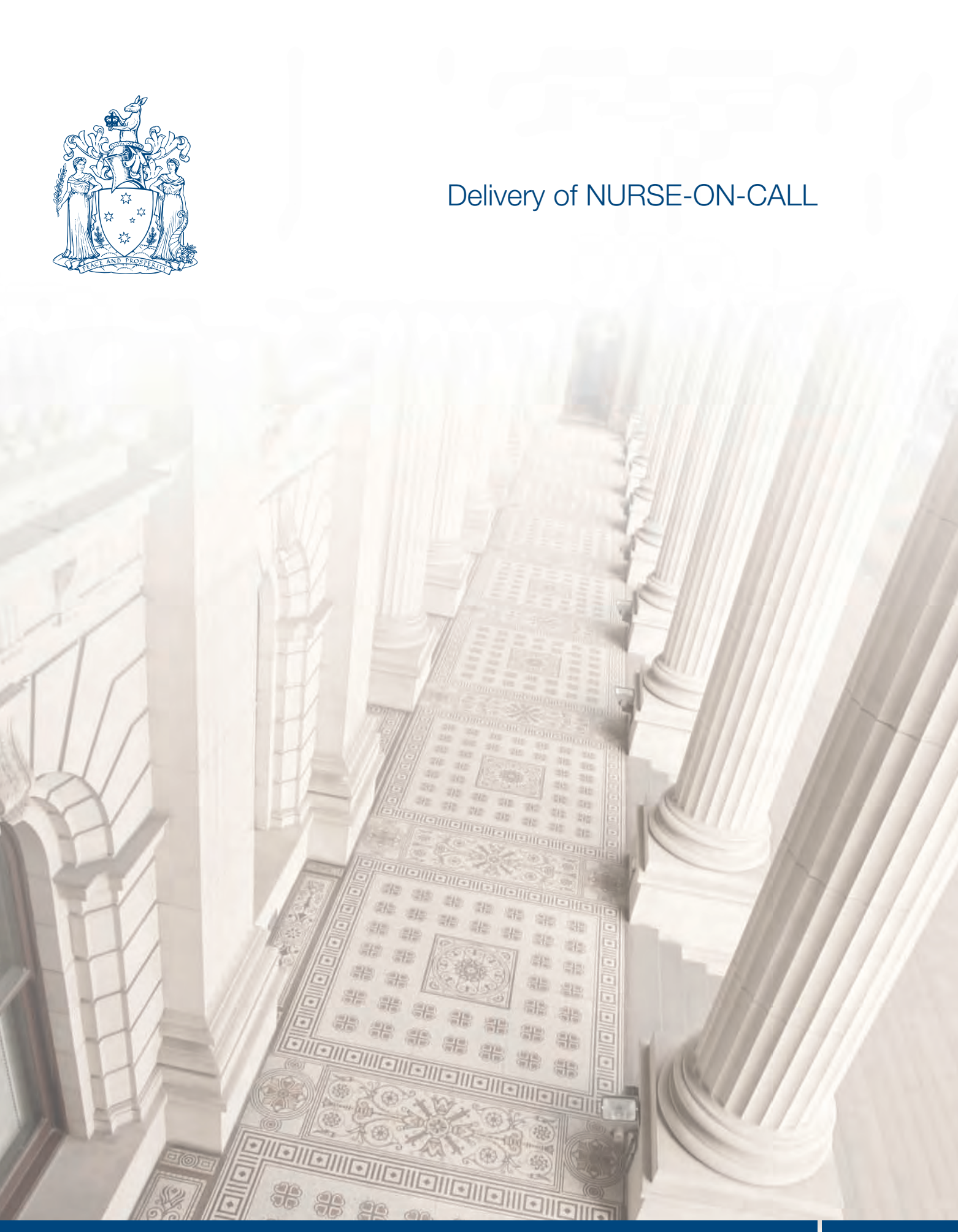
Delivery of NURSE-ON-CALL



Victorian Auditor-General's Report | September 2010 | 2010-11:8

VICTORIA

Victorian
Auditor-General

Delivery of NURSE-ON-CALL

Ordered to be printed

VICTORIAN
GOVERNMENT PRINTER
September 2010

PP No 367, Session 2006–10

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ISBN 978 1 921650 52 9

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Delivery of NURSE-ON-CALL*.

Yours faithfully

D D R PEARSON
Auditor-General

15 September 2010

Contents

Audit summary

The NURSE-ON-CALL service (NOC) was established in June 2006 with funding of $8.5 million per annum for three years. The principal aim of the service was to provide the community with readily accessible advice on medical matters to assist callers' decisions about whether to manage their symptoms themselves, seek general practitioners or hospital services. A secondary aim was to reduce demand on hospital services by diverting cases where acute care was not warranted.

The service uses registered nurses to offer health and medical advice over the phone at any time of the day or night. The Department of Health (DH) contracted delivery of NOC to a service provider which supplies the staffing, recruitment and training, and software.

The equivalent of NOC is provided as part of a national approach called *Health Direct* in all states and territories except Victoria and Queensland. In these jurisdictions, state-specific services are run. In the case of Victoria, the service is delivered by the provider that delivers *Health Direct.* In Queensland it is delivered by the state government.

This audit reviewed NOC to assess whether the public was able to access the service easily, if they were getting sound advice, and whether it was being effective in diverting demand away from hospitals. It also looked at whether DH was managing the contract so as to get optimal results from the service.

Conclusions

The audit concluded that, overall, NOC is a safe and cost-effective service. However international experience suggests there is scope to improve the quality of advice given.

While client surveys show those using the service were highly satisfied, it is not clear that those with language or special communication needs find the service accessible.

There is also significant scope for DH to achieve better value-for-money from the contract through more active contract management. Before the contract ends in March 2011 it will be important for DH to rigorously assess the current service provider's performance, as part of a wider review to confirm the ongoing need for, and design of the service. It will also be important, if the service continues, that DH address the weaknesses in the current contract that confer advantages to the service provider without a commensurate risk transfer.

Findings

Quality of advice

The provider is responsible for the clinical safety of its advice. Total reported incidents are extremely low at 105 out of 1.47 million calls. While overall the service is safe, 4 per cent of calls reviewed through mystery caller testing did not meet clinical safety standards. Further, there are no financial incentives to encourage the provider to improve its performance in terms of quality.

The audit found that DH has not used all available powers under the contract to assure the quality and reliability of the service. A preferable model would see clinical oversight by an independent third party, if not by DH, and fair penalties for under-performance in provision of clinical advice.

Role in demand management

NOC has undoubtedly saved health system costs by diverting callers from using ambulances or going to hospitals, where this course of action was not warranted by symptoms. We estimated an annual saving in health service resources of $4.6 million as a result. This is before other savings such as savings to individuals and to primary health services, and savings for hospitals arising from the transfer of calls to NOC have been factored in. This is an overall positive result, given the $9.9 million annual investment in the service and that its purpose was to improve health outcomes for callers through provision of timely and accurate advice.

Access

The service has not been proportionately accessed by different groups in the community. There has been extremely low use of interpreters to assist callers from non-English language backgrounds and hearing and speech impaired callers are also significantly underrepresented. However, DH has not examined why this is.

The consumer view

The service provider reports that customer satisfaction is high according to its surveys. However, the survey design warrants review to ensure the right questions are asked, and that the form of survey encourages participation.

Service provider performance

The timeliness performance target requires 80 per cent of calls to be answered within 20 seconds. This target was reasonable and based on standard call centre performance. From 2006 to mid 2009, the service provider routinely failed to meet this target despite having two key advantages. Firstly, until recently it influenced its own performance benchmarks by itself determining what was the 'normal' call volume it could be expected to deal with, and thus when timeliness targets would not apply. Secondly, it had the capacity to answer calls interstate using staff employed interstate, in times of high caller demand.

The contract setting the relationship between funder and provider did not have the right incentives for the service provider to perform well on timeliness. In particular, penalties for under-performance were weak and it was not until negotiations to increase the penalty in August 2009 that the service provider started meeting targets for timely answering of calls.

Since then, performance has improved and the service provider has met its performance standards.

The next phase of the service

Recognising that up to 40 per cent of NOC calls are currently being answered in other states by staff employed by the provider of the national service, *Health Direct,* with no apparent quality issues, the rationale for continuing NOC as a stand alone service is unclear.

The NOC contract ends in March 2011. In its planning for the next contract DH should undertake a comparative cost-benefit analysis of continuing with a Victorian specific service or joining the national system.

Recommendations

Number	Recommendation	Page
1.	The Department of Health should routinely measure awareness, usage and understanding of the service by callers with English language difficulties and hearing or speech impaired callers to assess whether their needs are being met.	18
2.	The Department of Health should review the methodology used in mystery shopping exercises and caller satisfaction surveys, to gain assurance that results are reliable and representative.	18
3.	The Department of Health should shift responsibility for caller satisfaction surveys from the service provider.	18
4.	The Department of Health should rigorously evaluate the service provider's performance and the appropriateness of the current contractual terms to inform its approach to the next contract.	28
5.	The Department of Health should undertake a comparative cost-benefit analysis of its procurement options including competitively re-tendering the contracted services.	28

Submissions and comments received

In addition to progressive engagement during the course of the audit, in accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health with a request for submissions or comments.

