Western Australian
Auditor General's Report

SIHI: District Medical Workforce Investment Program

Report 4: April 2015

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WESTERN AUSTRALIAN AUDITOR GENERAL'S REPORT

SIHI: District Medical Workforce Investment Program

Report 4
April 2015

THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

SIHI: DISTRICT MEDICAL WORKFORCE INVESTMENT PROGRAM

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance audits are an integral part of the overall audit program. They seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

This audit assessed whether the District Medical Workforce Investment Program has improved access to medical staff and 24 hour emergency services for people living in the southern inland area of the State. This area extends from Kalbarri and Meekatharra in the north, to Laverton in the east, down to Esperance in the south east. We visited five hospitals within this area during the audit.

My report found that the Program has increased access to emergency medical services, which have been stabilised through the provision of more consistent 24/7 medical cover across the district networks. However, I also found that the Program's full benefits are yet to be realised, which has impacted primary and Aboriginal health services, and increased the need for locums to fill ED rosters.

Royalties for Regions funding of the Program is scheduled to cease in 2016-17, so the WA Country Health Service needs to plan now how it will sustain these services beyond then.

I wish to acknowledge the staff at WA Country Health Service for their cooperation and for the valuable role they play in delivering emergency services to rural areas.

COLIN MURPHY
AUDITOR GENERAL
23 April 2015

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Auditor General's Overview

In the period up until 2011, Government recognised that falling numbers of GPs in the State's southern inland area was resulting in a frequent lack of emergency medical cover, particularly on weekends, and, in unacceptable numbers of clinical incidents in rural hospitals.

To improve emergency medical cover for people in those communities, Government in 2011 committed just over $180 million in Royalties for Regions funding to invest in a four year program to enhance the southern inland health workforce. The WA Country Health Service (WACHS) planned to use these funds to close the gaps in emergency medical care, mainly by incentivising more GPs to work in rural communities and to be on call and on site for round the clock emergency cover.

The Program has had some significant success, but some aspects have been delayed and some of the desired outcomes not achieved. Perhaps most unusually, costs to date are much less than budgeted which has seen the Program extended by two years and millions of dollars diverted to other health areas.

The Royalties for Regions funding for the Program is scheduled to end in 2017. Before then, WACHS needs to develop a clear understanding of what aspects of the Program have worked well and how to sustain and build on the improvements that recent investment has delivered. Without it, the potential exists for services to slip back to the unacceptable and risky levels of pre 2011. We will be watching with interest how WACHS deals with this issue.

Executive Summary

Introduction

This report provides an assessment of whether the District Medical Workforce Investment Program has improved access to medical staff and 24 hour emergency services for people living in the southern inland area of Western Australia.

The southern inland area extends from Kalbarri and Meekatharra in the north, to Laverton in the east, down to Esperance in the south east. As part of our audit we visited five hospitals within this area.

Background

People in the State's southern inland area face challenges in easily accessing healthcare and emergency medical services. Prior to 2011 there was:

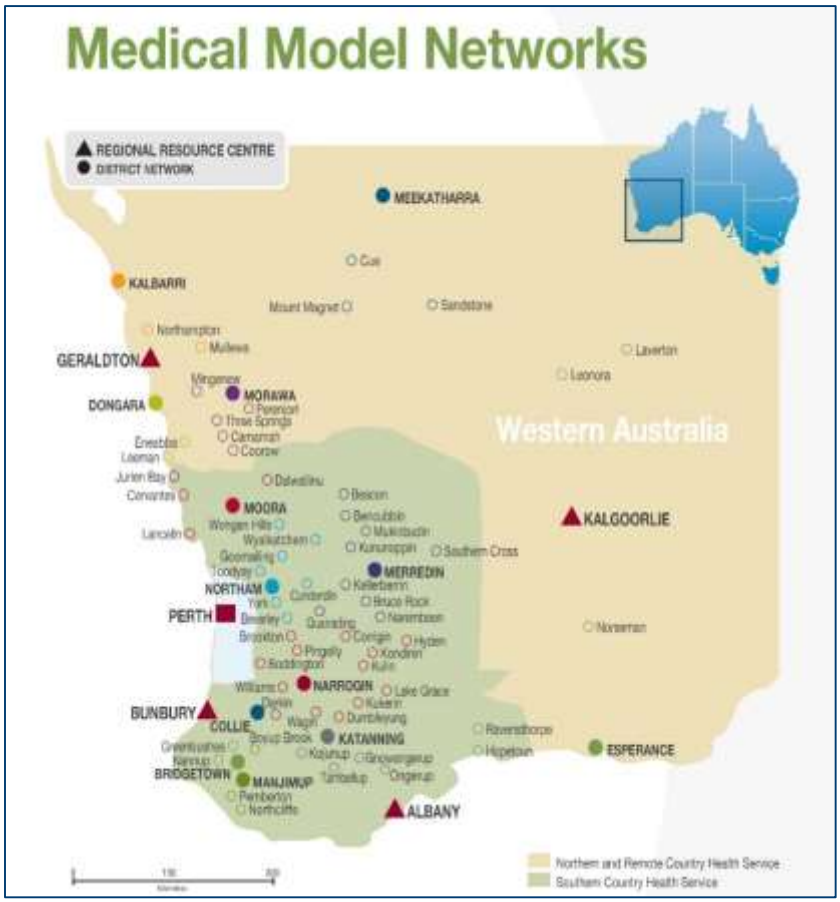
- a frequent lack of medical cover across multiple hospital sites on Fridays, weekends and public holidays
- an increasing and unacceptable number of clinical incidents in district and small hospitals
- a reliance by some district hospital Emergency Departments (EDs) on General Practitioners (GPs) in small towns to provide medical cover by phone
- GP shortages and a reliance on international medical graduates.

Attracting and retaining GPs and providing sustainable access to emergency services has been a critical issue in rural areas. The Wheatbelt Emergency Services Review conducted by the WA Country Health Service (WACHS) in 2010 found inconsistent availability of GPs meant the historic model of health service was not sustainable.

The District Medical Workforce Investment Program (the Program) is part of the $565 million Southern Inland Health Initiative (SIHI), with $325 million in hospital capital works allocated over five years and $240 million invested in the health workforce and health services over four years.

The Program aims to improve 24 hour emergency cover and increase primary healthcare in the southern inland area. It also intended to increase delivery of Aboriginal healthcare services. The Program is funded by Royalties for Regions and managed by WACHS. The Program started in July 2011 with a budget of $182.9 million over four years. Expenditure to December 2014 totalled $56 million.