Agency views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report. Their full section 16(3) submissions and comments, however, are included in Appendix E.

1 Background

1.1 Introduction

Timely health advice can improve patient outcomes and reduce demand on other areas of the health system. An ageing population and increasing chronic disease are driving demand for primary health care services. However, with fewer general practitioners and bulk billing clinics, access can be problematic. This can create service delays or unnecessary calls to, or presentations at emergency departments. Alternate service models are increasingly important in improving service accessibility and demand management.

Telephone health information and advice services began in the 1990s in the United States, Australia and New Zealand. These services offer the public quick and accessible health information and advice. Operators use computer software to advise callers about the best course of action for the symptoms they describe, and make recommendations, ranging from ambulance transfer to self-care. While emphasis was initially on determining priority based on condition, telephone health lines have expanded to include services such as mental health and chronic disease management.

1.2 The NURSE-ON-CALL service

In 2006 the government provided $8.5 million to set up the NURSE-ON-CALL (NOC) service to:

- reduce telephone demand on public hospital emergency departments
- provide alternative modes of advice and referrals
- increase public access to advice and information about health care options.

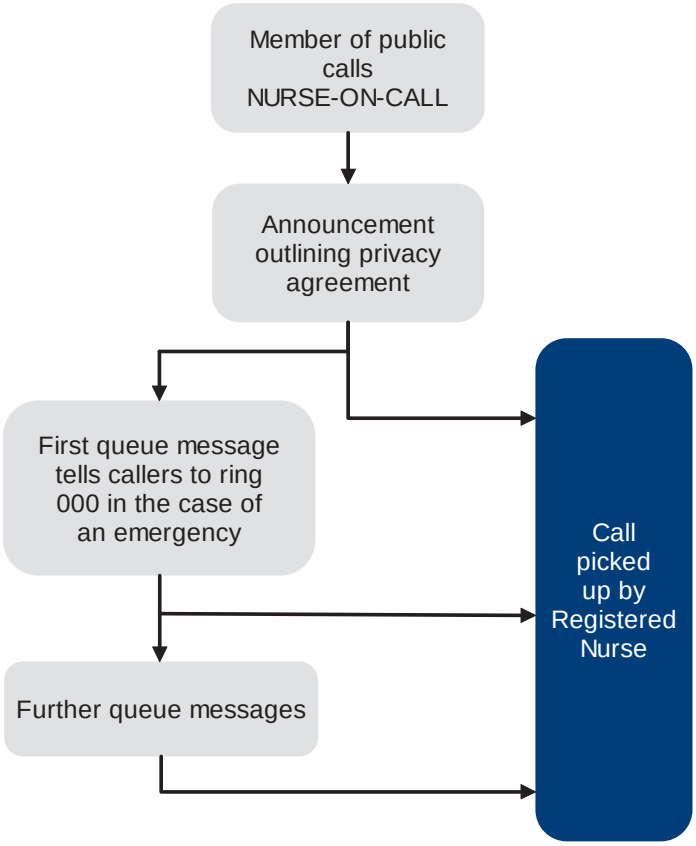
In 2009–10 NOC cost $9.9 million.

NOC is a 24-hour, seven-day a week telephone service. Callers can ring from anywhere in Victoria at the cost of a local call, although callers using mobile phones incur a higher charge.

NOC provides access to an interpreter for those who need this or the National Relay Service, a teletype service for hearing and/or speech impaired callers.

Figure 1A shows NOC's call management process.

Figure 1A
NURSE-ON-CALL flowchart



Source: Victorian Auditor-General's Office, using Department of Health information.

Registered nurses follow automated clinical guidelines that direct them through a series of questions to determine the severity of the caller's condition and the recommended response. The service provider reviews and updates the guidelines annually.

The software helps nurses to eliminate possibilities, such as immediate life-threatening issues, before they reach a clinical conclusion. Nurses can also use their clinical judgment to 'override' the software-based recommendation to a more urgent course of action. When this happens, the nurse must record the advice and information provided and justify why they did not follow the guidelines.

Nurses can also help callers with general information and advice, or provide contact information about local health care providers such as a general practitioner or pharmacy.

1.3 Roles and responsibilities

Service provider

The Department of Health (DH) contracts a service provider to supply all NOC services, including staffing, recruitment and training, and software. The provider's call centre is in Richmond; however, it has a work at home program, which almost 70 per cent of NOC call operators use.

The provider also delivers *Health Direct,* a Commonwealth, state and territory funded health advice line that operates in all states and territories, except Victoria and Queensland.

The NOC contract has an initial three-year term, with two one-year options to extend. Both options have been exercised and the contract will expire in March 2011.

Under the contract, the provider is responsible for managing NOC's clinical risks. This includes its ability to correctly diagnose symptoms and minimise incidents that result or could have resulted, in unexpected harm to the patient.

The Department of Health

Project Board

The NOC Project Board meets quarterly to review and approve major projects and decisions that affect NOC. Board members include directors from different DH branches, including Quality, Safety and Patient Experience, Integrated Care and Strategy, Policy and Finance.

Liaison Committee

The NOC Liaison Committee meets every six months. It is responsible for communicating and consulting with other stakeholders about:

- overall service provision
- analysis and review of performance data
- marketing and communications strategies
- strategic planning.

The provider's National Operations Manager, Director of Clinical Quality and Relationship Manager also go to committee meetings. DH attendees include the NOC contract management team, as well as managers from Corporate Services, Integrated Care, Corporate Communications, Acute Programs, Prevention and Population Health, Health Services Performance, and Communicable Disease Prevention and Control.

Clinical Risk Management Reference Group

DH set up the Clinical Risk Management Reference Group (CRMRG) to advise it on clinical risk management issues across all Victorian health services. The group meets quarterly and comprises clinicians, health professionals, quality managers, hospital board members and consumers. From February 2009, the provider has had to report sentinel events to the CRMRG. Sentinel events are relatively infrequent, clear-cut events that occur independently of a patient's condition and commonly reflect health system and process deficiencies. They can result in undesirable outcomes for patients. For example, an unexpected death or hospitalisation.

Contract management meetings

The provider and DH hold quarterly contract management meetings to discuss a range of issues such as performance management, industrial relations and improvements to the contract etc. Representatives from the provider include the general manager and the NOC relationship manager. DH representatives include the Director of Integrated Care, and the NOC manager and team leader.

Contract management team

The NOC contract management team in the Integrated Care Branch of DH is responsible for a range of day-to-day activities that support governance, contract management and performance monitoring of the contract. The team meets with the provider’s relationship manager monthly to discuss performance data and contract management issues.

1.4 Customers

NOC handles about 1 000 calls per day and more than 350 000 calls annually. Most callers use the service after hours, with the majority of calls on Sunday evenings. More than 70 per cent of Victorians live in metropolitan Melbourne, but on a per capita basis there is a heavier reliance on NOC in regional areas. In 2009–10, 26 per cent of total calls to NOC were from regional and rural areas.

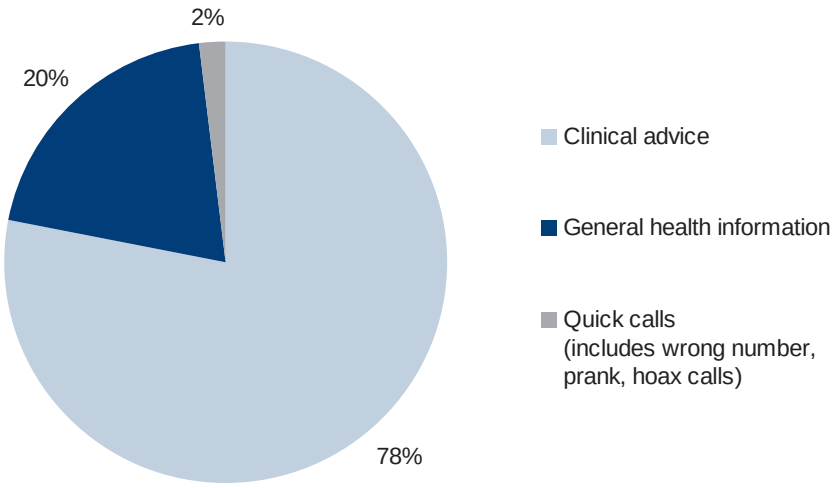
NOC is a popular service for parents, particularly mothers, with 24 per cent of callers wanting advice for children aged one to four years old.

In 2009–10 the most frequently used guidelines were:

- abdominal pain/discomfort
- vomiting (paediatric)
- medication question
- chest pain discomfort
- fever (paediatric).

As Figure 1B shows, nurses also give general health information including contact information about health providers, such as general practitioners.

Figure 1B
Percentage of calls by outcome



Source: Victorian Auditor-General's Office, using Department of Health information.

1.5 Audit objective and scope

The audit objective was to assess the effectiveness of the NOC service through the:

- accessibility and timeliness of health information and advice
- appropriateness of client outcomes
- appropriateness of health services outcomes
- adequacy of performance monitoring and reporting for the NOC system.

1.6 Audit method and cost

The audit was performed in accordance with the Australian Auditing and Assurance Standards. The total cost of the audit was $240 000.