The Program aims to attract more GPs to deliver emergency and primary healthcare in the 12 district networks (Figure 1). Under the Program each district network has a main hospital, which provides 24 hour, seven days a week emergency healthcare either by having doctors on site at the hospital emergency department or on call to respond within a specified time. These main hospitals support smaller hospitals within the district network by accepting patients and assisting by telephone or Emergency Telehealth Services.



Source: WACHS

Figure 1: SIHI district networks

WACHS estimated that 44.7 additional full time staff were required to maintain services to EDs and patients requiring urgent medical treatment (acute cases). These additional staff would include GPs, emergency specialists, locums and salaried doctors. Nurse practitioners were also needed to support ED services.

The number of rural GPs impacts the delivery of emergency healthcare services because in addition to their general practice, rural GPs often provide emergency healthcare cover. The Commonwealth Government is responsible for funding GP services but the State Government manages and funds emergency healthcare services. The Program intended to attract more new and existing local GPs to provide emergency healthcare services, through a range of incentive payments. This includes the cost of relocation as well as incentives based on:

- a GPs involvement in ED cover
- procedural services like anaesthetics, obstetrics, and general surgery
- sub-specialities such as Aboriginal health.

The range of Program incentives are shown at Appendix 1.

Audit Conclusion

The Program has significantly improved access to medical staff and 24 hour emergency and acute cover for people living in the southern inland area of Western Australia.

ED services have been stabilised through the provision of more consistent 24/7 medical cover across the district networks using a mix of GPs, salaried doctors, emergency specialists, ED nurse practitioners and locums. However, while the number of GPs has increased, the total number of new and existing GPs attracted to the Program has been 34 per cent less than the initial target. This has limited the intended benefits of the Program, including to primary and Aboriginal health services, and increased the need for locums to fill ED rosters.

Aspects of the Program's planning and implementation could have been better managed. WACHS overestimated the costs and there have been delays in establishing rosters and implementing parts of the Program. Approximately three and a half years into the four year Program, only $56 million of the $182.9 million budget was used. In June 2014, WACHS reallocated the remaining funds by transferring $33 million to SIHI capital works and another health project and by extending the Program by two years to 2016-17. The forecast cost is now $149.9 million.

WACHS has established a financial and accounting framework to manage and monitor the SIHI investment but there are weaknesses in contract administration and processes to confirm the delivery of medical services.

Improvements to data capture, monitoring and evaluation would provide evidence of Program achievements and inform future planning. This is important given that Royalties for Regions funding of the Program is scheduled to cease in 2016-17. WACHS needs to be planning now how it will sustain these services beyond then. Key to WACHS making informed decisions will be the capture and evaluation of the right performance data to establish what has and has not worked.

Key Findings

The Program has improved healthcare in the southern inland area:

- the number of GPs has increased by 24 to 123 since July 2011, with 95 of these GPs signed up to the Program (Table 2) to provide ED cover and health clinics. Emergency specialists, hospital employed doctors, GP proceduralists and ED nurse practitioners have also been engaged to support the delivery of ED and acute cover across the district networks
- district hospitals in Esperance, Northam, Narrogin, Merredin, Collie, Katanning, Manjimup and Bridgetown now provide continuous ED coverage. The effect of the enhanced capacity at these district hospitals is evident. ‘Emergency’ and ‘urgent’ presentations have increased by 25 per cent with 19 per cent more patients seen by a doctor (Figures 2 and 3)
- GPs are being retained in towns for longer and delivery of GP services at general community and Aboriginal health clinics have increased
- there are now GPs on call at 10 smaller network hospitals
- Emergency Telehealth Services (ETS) videoconferencing is now available in 49 southern inland area hospitals. Specialist Emergency Physicians provide healthcare via video link from Perth to support remote ED staff with patient treatments.

There is still a shortfall of 20.5 GPs which is affecting capacity to support both primary health and ED cover in some district networks in the southern inland area (Table 2). Because less

GPs have been attracted than planned, there are gaps in ED rosters and the planned benefits to primary and Aboriginal healthcare services are yet to be fully achieved. GPs have taken-up only 166 of the 249 available general community health clinics and only 26 out of 89 available Aboriginal health clinics.

Approximately three and a half years into the four year Program, only $56 million of the $182.9 million budget had been used. This was because:

- the Business Case supporting the original budget was costed against a salaried ED and acute care model. However, in practice WACHS is relying more on GPs working on site or on call at district hospitals, and is less reliant on salaried doctors and specialists. This is a lower cost workforce model for ED service requirements at some district hospitals, particularly those with on call ED cover only
- there were delays contracting doctors and establishing ED rosters. It took eight months to establish rosters at all district hospitals
- the original budget included $32.7 million for 'other goods and services' and for overheads, but only two per cent of this has been spent. Specific Program initiatives such as electronic medical records are yet to be implemented
- there has been low GP take-up of general community and Aboriginal health clinics.

Of the $104.8 million remaining in the Program budget, $72 million will be used to extend the Program to 2016-17, $26 million has been reallocated to capital projects in another SIHI stream and $7 million was re-directed to a Renal Program (Figure 4).

WACHS did not track Program status against an implementation plan. An implementation plan was a critical part of governance because the incentives based workforce program was new to WACHS. It also could have helped identify and address Program delays. Without an implementation plan, there was a lack of clear timeframes, roles and responsibilities and risk management in establishing key parts of the Program such as ED rosters at district hospitals and electronic medical records. WACHS is now developing an implementation strategy that will guide delivery until the end of the Program.

We found weaknesses in the Program's contract administration and GP payment processes which may lead to contractual disputes and increases the risk that incorrect incentive payments will be made. For example, 40 GP contracts omitted the clause detailing the minimum ED roster requirements and our testing identified three instances from 77 transactions where GPs were paid $50 000 incentives for a level of ED service they did not fully provide. WACHS has started to update Program guidelines and is putting in place audit and controls to ensure stronger financial governance.

WACHS is reporting KPIs as part of the Memorandum of Understanding with the Department of Regional Development. However it is not monitoring and reporting on some parts of the Program and sometimes lacks up-to-date information on the services delivered by GPs. This limits their ability to provide accurate data in a timely manner, evaluate Program outcomes and determine whether the health needs of the district networks are being met.

WACHS is only in the early stages of evaluation planning and has not yet started to measure the appropriateness and effectiveness of the district hospital workforce models and current mix of incentives. There is a real possibility of GPs leaving the area if the incentives cease. Planning to ensure the sustainability of emergency cover beyond 2016-17 is a key issue for WACHS, government and the local community.

Recommendations

The WA Country Health Service should by January 2016:

- **evaluate the effectiveness of the Program, incentives and ED workforce models at district hospitals**
- **prepare a strategy outlining how the Program will be managed, resourced, monitored and delivered until the Program's new end date of 2016-17**
- **strengthen governance, contract management and verification processes for payments which may include conducting periodic audits to ensure GP contracts are current, GP qualifications (credentials) are checked and they have provided medical services as invoiced.**

The WA Country Health Service should by July 2016:

- **have conducted robust planning and cost estimates for sustaining medical services beyond 2016-17.**

Response from WA Country Health Service

WA Country Health Service welcomes the findings and recommendations of the Office of the Auditor General's audit and the commitment to addressing them is evidenced by work already commenced.

The Southern Inland Health Initiative (SIHI) has transformed access to medical and emergency care across a large part of inland Western Australia. People living in many southern inland towns in Western Australia now have access to 24 hour emergency medical services and improved access to doctors in hospitals and General Practice where previously there was no, or very limited access to doctors, particularly during weekends.

Significantly, the General Practice landscape has been strengthened. There has been a demonstrated 70% improvement in the General Practitioner retention rate at the four year mark, indicative of the program's success in supporting and retaining General Practitioners in communities. In addition WA Country Health Service has evidence demonstrating improved access to emergency and acute care with more non-urgent care being provided by General Practitioners.

WA Country Health Service is proud of the 24 GPs and 16 FTE specialist, locum and hospital employed doctors, plus five Nurse Practitioners that have been attracted to these areas. This Program has successfully achieved the right balance between ensuring both General Practitioner and acute care access.

One of the outstanding successes of the SIHI program is the establishment of the "Premier's Award" winning Emergency Telehealth Service which is now available in 54 country hospitals and has played a crucial role in supporting medical and nursing teams to help save the lives of country patients. The Emergency Telehealth Service has provided 11,665 occasions of service since 2012. Patients and clinicians testimonies show the impact this is having for patients, the doctors and nurses in hospitals. The Emergency Telehealth Service won the Premiers Award for Excellence in 2014 in the "Improving Government" category.

WACHS has prioritised general practice, emergency and acute care workforce effort and services in response to significant service deficits, and safety and quality concerns. Securing the workforce was a prerequisite for the implementation of communication and information systems and broader health service initiatives that are dependent on a secure General Practitioner and doctor workforce in addition to a stable acute and emergency services. These service supports and systems are now being implemented.

WA Country Health Service is committed to improving aspects of the Southern Inland Health Initiative and will use the Performance Audit to support strengthening of the Program.

Audit focus and scope

This audit assessed if the District Medical Workforce Investment Program (the Program) has improved access to medical staff and 24 hour emergency services in the southern inland health area.

We had three main lines of inquiry:

- Does WACHS understand the southern inland area health needs for improved access to GP and emergency services?
- Is WACHS administering Program funds appropriately to GPs in the southern inland area?
- Is the Program improving the accessibility of GP and ED services in the southern inland area?

We also conducted a community survey to gauge community perceptions of the Program, emergency cover and GP services. We received 445 responses from people in the southern inland area.

We did not measure health outcomes, or assess the quality of medical services delivered within the southern inland area during the audit.

We conducted the audit in accordance with Australian Auditing and Assurance Standards.

Access to ED services has increased but the full benefits of the Program are yet to be realised

The Program has stabilised ED cover at district hospitals

Before the Southern Inland Health Initiative (SIHI) there were not enough GPs to provide Emergency Department (ED) cover throughout the southern inland area. The Program has significantly improved access to ED services by increasing the number of GPs participating on ED rosters at district hospitals[1] to provide more consistent 24/7 doctor cover across these district networks. In December 2014 there were 123 GPs in the southern inland area, 24 more than when the Program started in July 2011. This combined with hospital employed doctors, locums, and emergency specialists has improved ED and acute (urgent) cover at district hospitals.

WACHS has used incentive payments to engage new and existing GPs to participate on district hospital ED rosters (Table 1). This includes doctors in hospitals as well as on call. Other staff have been attracted to support the delivery of emergency and acute medical services, including ED nurses practitioners and GP proceduralists.

District network	24 hour on site roster	24 hour (12 hour on site /12 hour on call) roster	24 hour on call roster (within 10 minutes)	24 hour GP local availability (within 20-30 minutes)	Urgent medical services	Salaried GP, and/or emergency specialist	ED nurse practitioner	ETS
Northam	✓				✓	✓	Recruiting	✓
Merredin		✓				✓	✓	✓
Narrogin		✓			✓		✓	✓
Moora				✓			N/A	✓
Morawa				✓			N/A	✓
Dongara							N/A	✓
Kalbarri				✓			N/A	✓
Meekatharra						✓	N/A	✓
Katanning			✓				Recruiting	✓
Collie			✓		✓		✓	2015
Warren Blackwood (Bridgetown and Manjimup)		✓	✓		✓		✓	2015
Esperance		✓			✓		✓	✓

Source: WACHS and OAG

Table 1: ED and urgent medical cover at district network main hospital sites at 31 December 2014

[1] Esperance, Northam, Merredin, Narrogin, Katanning, Collie, Manjimup/Bridgetown

Incentive payments to GPs vary based on geographical location, Program eligibility requirements and the commitment to the various rosters and work undertaken by them. As an example, a new GP contracted to provide rostered ED services only at a district network site, such as Narrogin, may receive $159 000 per year. They would receive the $50 000 ED incentive payment each year, plus about $69 000 for completing the minimum 46 ED shifts per year, either working in the hospital or on call. If the GP was new to the southern inland area they may also be eligible for an $80 000 attraction and assistance incentive paid quarterly in arrears over two years.

The Program also provides 'close availability' payments to GPs working in 10 smaller rural network towns to be on call and respond to emergencies at the local hospital or nursing post.

Also part of the Program is the Emergency Telehealth Service (ETS) which improves patient access to emergency doctors. The ETS currently employs seven full time Specialist Emergency Physicians. ETS uses videoconferencing equipment fitted in EDs to allow these doctors to examine and talk to patients and to guide 'on the scene' medical staff with the diagnosis, treatment and arrange transfers for patients. The ETS commenced in August 2012 and was in use in 49 hospitals within the district networks by the end of 2014. Collie, Bridgetown and Manjimup hospitals are expected to have ETS in 2015.