1.7 Report structure

The rest of this report is structured as follows:

- Part 2 assesses the service provider's performance in delivering a quality, accessible, appropriate service.
- Part 3 assesses the design and management of the contract.

2 Effectiveness of the NURSE-ON-CALL service

At a glance

Background

The NURSE-ON-CALL service can play an important role in directing callers to the health service they need and, where appropriate, diverting patients from acute services by providing immediate, expert health advice. Success depends on whether people can access the service and if they get clinically safe advice.

Conclusion

The NURSE-ON-CALL service has saved health system costs and has benefited callers by providing access to relevant medical advice. There is opportunity, however, to improve the clinical safety of advice, timeliness of the service and usage by all sections of the community.

Findings

- Four per cent of calls reviewed through mystery caller testing did not meet clinical safety standards.
- In 30 of the 52 months reviewed, the service did not meet the required target of answering 80 per cent of calls within 20 seconds.
- The number of callers asking for an interpreter is inordinately low and the Department of Health has not investigated this.
- Customer satisfaction has been consistently high although the rigour of the survey methodology is not assured.
- The service has saved resources in other parts of the health system.

Recommendations

The Department of Health should:

- routinely measure awareness, usage and understanding of the service by callers with English language difficulties and hearing or speech impaired callers to assess whether their needs are being met
- review the methodology used in mystery shopping exercises and caller satisfaction surveys, to gain assurance that results are reliable and representative
- shift responsibility for caller satisfaction surveys from the service provider.

2.1 Introduction

The NURSE-ON-CALL (NOC) service should be available and accessible to all Victorians including callers with English language or other communication difficulties. Information and advice should be clinically safe. It is also important that the service is efficient and delivers the optimal value for the resources used.

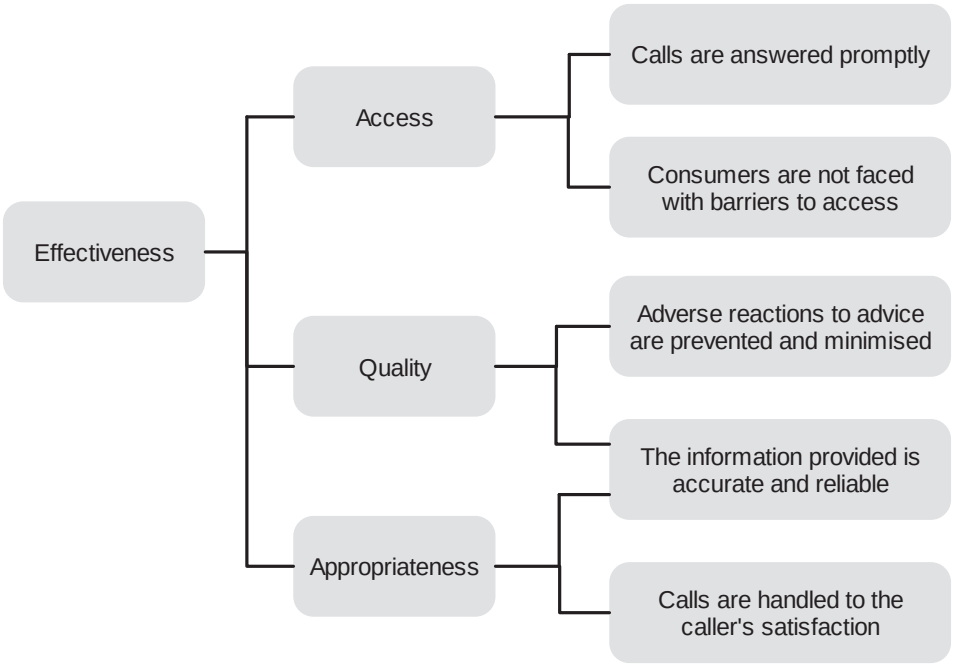
2.2 Background

The Department of Health (DH) has minimum performance standards (MPS) to measure the effectiveness of NOC including:

- the speed of connection to a registered nurse
- the required service level, for example, 80 per cent of calls answered within 20 seconds
- the proportion of calls getting a busy signal
- the rate at which calls are abandoned
- caller satisfaction
- clinical and customer service results.

The MPS for NOC are listed in Appendix A and reflect well-established indicators of an effective service including access, quality and appropriateness. In the context of a telephone advice service such as NOC, performance can be measured against the requirements shown in Figure 2A.

Figure 2A
Indicators of an effective telephone advice service



Source: Victorian Auditor-General's Office.

2.3 Conclusion

Over the last four years NOC has saved money for the health system and benefited the public by giving them immediate access to medical advice. However, DH has not used its powers under the contract to assure the quality of the service.

From 2006 to mid 2009 the service provider struggled to meet the standard call centre target of answering 80 per cent of calls within 20 seconds, with even small demand increases affecting its performance. Performance has now improved and the service provider has met its targets for timeliness.

There has been low use of interpreters and teletype services but DH has not examined this to find out why and whether the needs of people with English language difficulties are being met. Although the service provider uses a 'mystery caller' system to test the quality of the nurses' advice, the callers are fluent English speakers. Customer surveys also do not assess how users of interpreter or teletype services experience the service.

Of 800 'mystery' calls made, 31 calls or 4 per cent did not meet clinical safety standards.

The service provider reports that customer satisfaction is high. However, the validity of the results is not independently assured.

2.4 Access

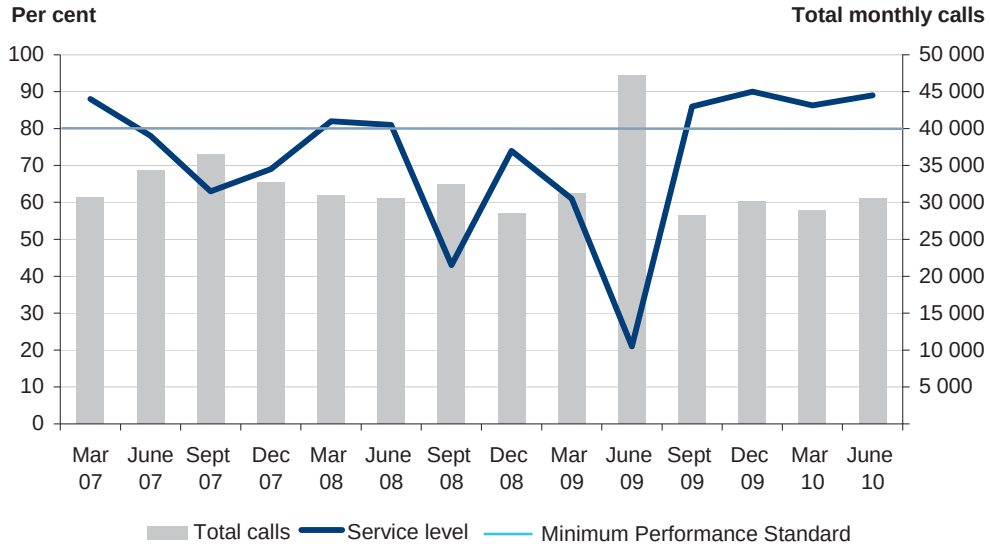
NOC calls should be answered promptly and the service should be accessible to people who face language or other communication barriers.

A minimum number of calls to be answered in a defined period is used to measure public access. The NOC contract requires 80 per cent of calls to be answered within 20 seconds, consistent with call centre industry standards. The service has not done this well however, failing repeatedly in its first four years of operation.

The average time for callers to speak to a registered nurse in 2009–10 was 33 seconds. This is an improvement from 2008–09 when callers waited almost two minutes to speak to a nurse.

As Figure 2B shows, even small seasonal increases in demand caused the service to fall off in both 2007 and 2008. Performance was worst in June 2009 following the H1N1 influenza or 'swine flu' event, when calls exceeded 45 000, and only 21 per cent of calls were answered within 20 seconds.

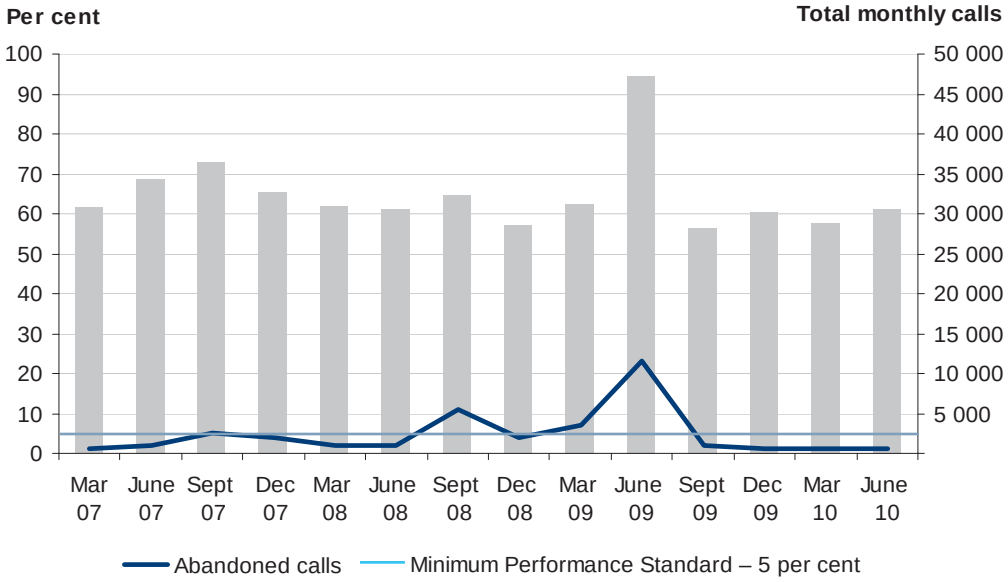
Figure 2B
Performance against service level



Source: Victorian Auditor-General's Office, using Department of Health information.