Emergency Telehealth Service (ETS)

The ETS is used in towns when doctors are not available and where nurses or GPs require more assistance with emergency treatments. WACHS advised that the ETS is improving patient treatments, the training of medical staff, and reducing some transfers. During our audit we received positive feedback from nursing staff and community members that had used the ETS. Survey respondents commented:

"Without access to doctor service, the ability for nursing staff to access ETS when needed has proved to be most important."

"ETS has been responsible for saving one life and has supported the ED staff with many other presentations."

Our community survey also indicated some community members wanted the ETS installed at their local hospital. In towns where the ETS was installed some community members wanted the service to operate 24 hours a day, seven days a week, to ensure better access to doctors. Survey respondents commented:

"The ETS needs to be 24/7, then there would be no need to travel to Merredin."

"After 11pm when the ETS is no longer available the current doctor is extremely hard to contact and doesn't attend."

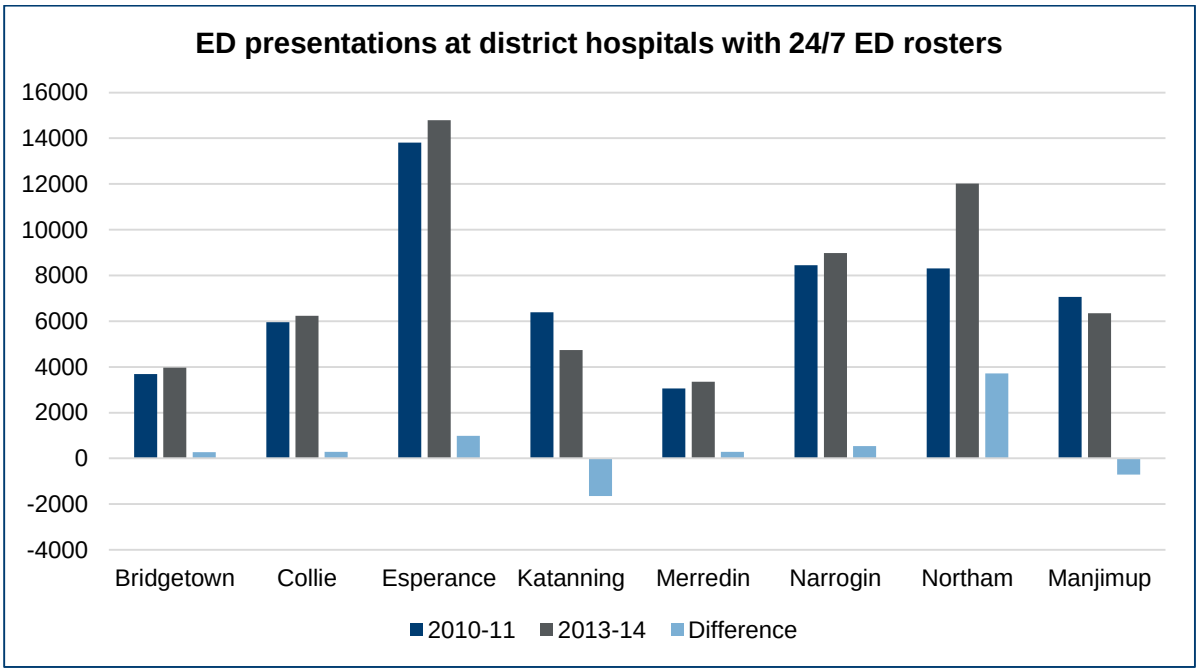
Overall ED cover at district hospitals has improved, though, occasional gaps occur. For instance, Merredin hospital did not have a GP, salaried doctor, specialist or locum doctor to provide rostered ED services on two occasions during 2014.

Under the Program, it is WACHS' responsibility to ensure that district hospitals have doctors available at all times. When there is no rostered doctor working in a district hospital, nursing staff provide ED services with ETS back up. In the event that a district hospital is unable to provide medical support to its network hospitals, there is an increased risk of a clinical incident occurring. WACHS advised it aims to reduce this risk by contacting a doctor in another network town, using the ETS, transferring patients to a nearby hospital, or evacuating patients via the Royal Flying Doctors Service.

Access to medical services has improved but many in the community are unaware of the changes

The implementation of the Program in 2011 is considered the main reason for why more patients are attending the EDs at district hospitals, more of these presentations are of a serious nature and more of the patients are treated by a doctor.

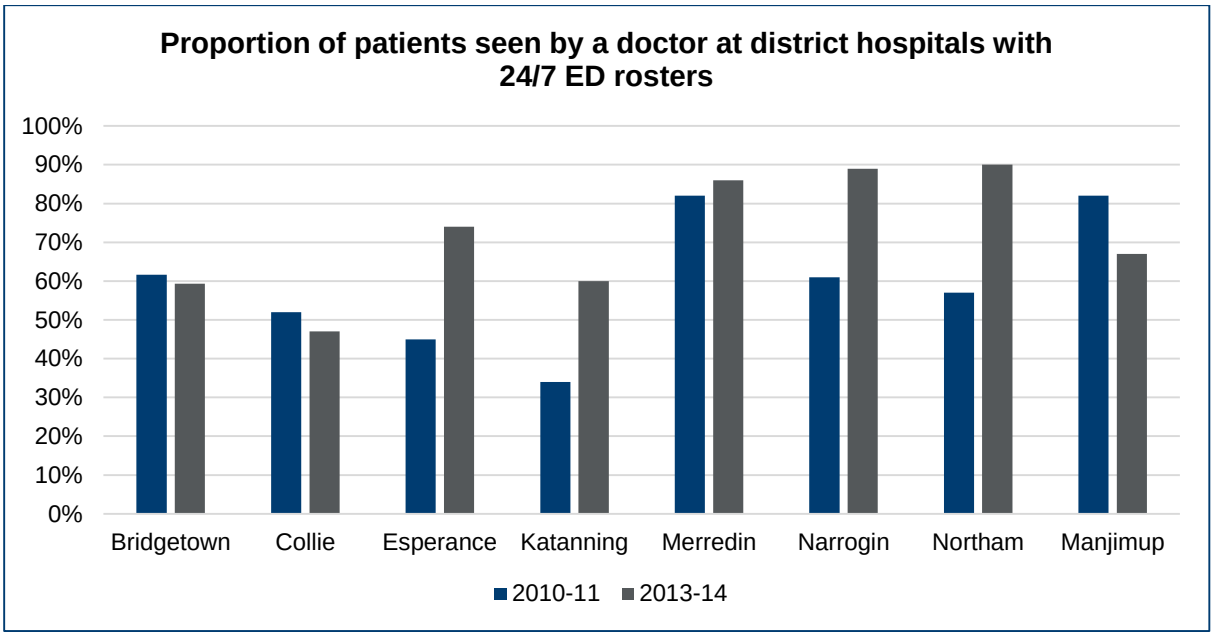
Since 2010-11, the overall number of presentations has increased by about seven per cent (Figure 2) while presentations categorised as an 'emergency' or 'urgent' increased 25 per cent.



Source: WACHS and OAG

Figure 2: ED presentations at district hospitals with 24/7 ED rosters (2010-11 and 2013-14)

The number of ED patients seen by a doctor at district hospitals as a proportion of total presentations has increased by 19 per cent (Figure 3). However Bridgetown, Collie and Manjimup hospitals had a decrease but with a corresponding increase in the number of patients seen by a nurse. This is partly due to two ED nurse practitioners starting in 2013 at Collie and Manjimup hospitals, who treat less serious presentations.



Source: WACHS and OAG

Figure 3: Proportion of patients seen by a doctor at district hospitals with 24/7 ED rosters (2010-11 and 2013-14)

Apart from Dongara, the proportion of total presentations seen by a doctor also improved at district network main hospitals in Kalbarri, Meekatharra, Moora and Morawa. Overall the increase was just over 10 per cent.

Although presentations at district hospitals with 24/7 ED rosters has increased, the overall number at all southern inland hospitals has decreased by about 11 per cent as presentations at smaller network town hospitals fell during this period. This is the result of more non-urgent patients visiting GPs.

Our community survey showed there were mixed views on whether access to emergency and primary health services in their community had improved over the past two years.

Seventy two per cent of the 445 survey respondents were not aware of changes to hospital ED services in their local community or district. The survey showed that respondents have different perceptions of the medical services provided in their town and identified a range of local needs. The survey indicated a need for WACHS to improve its communication and consultation with local communities to ensure that the improved services were fully utilised as well as to better understand any changing needs.

Planned benefits to primary and Aboriginal healthcare services are yet to be fully achieved

Medical staff have increased but gaps remain in ED rosters

The Program aims to attract and retain a medical workforce to deliver emergency cover and primary healthcare within the district networks. Its business case specified 44.7 additional full time staff provided by a mix of GPs, emergency specialists, salaried doctors and locums. However, the main strategy was to develop and retain the GP workforce to participate in the district networks.

In February 2012, WACHS determined that 99 GPs were in the southern inland area but that 143.5 were required. The GP workforce gap was calculated using a Commonwealth Government medical workforce modelling ratio of one GP to 1 000 population across the district networks.

At December 2014, 123 GPs were thought to be working in the southern inland area which is 20.5 GPs less than considered necessary to support both emergency and primary healthcare services (Table 2).

District network	Required number of GPs	February 2012		December 2014	
		Actual number of GPs	GP gap	Actual number of GPs	GP gap
Northam	24	18	-6	25	+1
Merredin	12	10	-2	10	-2
Narrogin	16	12	-4	17	+1
Moora	10	9	-1	8	-2
Morawa	7	4	-3	2	-5
Dongara	6	3	-3	1	-5
Kalbarri	5	3	-2	3	-2
Meekatharra	0.5	0	-0.5	2	+1.5
Katanning	13	7	-6	10	-3
Collie	12	8	-4	8	-4
Warren Blackwood (Includes Manjimup and Bridgetown)	18	11	-7	18	0
Esperance (Includes Laverton, Leonora and Ravensthorpe)	20	14	-6	19	-1
	143.5	**99**	**-44.5**	**123**	**-20.5**

Source: WACHS, Rural Health West and OAG

Table 2: SIHI GP workforce gap

Of the 123 GPs, 95 have signed up to the Program of which 57 had agreed to participate on ED rosters (Appendix 2). The fewer than necessary GPs on the ED roster has required GPs to do more shifts to fill the gaps and the employment of additional salaried doctors and locums (as initially allowed for in the Program's business case). While the use of locums is common in providing medical services, they are usually temporary arrangements and the community does not benefit from the extra primary health services provided by GPs.

The recruitment of seven full time ED nurse practitioners has also been challenging. The first appointment was made in early 2012 but in December 2014, only five had been recruited. ED nurse practitioners play an important role treating patients with less serious conditions which helps to reduce waiting times in the ED.

Delivery of general community and Aboriginal health clinics has been well below target

The Program provides incentive payments for GPs to deliver services at general community health clinics and Aboriginal health clinics in nominated towns within the district networks. GP take-up has been low, and delivery of the clinics has fallen well short of targets with only two thirds of the planned number of general community health clinics delivered and less than one third of Aboriginal health clinics.

Of the 95 GPs currently receiving Program incentives, 45 GPs are delivering services at 166 out of a target of 249 general community health clinics. The take-up is even less for Aboriginal health clinics with just 18 GPs servicing 25 out of a target of 89 clinics.

The extent of analysis and planning that supported the provision of GP services at the health clinics was less than we expected and helps explain the poor take-up. For instance, WACHS has no alternative strategy in the event of low GP take-up and delivery of services to health clinics. In addition, WACHS failed to adequately identify the clinics needed to service southern inland towns, particularly Aboriginal health clinics.

WACHS determined the need for clinics by identifying current GP services and reviewing demographics for each town. However this process did not always target identified community needs. Some towns already had existing Aboriginal medical services while in other locations GPs commented that their town did not need an Aboriginal health clinic.

The Program is currently $105 million under budget due to overestimated costs and delays

The budget was based on salaried doctors, however GPs are delivering more on site and on call medical services

The Program is operating at a significantly lower cost than was originally expected. By December 2014, expenditure totalled only $56 million of the $182.9 million budget with eventual total expenditure forecast to be about $105 million under budget at 30 June 2015.

The business case supporting the original $182.9 million was costed using a salaried ED and acute workforce model at district hospitals. Subsequently, WACHS implemented ED workforce models that were more reliant on GPs working on site or on call in the hospitals and less reliant on salaried doctors and specialists. This is a lower cost workforce model for ED service requirements at some district hospitals, particularly those with on call ED cover only. At 31 December 2014, about $33 million or over 50 per cent of total expenditure was on payments to GPs, and about $13.4 million was spent on salaried doctors, emergency specialists and locums (Figure 4).

WACHS advised they used contemporary workforce planning modelling to estimate the 44.7 additional full time doctors required for district hospitals. This modelling was also based on workforce arrangements in district and small hospitals outside the southern inland area. WACHS could not provide original planning documents.