Figure 2C shows that performance in meeting the MPS relating to the number of calls abandoned after 20 seconds has been variable, with under-performance in 2008 and 2009.

Figure 2C
Calls abandoned after 20 seconds



Source: Victorian Auditor-General's Office, using Department of Health information.

DH can penalise the service provider for not meeting the minimum targets. Until November 2009, the maximum amount for a recurring breach was $30 000 a month or only 4 per cent of monthly revenue. DH doubled the penalty to $60 000 as part of a contract extension in November 2009. Negotiations to increase the penalty in August 2009 coincided with a marked improvement in performance and since then the service provider has consistently met the minimum performance standards for timeliness, as shown in Figures 2B and 2C.

Equity of access

NOC should be accessible to all Victorians, including callers with English language difficulties and hearing or speech-impaired callers, if it is to be effective and equitable.

Victoria is Australia's most culturally diverse state. Over 23 per cent of Victorians were born overseas, of whom 72 per cent were born in non-English speaking countries. Thus many potential callers may not speak English, or may have English as their second language.

The use of translation services for NOC was low, with fewer than 100 interpreters used out of a total of 338 824 calls in a 12 month review period, and only 38 calls to the National Relay Service recorded for hearing or speech impaired callers.

To make the best use of NOC, the public needs to know they are available when calling NOC. The NOC website advertises that people can use an interpreter. The NOC brochure is available on the website in 16 languages and is handed out to community groups on request.

As part of the NOC launch in 2006, DH ran a promotional campaign in 16 languages as well as English telling all Victorian households about the service. Since then there have been no strategies targeting callers with English language difficulties.

A similar service in the United Kingdom, *NHS Direct,* routinely measures awareness, use and understanding of the service among communities from non-English speaking backgrounds to identify issues with access and areas for improvement.

2.5 Quality

In the context of NOC, delivering a quality service involves providing advice that is clinically safe.

The service provider undertakes a number of internal quality assurance activities such as regular call monitoring and call coaching to assess nurses' compliance with customer service, procedural and clinical guidelines, and consistency of advice.

It provides DH with annual reports detailing its operational and clinical governance framework, human resources, disaster recovery and emergency response plans. It also reports results of regular 'mystery' caller exercises and customer satisfaction surveys, used to test the quality of the service.

2.5.1 Preventing clinical incidents

Clinical incidents result or could result in unexpected harm to the patient. They can have serious consequences and may deter people from using the service. In some cases they can end in death.

While not all clinical incidents can be prevented, it is critical to minimise risks by identifying actual and potential incidents and trying to prevent them in the future. The service provider reviews all incidents to identify the causes such as:

- not following an operational protocol correctly
- missing cues from the patient
- poor clinical decision making and advice
- errors in documentation or while using the computer
- process issues such as poor customer service.

On a monthly basis the service provider reports total risk incidents to DH with a summary of the cause of the incident and action taken in response.

Total reported risk incidents are extremely low at 105, or 0.007 per cent, out of 1.47 million calls.

There have been no reported sentinel events, that is, events that result in unnecessary outcomes such as an unexpected death and reflect system and process deficiencies of the NOC service.

Numbers of reported incidents do not correctly reflect clinical safety as some incidents go undetected. In 2008, for example, the service provider only found out that a patient had died, seven months later when it was asked about the patient's medical records. While the nurse's advice had been appropriate in this case, the seven month delay highlights the potential for clinical risks to go undetected.

Given this potential, quality assurance measures are particularly important.

2.5.2 Accuracy and reliability of advice

The service provider contracts mystery caller exercises to a third party. Every six months actors posing as patients make 100 calls in English to NOC using scripts. The actor gives cues designed to lead the nurse to an expected result, for example, by mentioning dry lips and thirst to indicate dehydration.

At the time of the audit, mystery callers had made 800 calls to NOC. In 16 per cent of calls, the nurse did not reach the expected advice result.

Advising patients to take a more serious course of action than expected suggests the nurse is being cautious. It may not lead to the most efficient use of health services but is still clinically safe. However, advice that is less urgent can have serious results for patients who need immediate attention.

While in 6 per cent of calls the advice was safe, in 82 calls or 10 per cent the advice was potentially unsafe. A medical examiner appointed by the sub-contractor reviewed these 82 calls and decided 31 of them were unsafe. This represents 4 per cent of the total mystery calls made.

The results of mystery call testing has improved, with 2 per cent of calls assessed as unsafe in 2009–10 compared with 5 per cent in 2008–2009. This may reflect the maturity of the service which is now in its fifth year.

The most common reason for assessing the NOC call as unsafe was the nurse's failure to pick up on cues given by the caller, as shown in Figure 2D.

Figure 2D
Example of investigation by medical examiner

Findings from investigation	Outcome
Example One The treating nurse missed information about length of pain from the complaint. The recommended action was 'See general practitioner within 24 hours' but it should have been 'See doctor immediately'.	The nurse had call coaching focusing on picking up cues from callers.
Example Two The treating nurse failed to take account of information about the patient's dehydration including dry mouth and poor fluid intake. The recommended action was 'See doctor in four hours' but should have been 'Attend emergency department immediately'.	The nurse had call coaching focusing on picking up cues from callers.

Source: Victorian Auditor-General's Office, using Department of Health information.

There are also limitations in the mystery caller methodology.

Given that there are over 300 000 calls to NOC each year, the annual sample size of 200 mystery calls is small. Mystery patients use the same set of scripts each time, which significantly limits the scenarios that test the nurses. Finally, as all the mystery patients are fluent English speakers, the service provider cannot assess how non-English speakers or hearing or speech impaired callers might experience the service.

The NOC contract does not specify the number of potentially unsafe calls permitted in mystery caller exercises. In the absence of a minimum standard, international experience provides a point of reference for NOC. The 2003 *Evaluation of NHS Direct* in the United Kingdom examined the appropriateness of advice in 2748 calls in terms of the 'necessariness' of contacts with services following the call. It found that overly cautious advice leads to unnecessary contacts with other health services in 13 per cent of calls, and insufficient contact in about 1 per cent of calls.

This is consistent with results of a review of calls made to the *Healthline* service in New Zealand in 2005, which found 1 per cent of calls were unsafe.

Although the studies are not directly comparable with the mystery caller exercises, the fact that the exercises are not well designed and that 4 per cent of mystery calls were unsafe, points to the need for better assurance regarding safety of NOC information and advice.

2.6 Appropriateness

Customer satisfaction can be used to measure if the service is appropriate to callers' needs. Customer surveys indicate if callers trust the service and would use it again, as well as how it could improve.

Each month, a random sample of 400 consenting callers are posted a survey within five weeks of their contact with NOC. This is about 1.5 per cent of total monthly calls. While the average response rate is low at 31 per cent, overall satisfaction rates are consistently high with 98 per cent of callers saying they would use the service again.

Figure 2E
Surveys results – caller satisfaction by percentage

	Mar 07–Aug 07	Sep 07–Feb 08	Mar 08–Aug 08	Sep 08–Feb 09	Mar 08–Aug 09	Sep 09–Feb 10
Response rate of 2400 callers	33	33	32	24	31	31
Overall satisfaction	98.8	99.1	98.4	99.6	98.2	98.9
Satisfaction with time spent in queue	88.7	89	94.7	89.5	84.8	87.3
Perception of whether nurse listened carefully	100.0	99.6	99	99.2	99.2	99.1
Would the caller use the service again	96.9	98.4	98.6	97.7	97.4	97.9

Source: Victorian Auditor-General's Office, using Department of Health information.

As part of the mystery caller exercises, mystery patients also evaluate whether they were satisfied with the call. These results are also extremely high, ranging from 97 to 100 per cent, and are consistent with the responses to the survey. Details of results are shown in Appendix B.

Callers clearly see NOC as a worthwhile service that meets their needs. However, there are also some limits in their methodology.

The average response is rate is low at 31 per cent or 744 out of 2 400 callers. Using other survey methods such as telephone may improve this. The survey also fails to record feedback from callers who face barriers accessing NOC such as those callers needing an interpreter or teletype service. This is a significant gap which stops the service provider from identifying improvements.

Although a third party posts the surveys to callers and collates the survey data, this party is not independent as it is engaged by the service provider. Further, the results are summarised and reported to DH by the provider, undermining their objectivity.