Understanding historical ED service delivery, and the number and type of ED presentations, as well as local needs, is important when estimating staffing levels and the mix of doctors (e.g. GPs, specialists and salaried doctors) required for each district hospital. This could improve the robustness of planning and cost estimates for future medical services and workforce modelling beyond 2016-17.

Some Program initiatives were delayed

It took five months to establish the first district hospital ED rosters, with the remaining rosters commencing in February 2012, eight months after the Program started. WACHS advised this was because they needed to consult with GPs and regional stakeholders, and prepare and negotiate GP contracts. There was no implementation plan and we saw no other documented evidence of plans and timeframes for implementing these processes.

The original budget also included $32.7 million for ‘other goods and services’ such as clinical governance, accommodation, transport, electronic medical records, training and marketing and overheads. Due to the focus on establishing the ED rosters and inadequate planning, WACHS has not yet implemented other Program initiatives such as electronic medical records and the country health information system within ‘other goods and services’. By December 2014, only $800 000 of the $32.7 million had been spent.

WACHS did not have an implementation plan to track Program status. The lack of clear timeframes, roles and responsibilities and risk management processes increased Program risk in establishing key parts of the Program. [GC1][GG2]An implementation plan could have helped identify and address Program delays and was important given that this type of incentives based workforce program was new to WACHS. WACHS has advised it is developing an implementation plan that will guide delivery for the remaining years of the Program.

Over $30 million has been reallocated to other projects and the Program has been extended to 2016-17

Since the original approved business case, there have been several changes to the Program's expenditure profile in consultation with the Department of Regional Development (DRD) and the Department of Treasury. Of the estimated $105 million remaining funds, almost $72 million will be used to extend the Program by two years to 2016-17. The majority of these funds will be spent on salaried doctors, GP incentives, expansion of the ETS and the implementation of other Program initiatives including electronic medical records and the country health information system.

Of the remaining $33 million, $26 million was reallocated to capital projects in another SIHI stream and $7 million was re-directed to a Renal Program (Figure 4). The expected cost of the Program is now $149.9 million.

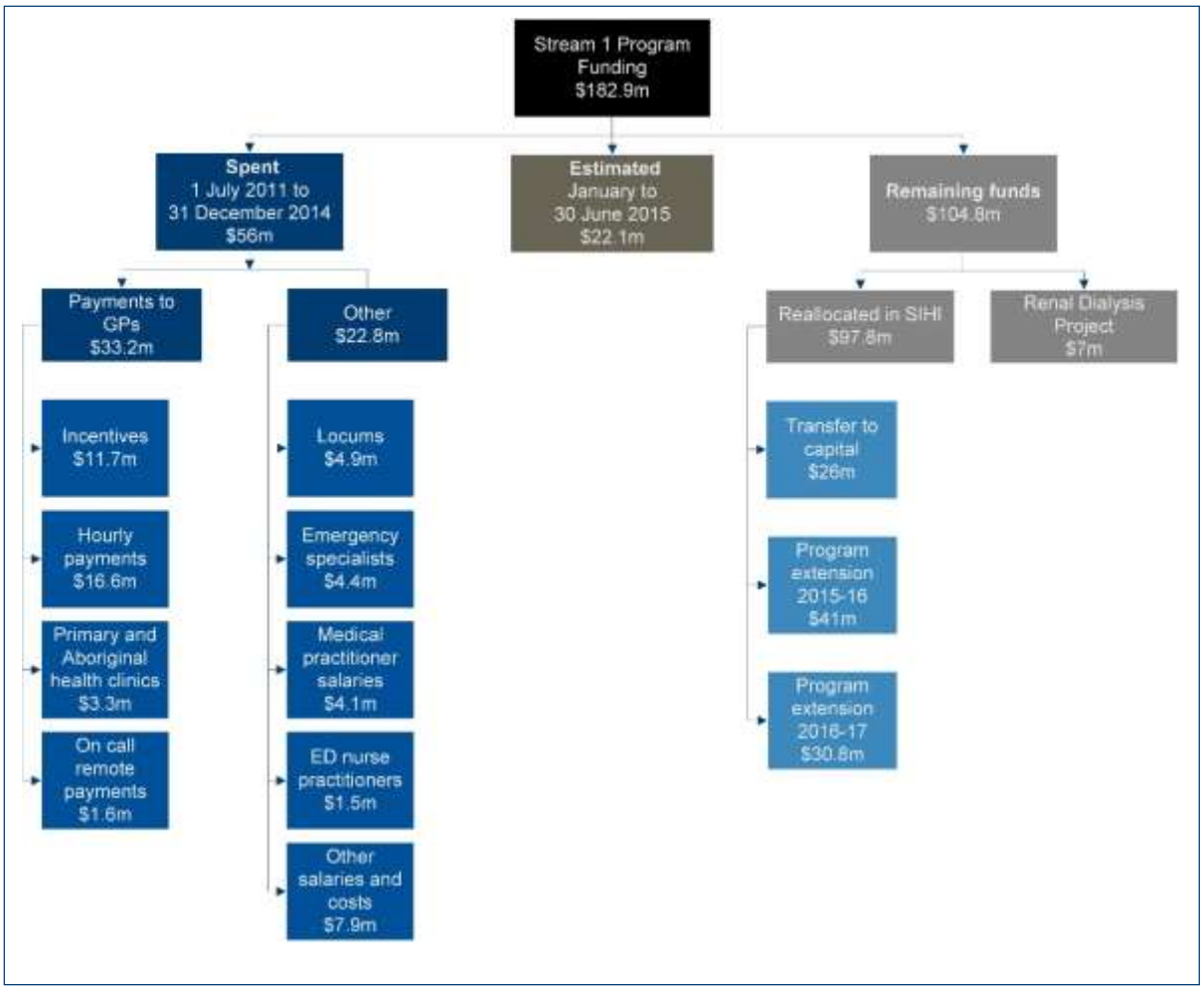


Figure 4: Program expenditure and remaining funds at 31 December 2014

There are weaknesses in Program administration and monitoring resulting in overpayments to doctors

Administrative weaknesses can undermine confidence in the Program

Poor oversight has contributed to administrative errors, inconsistent processes for verifying medical services and a lack of standardised process across district and regional sites. Of the 77 transactions tested, we found three instances where this led to incorrect payments to GPs. During our audit WACHS started to address these verification and payment issues.

Contract administration errors have been made

WACHS issues the contracts with the GPs engaged under the Program, but responsibility for negotiating and monitoring the contracts rests with the individual regional sites (Figure 5).

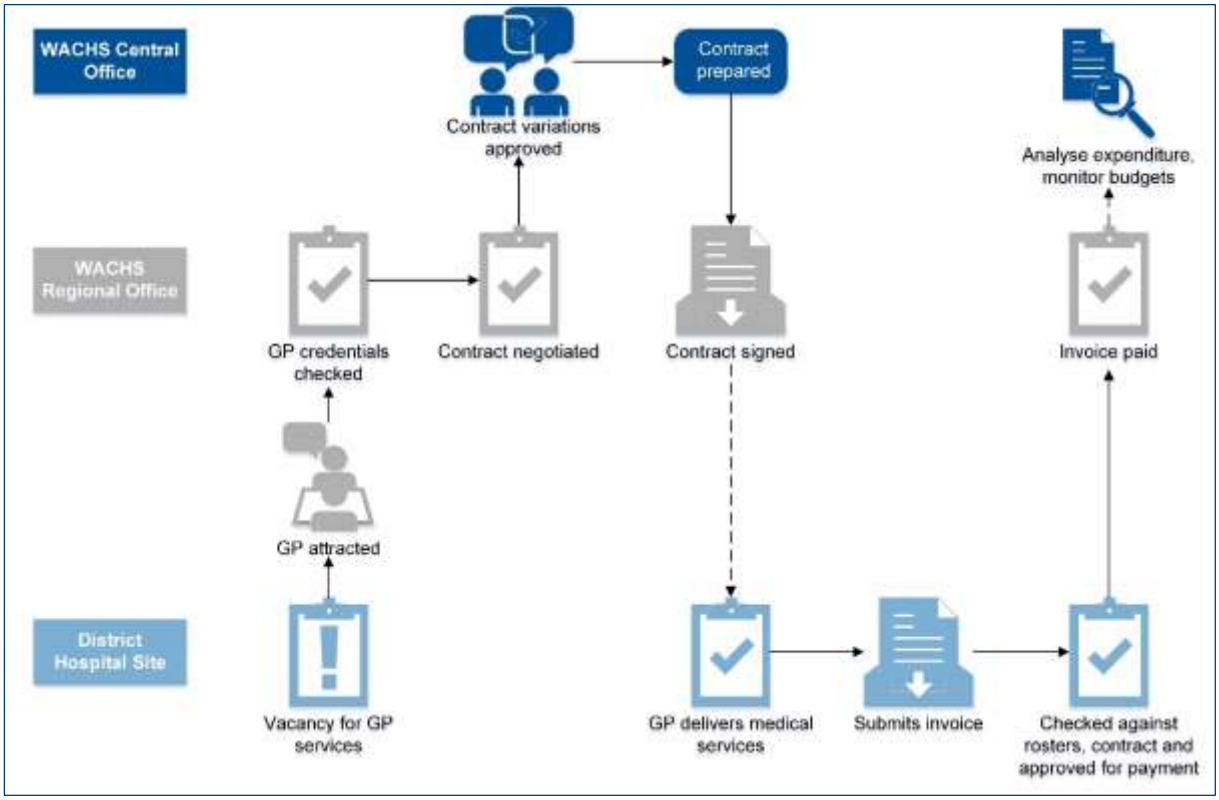


Figure 5: WACHS central and regional oversight

WACHS mistakenly issued 40 contracts to GPs in late 2013 which were missing the clause detailing the minimum roster requirements to receive the ED incentive. WACHS' legal advice was to not reissue or amend the contracts. This means GPs may be paid ED incentives even though they have not worked their minimum hours. While we found no instances of this during our audit, ED shifts need to be monitored by regional sites and the central WACHS office, to decrease the risk of overpayment of incentives.

Participation in ED services is a requirement to receive the attraction and assistance (A&A) incentive. Due to a contract error one GP continued to receive A&A payments, despite having their credentials to deliver ED services and their ED incentive cancelled. WACHS has since changed the Program contract to link the two incentives so if a GP no longer receives the ED incentive they do not receive the A&A payments.

There are weak and inconsistent processes for verifying medical services

We found a number of weaknesses in the processes for paying GPs that need to be fixed to avoid future payment mistakes:

- GPs must submit regular invoices for the time they have worked within the Program. However, many GPs submit invoices in an inconsistent format and at irregular intervals. This makes it difficult for WACHS to substantiate claims for payment. For instance, one GP submitted a claim for payment for $129 000, nine months after they started delivering services at general community and Aboriginal health clinics.
- There were no specific verification processes required for some incentive payments. GPs who claim the on call incentive, often in smaller network sites, and general community and Aboriginal health clinics are paid without evidence that they performed these services. A lack of verification processes increases the risk that these incentive payments will be made without services being delivered.
- Some GPs work fewer hours than others for the same incentive payment because the requirements are not standard across district hospitals. At the start of the Program, GPs were required to participate in at least one qualifying rostered ED shift per week. ED shifts varied from 24 hours on call at one hospital to a rostered 12 hour day shift on site followed by 12 hours on call at another. Despite Program guidelines stating the hours required to work, some regions were changing the qualifying hours for ED shifts. As a result of our audit, WACHS changed the Program guidelines to reinforce the requirement that GPs work an average of one qualifying ED shift of 12 hours per week, totalling a minimum of 46 shifts (552 hours) per year. Any changes to qualifying shifts must now have central office approval.
- There are also no minimum roster requirements for 'procedural incentive' payments. This incentive payment is made on the basis of a proceduralist GP participating on the published roster. As a result some GPs are rostered more regularly than others yet all proceduralist GPs receive $40 000 per year.

Incorrect payments were made to some GPs

Our testing identified three instances out of 77 transactions where GPs were paid ED incentives they were not eligible to receive. Appropriate monitoring of shifts worked is necessary to ensure that payments comply with Program requirements.

Three GPs were paid despite not working their required ED shifts

GPs are required to complete 46 ED shifts per year to receive the incentive payment. As part of our audit we tested a sample of one per cent of all incentive payments. In this sample we found three cases where GPs were paid the full incentive payment of $50 000, but had not completed the required number of ED shifts. This included one GP who only completed 16 out of the required 46 shifts, yet was paid the full incentive.

As a result of our audit, WACHS has revised incentive application forms and is currently making changes to Program guidelines as well as strengthening central and regional governance and contract processes.

Program data and evaluation could be better utilised to inform future planning

Processes and systems for monitoring Program data need improvement. WACHS sometimes lacks up-to-date information on the services GPs are delivering due to inadequate processes for capturing information from the doctor database and a reliance on regional offices to advise of any changes. This also limits WACHS ability to provide accurate data in a timely manner.