2.7 Efficiency

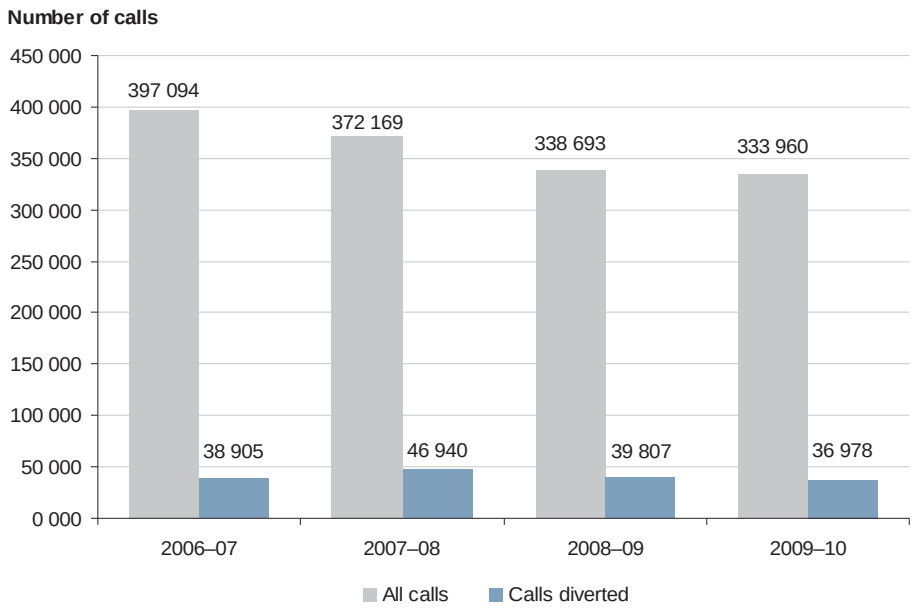
In addition to examining the impact of NOC on callers, we assessed outcomes for the health system and whether the service contributes to greater efficiency.

The NOC service can play an important role in managing demand, directing callers to the health service they need and, where appropriate, diverting patients from acute services by providing immediate, expert health advice. The experience of Western Australia and the Australian Capital Territory shows that if callers follow the advice, the shift away from the emergency department (ED) and ambulance services to General Practitioners and self-care may cut emergency attendances by 40 per cent.

It is difficult to measure the effect of NOC on health services as healthcare models develop and demand drivers change. Health services are under growing pressure due to the ageing population and the increase in chronic diseases. To compensate, new ways to divert the public from the ED or hospital admission have been introduced in recent years. Hospital in the Home, for example, treats patients in their homes, while the Hospital Admissions Risk Program aims to reduce hospital admissions by working with frequent users of hospitals or at-risk patients such as people with chronic respiratory or heart disease.

The service provider counts the calls transferred from public hospital EDs to NOC. The service has taken an average of 40 657 calls from public hospital EDs each year thus reducing demand on staff time in EDs.

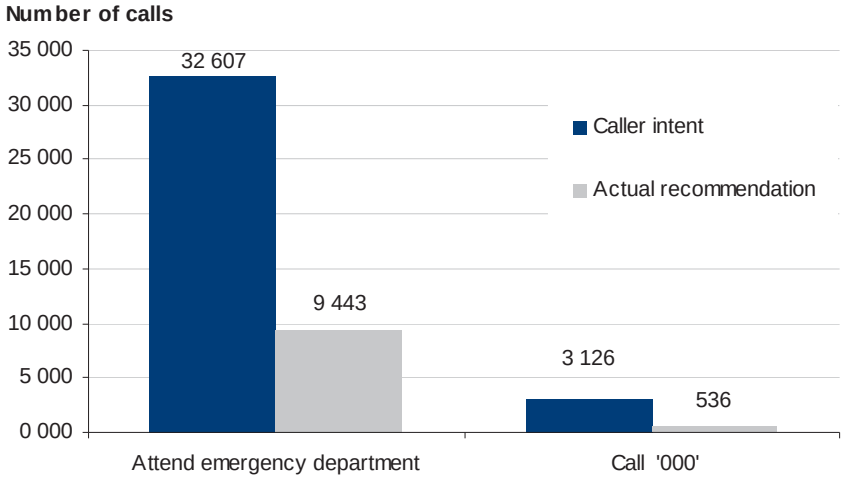
Figure 2F
Rate of calls diverted to NURSE-ON-CALL from emergency departments



Source: Victorian Auditor-General's Office, using Department of Health information.

As Figure 2G shows, of the 3 126 callers who had planned to ring an ambulance in 2008–09, NOC advised 2 590 or 83 per cent to take less urgent action. Of the 32 607 callers planning to go to a hospital ED, NOC recommended only 9 443 or 29 per cent to 'See ED immediately'.

Figure 2G
Caller intent versus nurse recommendation



Source: Victorian Auditor-General's Office, using Department of Health information.

While data suggests the rate of callers diverted from emergency services is high, it is indicative only as callers may not follow the nurse's advice. To measure the health system savings attributable to NOC, it is therefore necessary to know whether the caller actually followed the advice.

DH does not collect this information routinely but in 2008, it interviewed NOC callers over three months to assess whether they followed advice and what influenced them. Results indicate 68 per cent of callers follow NOC recommendation overall, with compliance ranging between 44 and 80 per cent according to the course of action recommended. Further information about this survey is provided in Appendix C.

The total number of patients diverted from emergency services indicates that NOC prevented at least 1 761 ambulance calls and 15 752 ED presentations in 2008–09.

Figure 2H
Minimum number of patients diverted from emergency services

	Intended course of action	NOC diverts caller by advising different course of action	Diverted callers assessed against average rate of compliance (68 per cent)
Call an ambulance	3 126	2 590	1 761
Attend emergency department	32 607	23 164	15 752
Total	**35 733**	**25 754**	**17 513**

Source: Victorian Auditor-General's Office, using Department of Health information.

Ambulance fees and the average cost of attending an ED are listed in Appendix D. This allowed us to estimate an annual saving in health service resources of $4.6 million for the callers that intended to go to an ED or call an ambulance. This is a positive result, given the $9.9 million annual investment in NOC and that its objective is primarily to provide an information service to callers and secondarily to manage demand on the health system.

Further savings from other callers, for example, where clients would have called on a doctor but were advised not to, and savings in time that clients spent finding treatment, mean the overall benefits are likely to exceed the costs of the NOC service.

Although it is clear that NOC has saved health system costs and has benefited callers, the contract's design and management weaknesses mean the service is not as efficient as it could be. This is discussed in part three.

Recommendations

1. The Department of Health should routinely measure awareness, usage and understanding of the service by callers with English language difficulties and hearing or speech impaired callers to assess whether their needs are being met.
2. The Department of Health should review the methodology used in mystery shopping exercises and caller satisfaction surveys, to gain assurance that results are reliable and representative.
3. The Department of Health should shift responsibility for caller satisfaction surveys from the service provider.

3 Contract design and management

At a glance

Background

The Department of Health contracted NURSE-ON-CALL to a service provider, which supplies the staffing, recruitment and training, and software. The contract started in January 2006 with a three-year term and two one-year options to extend. The options were taken up and the contract expires in March 2011.

Conclusion

Weaknesses in contract design and management have contributed to under-performance by the service provider. However the end of the contract in 2011 is an opportunity for the Department of Health to review past performance and rigorously assess its procurement options, including joining the national service.

Findings

- The Department of Health has only recently strengthened the contract to encourage optimal performance and specify a forecasting methodology to allow it to assess when to use penalties for under performance.
- The service provider transfers 30 to 40 per cent of calls to its staff interstate most months, which is contrary to the contract's intent that a focussed state-based service be provided. There are likely costs savings to the service provider, which the state has not benefited from.
- The chair of the national service estimated that there could be substantial savings to Victoria if it joined the national system.
- The contract terms relating to termination and intellectual property effectively advantages the existing service provider and preserves the status quo.

Recommendations

The Department of Health should:

- rigorously evaluate the service provider's performance and the appropriateness of the current contractual terms to inform its approach to the next contract
- undertake a comparative cost-benefit analysis of its procurement options including competitively re-tendering the contracted services.

3.1 Introduction

The Department of Health (DH) depends on the service provider for the NURSE-ON-CALL (NOC) service. It is therefore essential that the contract design encourages optimal performance and that management of the contract is effective in meeting the state's aim of providing a service that reduces the load on hospitals and offers quality health advice that can be easily accessed.

3.2 Conclusion

The design of the contract means that the NOC service is not operating as efficiently or as effectively as it should. The penalty regime is not sufficient to guarantee good performance in periods of high call volume, the state cannot share cost savings that the service provider might make in using staff interstate staff to answer NOC calls, and it faces a challenge to service continuity when the current contract expires in 2011.

Although the contract allows for penalties for failure, the penalties are low compared to the revenue the service provider receives, and do not apply to all performance standards. Because the service provider can avoid the penalty in periods of unforseen demand, it has little financial incentive to perform well at such times.

The contract permits higher payments to the service provider for reasonably incurred costs, such as changes in health sector wages. However, there is no corresponding right for the state to share in savings in internal costs over the contract term.

The contract licenses the state to use the service provider's intellectual property during the contract term unless it assumes responsibility for direct delivery of the service. These provisions favour extending the existing contract rather than re-tendering, if a Victorian specific service is to be maintained.

Any re-tendering of the NOC service, which expires in March 2011, will depend on DH's ability to manage the transition out of this contract.

While there were some improvements to the contract when it was extended in November 2009, the issues raised by this audit should be a priority for NOC in 2011 and beyond. To get value-for-money, DH should thoroughly evaluate all its procurement options.

3.3 Contract design

The contract's positive features include:

- a detailed description of the required services
- objectively measurable performance standards
- comprehensive reporting obligations
- the ability to monitor, review or audit the performance of the service.

However, the contract could be strengthened to maximise performance and value-for-money.

3.3.1 Incentives for performance

Although there are nine minimum performance standards (MPS) in the NOC contract, the performance penalty applies only to those standards relating to call responses:

- the minimum number of calls answered in a set time
- the call abandonment rate
- the number of callers who get a busy signal.

This means there is no financial incentive to improve performance against the remaining MPS including caller surveys and mystery caller exercises.

Further, the NOC service did not meet the required call response service level from 2006 to 2009. During this period the penalty for a recurring breach was capped at $30 000 a month or about 4 per cent of monthly revenue. As Figure 3A illustrates, this was not enough to stop recurring breaches in 2007–08 and 2008–09.

Figure 3A
Penalties for non-performance

	2007–2008		2008–2009	
	Performance result	**Penalty applied**	**Performance result**	**Penalty applied**
July	**Breach**	$5K	**Breach**	$2.5K
August	EC*		**Breach**	$30K
September	**Breach**	$30K	**Breach**	$30K
October	**Breach**	$30K	**Breach**	$30K
November	**Breach**	$30K	**Breach**	$30K
December	**Breach**	$30K	**Breach**	$26K
January	**Breach**	$9.5K	Met	
February	Met		EC*	
March	Met		EC*	
April	Met		**Breach**	$15K
May	Met		EC*	
June	Met		EC*	

Note: *EC refers to an extraordinary call volume where the penalty did not apply.
Source: Victorian Auditor-General's Office, using Department of Health information.

Following long periods of under performance, DH doubled the monthly penalty in November 2009 as a condition of the contract extension. It is still relatively low however, at a maximum monthly penalty of $60 000 or 8 per cent of monthly revenue for a recurring breach.

Negotiations to increase the penalty coincided with improved performance and the service provider has not been penalised since July 2009. In July 2010, NOC experienced a 23 per cent increase in call volume from the previous year and achieved its performance targets. However, whether the increased level of penalty is effective is yet to be adequately tested as call demand has otherwise been stable.

To encourage optimal performance, penalties should apply to all the performance standards and should reflect the severity and frequency of the failure. This warrants particular attention in securing a service beyond March 2011.

3.3.2 Exemption from the poor performance penalty

The contract imposes no penalty in cases of 'extraordinary' call volume, defined in the contract as a 5 per cent increase on forecast calls. While this is a reasonable position, at only 5 per cent above normal call volume the threshold for determining extraordinary demand is overly generous to the contractor.

There must be a forecast monthly call volume before DH can assess if call volumes are extraordinary. However the service provider was wholly responsible for forecasting call volumes. This created the risk that it would reduce the forecast numbers to avoid the penalty.

The contract did not specify how to forecast call volume and it was not until it was extended in November 2009 that DH clearly specified the process, enabling it to calculate forecast figures itself. From 2006 to late 2009, therefore, DH relied on the service provider to provide accurate forecasts.

There are no penalties if the service provider fails to meet performance standards in a 'major health crisis', such as disease outbreaks, natural disasters or accidents. In such cases the service provider is only required to use 'reasonable endeavours' to meet minimum standards.

Granting 100 per cent relief in major health crises and times of extraordinary call volume means the service provider will not be penalised irrespective of how badly it performs. The lack of a financial incentive in such periods means that when the public is most in need of the service, callers may face long delays. This happened in June 2009 after the H1N1 influenza or 'swine flu' event, when 31 per cent or 14 826 calls were abandoned.

Rather than granting total relief from the penalty in such periods, the contract could instead provide for a proportionate penalty that is linked to the rise in demand.

3.3.3 Potential cost savings

If the contract is extended, the service provider can raise the price to reflect extra costs like wage increases. DH cannot 'unreasonably refuse' to accept the cost increase provided that:

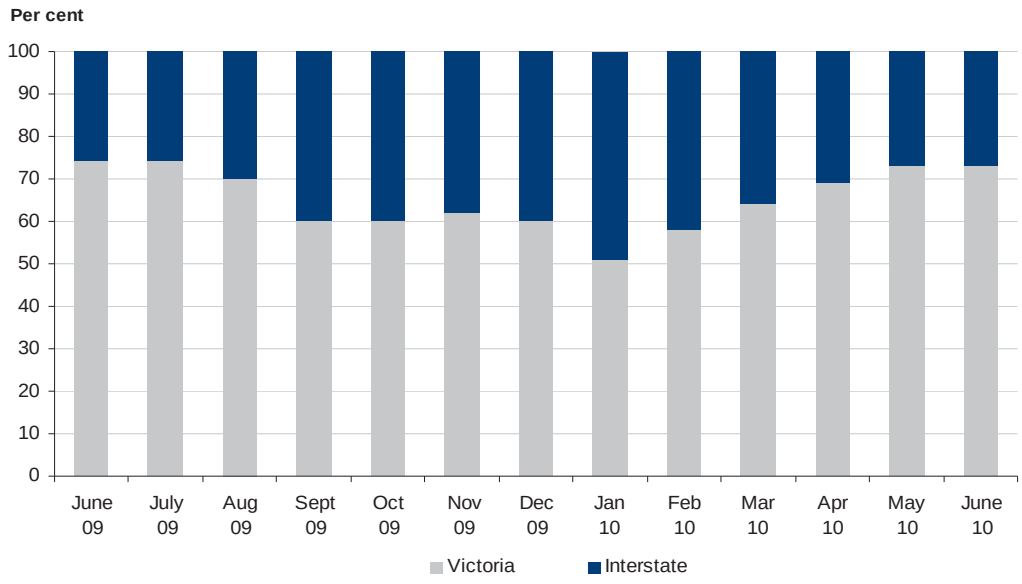
- it reflects external costs that are beyond the reasonable control of the service provider
- the service provider uses reasonable effort to mitigate the costs
- the service provider provides supporting evidence acceptable to DH.

However, there is no reciprocal right for the state to share in any savings such as from efficiencies made during the contract term. For example, potential cost savings from answering NOC calls interstate and from the rising number of nurses working from home.

The nature of the NOC service means that staff resources must be routinely managed to meet call demand. This is factored into pricing.

The NOC contract allows NOC calls to be transferred from Victoria to nurses employed by the service provider interstate in periods of extraordinary demand. While this has the advantage of improving timeliness for callers, the number of transferred calls is higher than what appears reasonable, with between 30 to 40 per cent of calls answered interstate most months, as Figure 3B shows.

Figure 3B
NURSE-ON-CALL call handler location



Source: Victorian Auditor-General's Office, using Department of Health information.

In January 2008, the NOC call centre stopped running overnight and nurses answered calls from home.

There are likely to be savings from answering calls interstate and using the Work at Home model, such as in office overheads. However, the contract design means the state does not benefit from any savings. This warrants attention in negotiating the arrangements to apply from March 2011.

3.3.4 Intellectual property and service continuity

DH has the opportunity to strengthen the terms of the contract when it is replaced in March 2011. However, the current contract creates barriers to entry for any new service provider.

The contract licenses the state to use the service provider's intellectual property during the contract term or if DH wishes to operate the service itself, the provider will extend the license to DH for a fee. This means that when the contract expires any new service provider will have to have their own systems ready immediately to prevent disruption to the service.

3.4 Adequacy of NURSE-ON-CALL contract management

Contract management includes monitoring performance so both parties meet their commitments. NOC has a detailed governance structure with senior representation from both parties. Nevertheless the NOC contract management has not been effective in addressing known issues.

3.4.1 Performance management

The NOC Project Board meets quarterly to review and approve major projects and decisions. Members include directors from different DH branches including quality, finance and corporate services. Issues identified in contract management meetings are escalated to the board, the body responsible for overseeing NOC's overall operations and managing risks.

The board minutes showed performance issues were apparent as early as 2007. As Figure 3C shows however, it was not until November 2009 when the third contract variation occurred that the board increased the penalty for under performance and addressed the absence of an agreed forecasting methodology.