We found examples where internal Program activity reports based on KPIs from the Memorandum of Understanding (MOU) with the DRD were not always updated, and often incomplete. Additionally, WACHS no longer reports the number of general community health clinics allocated to GPs under the new MOU agreed in June 2014. The accuracy and completeness of Program monitoring and reporting is important because this information is used to track progress, evaluate the Program and report performance to the Parliament, the community and local government. It is also required for reporting to the DRD as part of the MOU arising from the Royalties for Regions funding of the Program.

We also noted that the quarterly reports to the DRD are based on output indicators such as the number of GPs, rather than Program effectiveness measures. For example, a key objective of the Program is to maintain seamless ED cover however there was no KPI on this. A lack of measures on the Program's effectiveness limits the ability to inform Government on how well the Program is meeting its key objectives.

In 2012, WACHS engaged a contractor to develop a Benefits Realisation Framework that would measure the long term benefits of the SIHI investment. Measurements for this Program include the economic benefits of better quality of care and better access to appropriate care. These measurements are being refined as the Program continues. In late February 2015 WACHS received an update report from the contractor. They intend to use these updates to review progress made, drive improvements, as well as communicate outcomes to internal and external stakeholders.

WACHS collects many sources of hospital and workforce data but could use this information better to assess Program outcomes and inform future planning. In May 2014, WACHS recognised that it lacked performance measures to provide evidence of impact and outcomes for the short and medium term of the Program. As a result, WACHS developed a baseline data measurement plan and evaluation framework, however it has not yet started to measure the effectiveness and appropriateness of the district hospital workforce models and current mix of incentives.

Feedback from GPs and key stakeholders indicated Program incentives had attracted GPs to the southern inland area and influenced GPs' decisions to stay. A recent study showed an increase in the number of years GPs remain in towns where the Program applied. GPs and key stakeholders commented that if the incentives were ceased this would have a negative impact on GP attraction and retention. By extension, this would have a negative impact on medical services in the southern inland area. Planning to ensure the sustainability of services beyond 2016-17 is a key issue for WACHS, Government and the local community.

Appendix 1: Program incentives

Incentive payment	Frequency of payment
Emergency Department Service Provision Applies to nominated 1A (Esperance, Merredin, Narrogin, Northam) and 1B district network towns (Bridgetown, Collie, Katanning, Manjimup) – requires one rostered shift per week. WACHS equates this to 46 shifts per year after allowing for annual leave.	$50 000 per annum. Payments are generally made quarterly, and in arrears.
Emergency Service Roster Payment Rostered on site ('on the floor') at a 1A nominated district network town hospital for a shift at $200 per hour (inclusive of fee for service). Rostered close availability at 1A or 1B nominated district network town hospital at $50 per hour (exclusive of fee for service). Rostered close availability at a 2A or 2C nominated district town hospital at $300 per day (exclusive of fee for service).	Hourly rates paid on the basis of on site or on call shifts.
Procedural Service Provision For agreeing to participate in their specialty roster in 1A and/or 1B nominated district network towns as per the Medical Services Agreement.	$40 000 per annum. Payment is made quarterly in arrears.
GP Availability Payment GP that provides local call out to a nursing post, clinic/hospital for clinical requirements.	$300 per day plus fee for service.
Primary Health Service Provision Provision of general community health clinics in nominated towns for nominated days per week.	$100 per day, plus private billings and up to $300 travel payment.
Aboriginal Health Service Provision Provision of Aboriginal health clinics in nominated towns for nominated days per week.	$400 per four hours.
Attraction and Assistance payments Only available to GPs who relocate from outside the southern inland area into a participating location. Subject to the continuity of the ED service provision.	Upfront $10 000 payment and seven quarterly payments of $10 000 over two years.
Location incentive Only available where a GP lives in Southern Cross, Lake Grace, Norseman, Ravensthorpe/Hopetoun, Leonora or Laverton. GP must participate in availability rosters in Tier 2/3 nearby towns. Must be resident in one of these towns for a minimum of four nights per week, 46 weeks within a 12 month period.	Payment is $30 000 per annum and paid quarterly in arrears.

Appendix 2: GPs receiving incentives at 31 December 2014

District network	Number of GPs signed to incentives	Number of GPs receiving ED incentives*
Northam	11	6.5
Merredin	10	7.5
Narrogin	17	13
Moora	4	N/A
Morawa	2	N/A
Dongara	2	N/A
Kalbarri	6	N/A
Meekatharra	1	N/A
Katanning	10	8
Collie	5	5
Warren Blackwood (Bridgetown and Manjimup)	10	9
Esperance	17	8
	95	**57**

* Based on the number of GPs receiving $50 000 ED incentive. GPs can qualify for part time arrangements

Auditor General's Reports

Report Number	Reports 2015	Date Tabled
3	Asbestos Management in Public Sector Agencies	22 April 2015
2	Main Roads Projects to Address Traffic Congestion	25 March 2015
1	Regulation of Real Estate and Settlement Agents	18 February 2015
Report Number	**Reports 2014**	**Date Tabled**
22	Opinion on Ministerial Notification	18 December 2014
21	Training and Support for Justices of the Peace	26 November 2014
20	Ensuring Compliance with Conditions on Mining – Follow-up	19 November 2014
19	Purchasing Through Common Use Agreements - AGBA	12 November 2014
18	Audit Results Report – Annual 2013-14 Financial Audits	12 November 2014
17	Opinions on Ministerial Notifications	25 September 2014
16	Our Heritage and Our Future: Health of the Swan Canning River System	13 August 2014
15	Working with Children Checks	30 June 2014
14	Information Systems Audit Report	30 June 2014
13	Royalties for Regions – are benefits being realised?	25 June 2014
12	Government Funded Advertising	25 June 2014
11	Licensing and Regulation of Psychiatric Hostels	25 June 2014
10	Universal Child Health Checks Follow-Up	18 June 2014
9	Governance of Public Sector Boards	18 June 2014
8	Moving On: The Transition of Year 7 to Secondary School	14 May 2014
7	The Implementation and Initial Outcomes of the Suicide Prevention Strategy	7 May 2014
6	Audit Results Report – Annual 2013 Assurance Audits (Universities and state training providers – Other audits completed since 1 November 2013)	7 May 2014
5	Across Government Benchmarking Audits – Controls Over Purchasing Cards – Debtor Management – Timely Payment of Invoices	1 April 2014
4	Behaviour Management in Schools	19 March 2014
3	Opinion on ministerial decision not to provide information to Parliament about funding for some tourism events	18 March 2014
2	Charging Card Administration Fees	12 March 2014
1	Water Corporation: Management of Water Pipes	19 February 2014

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