Figure 3C
Contract management issues raised at the NURSE-ON-CALL Project Board

Date raised	Discussion item	Action noted
May 2007	Issue of nurse location discussed as 48 per cent of calls are being handled in Sydney.	Issue to be raised with the service provider in the future
Oct 2007	Operational defaults and penalty applied for May, June, July and September.	Noted
Dec 2007	Poor performance continuing. Discussion regarding whether the service provider should submit advanced forecasts.	Agreed that the contract would remain the same and advanced forecasts would not be requested
Feb 2008	Penalty applied for under-performance. Poor performance attributed to staff levels.	Agreed to continue to monitor service levels
Apr 2008	Discussion regarding calls taken from Sydney office due to poor recruitment response in Victoria.	DH to seek feedback on uptake of recent recruitment activity
Jun 2008	Percentage of calls handled in Victoria remains low.	Noted
Oct 2008	Poor performance attributed to higher than projected staff attrition.	Contract negotiations to include increase to the maximum penalty cap
Dec 2008	Full penalties have been applied since August 2008.	Noted
Apr 2009	Service levels have been below required levels. The service provider is claiming extraordinary calls for February.	DH to advise the service provider that the contract management meeting will include call forecasting
Jun 2009	DH and the service provider will work on a variation to the extraordinary calls clause to reflect a clear process.	Noted
Aug 2009	The service provider has claimed extraordinary calls for February, March, May, June and July. DH has sent its proposed methodology for calculating extraordinary calls.	Awaiting response from the service provider
Oct 2009	The proposed contract variation includes a new penalty regime, placing DH in a stronger position to enforce minimum performance levels, and a clear call forecasting methodology to assist in defining when the penalty can be applied for under performance.	Noted

Source: Victorian Auditor-General's Office, using Department of Health information.

Figure 3C also demonstrates that as early as May 2007 DH was concerned with the service provider's over-reliance on its interstate resources. This was not resolved, with 30 to 40 per cent of answered by nurses employed by the service provider in New South Wales most months.

In April 2009, the chair of the national service estimated that Victoria could save $5 million over two years if it joined the national system. Although it was not possible to substantiate this, it is reasonable to expect substantial savings though such a model.

By contrast it is not clear what the benefits of a state-based system are, and the frequent significant level of calls answered interstate serves to undermine any such benefits. This also does not align with the contract's intent and has likely saved costs for the service provider.

3.4.2 Managing clinical risks

For 10 months, DH did not provide an independent clinical body to oversee the service provider's clinical governance.

The original contract allowed for a clinical experts' reference group (CERG) for clinical advice, assessment and expertise. A CERG was formed in 2006 with membership of clinicians representing general practice, nursing, aged care, mental health, emergency medicine, ambulance, paediatric health and women's health.

The CERG met four times from August 2006 to 2007 and reviewed the service provider's clinical risk management including the clinical governance structure, incident investigation and resolution, and incident reporting.

As there were no adverse events the group disbanded in April 2008 believing it had met its terms of reference. It was agreed that NOC would be transferred to the statewide sentinel event program (SEP) used by all Victorian health services.

Sentinel events occur independently of a patient's condition and commonly reflect health system and process deficiencies and can result in unnecessary outcomes for patients. The aim of the program is to identify strategies to prevent or minimise the risk of sentinel events recurring.

DH expected NOC to transfer to SEP in June 2008 but this did not happen until February 2009. There was thus no independent clinical body to oversee NOC's clinical governance in the interim.

While DH is not directly accountable for NOC clinical governance, it is generally responsible for providing quality health services to the community. This means having a robust performance monitoring framework to assure that the service provider's clinical governance is adequate and that NOC is running safely.

Although the service provider continued to submit monthly clinical incident reports and results of its quality assurance activities, the absence of a clinical oversight committee in this period posed an increased risk to the safety of the NOC service.

3.4.3 Performance monitoring and assurance

DH relies on reports from the service provider to assure that its service obligations are met. The NOC reports cover customer satisfaction, human resources, service quality, operational risk management and stakeholder management.

The contract empowers DH to:

- appoint an independent expert to review the service provider's performance at any time, including analysis of the reports
- visit the service provider's premises every six months to monitor or observe performance; or to review or audit performance.

Although DH has the right to review and audit NOC every six months, it has never done so and therefore is unable to provide assurance regarding the reliability of the reports provided by the service provider.

3.5 Opportunities for improvement

The current contract for NOC ends in March 2011. In such situations, where major contracts come up for renewal, government departments can achieve better value for the community by undertaking a range of review and planning activities. Good practice would see:

- Initial planning for transition at the time the initial contract is designed. Contract transition arrangements should minimise disruptions to business activities and unexpected costs at the end of the contract.
- Preparation for the end of the contract to begin early, allowing time to review the performance of the current contract and identify what has worked well and what needs to be changed.
- Revisiting the rationale for the service to determine whether needs or consumer preferences have changed in a way that warrants variation of the service model.
- An assessment of procurement models so that the relative merits of options such as contract roll-over can be judged against going to the market for re-tender.
- Adequate time for this analysis so that the funder retains real choices and is not forced into a roll-over because time has run out.
- Redesign of any contract to reflect leanings and make sure there are appropriate incentives and penalties, and the parties' responsibilities are fair and balanced.

The approaching end of the NOC contract offers the opportunity for DH to address weaknesses in contract design and management by applying good practice. However, DH is already facing a challenge as a considered review and planning process for a contract on this scale would normally take longer than 12 months. It is therefore now an imperative that DH rigorously review past performance to assess whether the service is meeting appropriate standards for the resources invested, and to identify areas for improvement or an alternative approach.

To determine value-for-money, DH should comprehensively evaluate the costs, benefits and risks of the available procurement options.

If DH decides not to go to the market place through open tender, it should assess the benefits of joining the national service or undertake an 'open book' financial audit process to reveal the service provider's actual cost structure and assure value-for-money for the state.

Recommendations

4. The Department of Health should rigorously evaluate the service provider's performance and the appropriateness of the current contractual terms to inform its approach to the next contract.

5. The Department of Health should undertake a comparative cost-benefit analysis of its procurement options including competitively re-tendering the contracted services.

Appendix A.

Minimum performance standards required

The contract with the provider specifies the following minimum performance standards.

	Minimum performance standard
1.	Eighty per cent of calls each month must be answered by a call centre operator within a period of 20 seconds of calling.
2.	At least 99.5 per cent of calls per month will not receive an engaged signal.
3.	The service provider must ensure that 95 per cent of calls each month are not abandoned after 20 seconds.
4.	Callers who need to be transferred to a Registered Nurse or a more specialist operator may be placed on hold. At least 95 per cent of such calls each month will be on hold for 30 seconds or less.
5.	The service provider shall ensure a high level of customer satisfaction (over 95 per cent of callers being satisfied or very satisfied). The service provider must undertake yearly caller satisfaction surveys and the survey must cover at least 1 per cent of calls.
6.	The service provider must regularly evaluate calls to ensure compliance with customer service, procedural and clinical guidelines. The service provider shall regularly monitor at least 1 per cent of calls and report outcomes to the Department of Health (DH) for each six-month period during the period of service.
7.	The service provider must undertake mystery shopping of the NURSE-ON-CALL (NOC) service through an independent and external third-party. These calls shall monitor both clinical and customer service outcomes for NOC. The service provider shall report outcomes to DH for each six-month period.
8.	Total disruptions to NOC that prevent callers from gaining access to NOC will not exceed 3.5 hours in any month and no single disruption will exceed one hour.
9.	The service provider will maintain the business continuity plan, human resources quality plan, disaster recovery plan and emergency response plan to the satisfaction of DH.

Source: Victorian Auditor-General's Office, using Department of Health information.

Appendix B.

Caller satisfaction: results of mystery shopping exercises

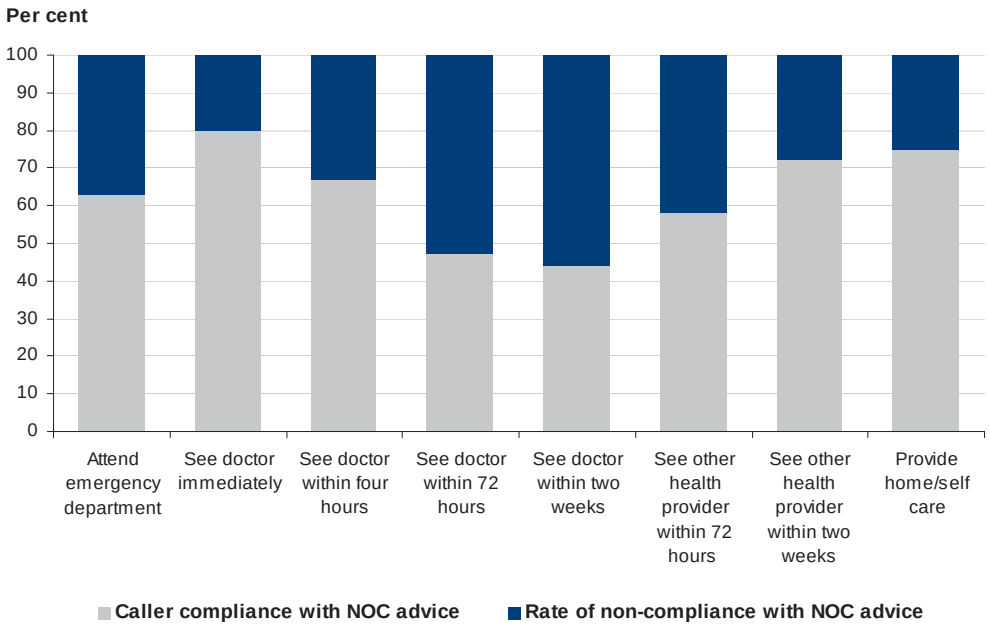
Question	Level of agreement by percentage				
	Dec 06–May 07	June 07–Nov 07	Dec 07–May 08	Oct 08–Dec 08	Dec 08–May 09
Did the length of time to answer the call seem reasonable?	100	96	99	100	97
Did you understand what the nurse was saying to you?	100	98	100	100	99
Did you feel the nurse had professional concern about you?	99	97	99	99	100
Did you feel the nurse listened to what you had to say?	99	97	98	100	98
Did you feel comfortable with the level of professional advice you were given?	99	97	98	100	98

Source: Victorian Auditor-General's Office, using Department of Health information.

Appendix C.

Results of the 2008 compliance survey

The following chart demonstrates the rate of compliance with NURSE-ON-CALL (NOC) advice, according to the course of action recommended.



Source: Victorian Auditor-General's Office, using Department of Health information.

Compliance ranges from a rate of 44 per cent for callers advised to see a doctor within two weeks, to a maximum rate of 80 per cent for callers advised to see a doctor immediately.

Common reasons for not following the nurse's advice were that:

- the condition improved
- advice seemed incorrect or unnecessary
- the patient was unable to book an appointment
- the course of action was inconvenient or too difficult and
- the patient, not the caller, refused to follow the advice.

Appendix D.
Cost estimates

Emergency department average cost per occasion of service

The following table provides the national average cost per occasion of service by triage category.

Triage category	Average cost
Admitted triage 1	1 188
Admitted triage 2	652
Admitted triage 3	558
Admitted triage 4	456
Admitted triage 5	237
Non-admitted triage 1	739
Non-admitted triage 2	505
Non-admitted triage 3	431
Non-admitted triage 4	321
Non-admitted triage 5	197
Did not wait	32

Source: Victorian Auditor-General's Office, using Productivity Commission information.

Ambulance Victoria general user fees

The ambulance fees below are current as of 1 January 2010.

Fee type	Cost
Metropolitan road fees	
Emergency road transport	$924.20
Attend no transport	$278.88
Rural road fees	
Emergency road transport	
Flagfall	$920.77
Time per minute	$11.15
Distance per kilometre	$1.09
Attend no transport	$268.31
Air fees (road transport fees are additional)	
Fixed wing (aeroplane)	
First hour or part thereof	$850.60
Each additional minute	$14.19
Rotary wing (helicopter)	
First hour or part thereof	$3 207.15
Each additional minute	$53.46

Source: Victorian Auditor-General's Office, using Ambulance Victoria information.

The state average for an ambulance is $865. This includes emergency transports and ambulance attendances where transport was not required.

Appendix E.

Audit Act 1994 section 16—submissions and comments

Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health with a request for submissions or comments.

The submissions and comments provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Submissions and comments received

RESPONSE provided by the Secretary, Department of Health

Department of Health

Secretary

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Melbourne Victoria 3001
DX 210311
www.health.vic.gov.au
Telephone: 1300 253 942
Facsimile: 1300 253 964

e2039822

Mr Des Pearson
Auditor-General
Victorian Auditor-General's Office
Level 24, 35 Collins Street
MELBOURNE 3000

Dear Mr Pearson

Thank you for your letter of 18 August 2010 and for providing a copy of your proposed report on '*Delivery of NURSE-ON-CALL*'.

The Department of Health (the department) agrees with the conclusions of the audit that:

- NURSE-ON-CALL is a safe and cost effective service;
- Users of the service are highly satisfied;
- NURSE-ON-CALL saves health system costs; and
- NURSE-ON-CALL has benefited callers by providing access to medical advice.

The department essentially accepts the recommendations in the report and will use the findings to improve the high quality of the NURSE-ON-CALL service.

However there are concerns, which were put to you in the department's response to the preliminary report, which I would like to reiterate.

The first point relates to safety of the service. NURSE-ON-CALL provides a safe, high quality service. Quality is assured firstly through operational and quality procedures of the provider which formed part of the original offer to the department and which form a schedule to the contract. These include the use of computer algorithms, which are underpinned by clinical guidelines and which are regularly reviewed, regular call monitoring and call coaching of nurses to monitor compliance with clinical procedures and guidelines, and third party accreditation of quality procedures. Secondly, quality is assured through other contractual requirements which include such things as annual reporting of quality plans; contract specifications in relation to the use of registered nurses and appropriate human resource planning and skills development. This range of quality assurance and improvement strategies, in many ways are similar to arrangements which apply to all health services. However, they do not seem to have been given appropriate weight.

RESPONSE provided by the Secretary, Department of Health – continued

The report places too much emphasis on mystery shopping results in assessing the quality and safety of the service. Further the report uses data from *NHS direct* and the *Healthline* service in New Zealand as benchmarks for the mystery shopping results of NURSE-ON-CALL. Given this information is not cited, it is not possible for us to validate this information. We do have concerns that the data presented may not be a valid comparator.

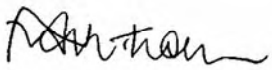
The second is the suggestion that the level of abatement in the contract for poor performance is solely responsible for the achievement or non achievement of performance standards. As discussed during the audit, a broad range of operational and contractual factors, along with the maturation of the service, contributes to performance. Linked to this issue of abatement is the assertion in the report that the contract has design weaknesses and has not been well managed. The department does not agree. Contract and operational standards are consistent with industry norms. Comprehensive governance arrangements and extensive reporting is required as part of contract management arrangements. Any under performance is actively monitored by the Board, and addressed with the provider through regular contract management meetings. The abatement regime is applied in line with the contract. The department will continue to review and improve on these arrangements.

The attachment provides my response to the recommendations.

I note that the service provider has been provided with an opportunity to review the report and has provided comment to you. I understand that a further meeting is proposed between your office and the provider. To the extent that any amendments you make to the report in response to the provider's comments relate to issues I have raised, I would appreciate a further opportunity to review to report.

Should you require any additional information, please contact Maree Guyatt, Director, Integrated Care Branch, on 9096 2015.

Yours sincerely



FRAN THORN
Secretary

RESPONSE provided by the Secretary, Department of Health – continued

Attachment

Response to recommendations

NURSE-ON-CALL was established in March 2006. Since that time the service has taken over 1.5 million calls. The performance of the service against a comprehensive range of performance standards is high and continues to improve with the maturation of the service. All standards have been met or exceeded since August 2009. The service is highly valued by the community as evidenced by its continued use, and the consistently high level of caller satisfaction.

NURSE-ON-CALL is a safe, high quality service. Registered nurses, using computer algorithms which are supported by clinical guidelines and reviewed regularly, provide medical advice 24 hours of every day, 7 days per week. The safety and quality of the advice NURSE-ON-CALL provides to Victorians is assured through a comprehensive range of quality activities. Regular call monitoring and call coaching to assess nurses' compliance with customer service, procedural and clinical guidelines, and consistency of advice are regularly undertaken. Minimum standards in the contract require annual submission of quality plans (i.e. risk management, quality control and quality improvement) and human resource plans for managing both resource and skill levels. These standards have been routinely met since the commencement of the NURSE-ON-CALL service. The provider also maintains third party accreditation which independently certifies the robustness of the quality assurance processes.

NURSE-ON-CALL has become an important element of the Victorian health system. This has been demonstrated in the state's response to recent emergencies. NURSE-ON-CALL is used to provide additional support during events like heatwaves, bushfires and the H1N1 influenza pandemic. For example, NURSE-ON-CALL provided the Bushfire Health and Counselling Line to respond to the fires of February 2009.

There is ongoing commitment to a NURSE-ON-CALL service. Future arrangements for provision of the service beyond the current contract have commenced and will take into account all relevant information including provider performance and cost benefit of a range of options. Any future procurement process will continue to be robust and subject to all Government processes to ensure the overarching principles of probity, value for money and risk management are satisfied.

The Department of Health (DH) provides the following comments in relation to each of the recommendations of the report.

Recommendation 1
DH accepts this recommendation.
Recommendation 2
DH accepts this recommendation and will work with the provider to review the methodologies for patient satisfaction and mystery shopping processes so that the service can be further enhanced.
Recommendation 3
DH accepts this recommendation in part and believes that the independence of the survey mechanism will be assured through the implementation of recommendation 2, the review of the methodologies used for both the Mystery Shopping surveys and the Consumer Satisfaction surveys.
Recommendation 4
DH accepts this recommendation. DH will continue to evaluate and monitor the contractor's performance as part of the established range of contract monitoring activities that will inform future developments in the provision of the service.
Recommendation 5
DH agrees that deliberations for future provision of the service should include analysis of a full range of procurement options. DH will continue to satisfy all government procurement processes to ensure that requirements in relation to value for money, probity and risk management are met.

Page 3

Auditor-General's reports

Reports tabled during 2010–11

Report title	Date tabled
Portfolio Departments: Interim Results of the 2009–10 Audits (2010–11:1)	July 2010
Taking Action on Problem Gambling (2010–11:2)	July 2010
Local Government: Interim Results of the 2009–10 Audits (2010–11:3)	August 2010
Water Entities: Interim Results of the 2009–10 Audits (2010–11:4)	August 2010
Public Hospitals: Interim Results of the 2009–10 Audits (2010–11:5)	September 2010
Business Continuity Management in Local Government (2010–11:6)	September 2010
Sustainable Farm Families Program (2010–11:7)	September 2010

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