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PERFORMANCE AUDIT

Management of Long Stay Patients in Public Hospitals

Office of the Auditor General
Western Australia

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The Office of the Auditor General acknowledges the traditional custodians throughout Western Australia and their continuing connection to the land, waters and community. We pay our respects to all members of the Aboriginal communities and their cultures, and to Elders both past and present.

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WESTERN AUSTRALIAN AUDITOR GENERAL'S REPORT

Management of Long Stay Patients in Public Hospitals

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THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

MANAGEMENT OF LONG STAY PATIENTS IN PUBLIC HOSPITALS

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 my Office's overall program of audit and assurance for Parliament. They seek to provide Parliament and the people of WA with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

This audit examined WA Health's system management of long stay patients. It also assessed the roles of the Mental Health Commission and Department of Communities in providing supporting services.

I wish to acknowledge the entities' staff for their cooperation with this audit.

CAROLINE SPENCER
AUDITOR GENERAL
16 November 2022

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Auditor General's overview

People staying in hospital after they are medically ready to leave is not good for them or for our health system. They are not in the right place for the care they need and extended stays block access to care for other patients. With an average length of stay for most other patients of just under three days, being in hospital for an extra week or 10 days is a long stay that has an impact. The impact is felt at each step of a patient's journey from ambulance through emergency department onto wards, and in the wait times for elective treatment. Some patients have been in WA hospitals for many weeks, months and even years beyond medical necessity.

WA Health does not have an effective system for managing long stay patients. WA Health's data on extended stays is not robust or effectively used. The Department of Health, as system manager, does not know, in real time, how many patients across WA Health remain in hospital when they are medically fit for discharge and therefore has limited understanding of the cost and impact on hospital bed capacity and patient flow. As I have highlighted before, without reliable data, and determined focus on continuous improvement, WA Health will struggle to recognise and adequately improve underlying systemic issues and make well-evidenced value for money investments. The recent *Independent Governance Review of the Health Services Act 2016* made similar findings regarding WA Health utilising live data, sharing information within WA Health and reporting performance.

While WA Health's existing data doesn't provide a complete picture, the data available does show that reducing the barriers to long stay patients leaving hospital would mean hundreds of people being in less expensive and more appropriate care settings, and potentially thousands of extra patients being able to access hospital care without the need for additional bed infrastructure.

Delivering those benefits is not something WA Health can do entirely on its own. Many of the people stuck in hospital have complex needs that require disability, aged care, mental health and housing supports. These services operate in an often fragmented landscape across multiple portfolios, sectors and levels of government that is difficult for individuals to navigate, and which no single entity controls.

Extended stays in hospital are not new, nor are the issues that cause them. While there has been sporadic action in the past, a focus is required to make sure patients are in the care setting they need and resources are used efficiently.

Collaboration over the last 18 months between WA Health, Department of Communities and the Mental Health Commission, and recent announcements from the Commonwealth Government on aged and disability care, indicate the timing is opportune for change. The benefits on offer are great and I encourage the Department of Health, as system manager, to work closely with all entities to better help those people for whom a hospital bed is somewhere to wait rather than get well.

Executive summary

Introduction

This audit examined if WA Health (the Department of Health and Health Service Providers) and other State government entities (Mental Health Commission and Department of Communities) have an effective system for managing long stay patients who no longer require hospital care. We focussed on monitoring of the issue and if efforts to address the issue were working.

Background

Within a healthcare system, hospitals ensure that services for patients with high medical needs and complex conditions are always available.[1] In Western Australia (WA), there are 80 hospital sites and 7,215 hospital beds. WA Health estimates the average cost of a hospital bed is $2,370 per day in 2022.

When hospital staff assess a patient as medically ready, they can be discharged (leave hospital). If it is not possible to discharge the patient because necessary supports are not available, the patient remains in hospital even though they no longer need hospital services. This includes patients waiting to access aged care or the National Disability Insurance Scheme (NDIS). It also includes social admissions, where patients enter hospital as there is nowhere else for them to go in the community, as families or service providers can no longer care for them.

In this audit, a patient who has been assessed as medically ready for discharge but remains in hospital is considered a long stay patient. This threshold was chosen to avoid examination of stays which are long but medically necessary. Long stay patients are unable to access services in the community that would better address their needs and are at increased risk of becoming unwell the longer they stay in hospital. They can become isolated and lose their connections to the community. The broader community is also impacted, as fewer beds are available for patients to receive necessary hospital services.

WA Health is made up of the Department of Health (the Department) and Health Service Providers (HSPs). The Department is the system manager for health care in WA. In this role it is responsible for the overall management, performance, and strategic direction of the WA health system. Its key purpose is to ensure the delivery of high-quality, safe and timely health services. This includes overseeing, monitoring and promoting improvements to the safety and quality of health services.

The HSPs are responsible directly for the delivery of safe, high quality, efficient and economical health services within their local communities. The HSPs that provide care directly to patients and included in this audit are:

- North Metropolitan Health Service (NMHS)
- South Metropolitan Health Service (SMHS)
- East Metropolitan Health Service (EMHS)
- WA Country Health Service (WACHS)
- Child and Adolescent Health Service (CAHS).

[1] World Health Organisation (WHO), Hospitals, WHO, viewed 9 September 2022, <http://www.who.int/health-topics/hospitals#tab=tab_1>.

Providing services for long stay patients also involves the Mental Health Commission (MHC) and Department of Communities (Communities). The MHC commissions mental health services from HSPs and Communities is responsible for social housing, child protection and some disability services. The Commonwealth Government is primarily responsible for administering the NDIS and the aged care system.

Conclusion

The Department, as system manager, has a limited understanding of the impact of long stay patients on hospital bed capacity, patient flow and cost. Its information is not robust enough to know, in real time, how many patients across WA Health remain in hospital when they are medically fit for discharge. As its information is not comprehensive, the Department does not have a robust, system wide view of the scale, cost and impact of long stay patients in public hospitals. When the average length of stay in hospital is just under three days, being in hospital even for an extra week or two can have an impact.

WA Health's long stay data is limited to point in time snapshots which are not system wide. The limited data available indicates that significant efficiency gains are available from patients being in the care setting that best matches their needs. For instance, snapshots between May 2021 and June 2022 identified that 486 patients waiting for NDIS or aged care services had spent approximately 40,000 days extra in hospital, at a cost of almost $95 million. Freeing up that capacity could have provided hospital access for over 14,000 more people and reduced the cost of caring for the long stay patients by $71.8 million.

Patients staying in hospital after they are medically ready to be discharged is a long standing issue, and while there have been some previous efforts to address it, the Department's long stay patient steering committee and working group were only established in March 2021. State entities have had some success working together on intensive individual case management for long stay patients waiting for NDIS or aged care services. The State Government recently announced $74 million in funding to focus on long stay patients, 80% of which is for transitional aged care beds. The Commonwealth Government also announced plans to improve the way the NDIS and hospitals work together. It is not yet clear how these initiatives will be implemented and what their expected impact is, or if any enduring systemic improvement of this long standing issue will result.

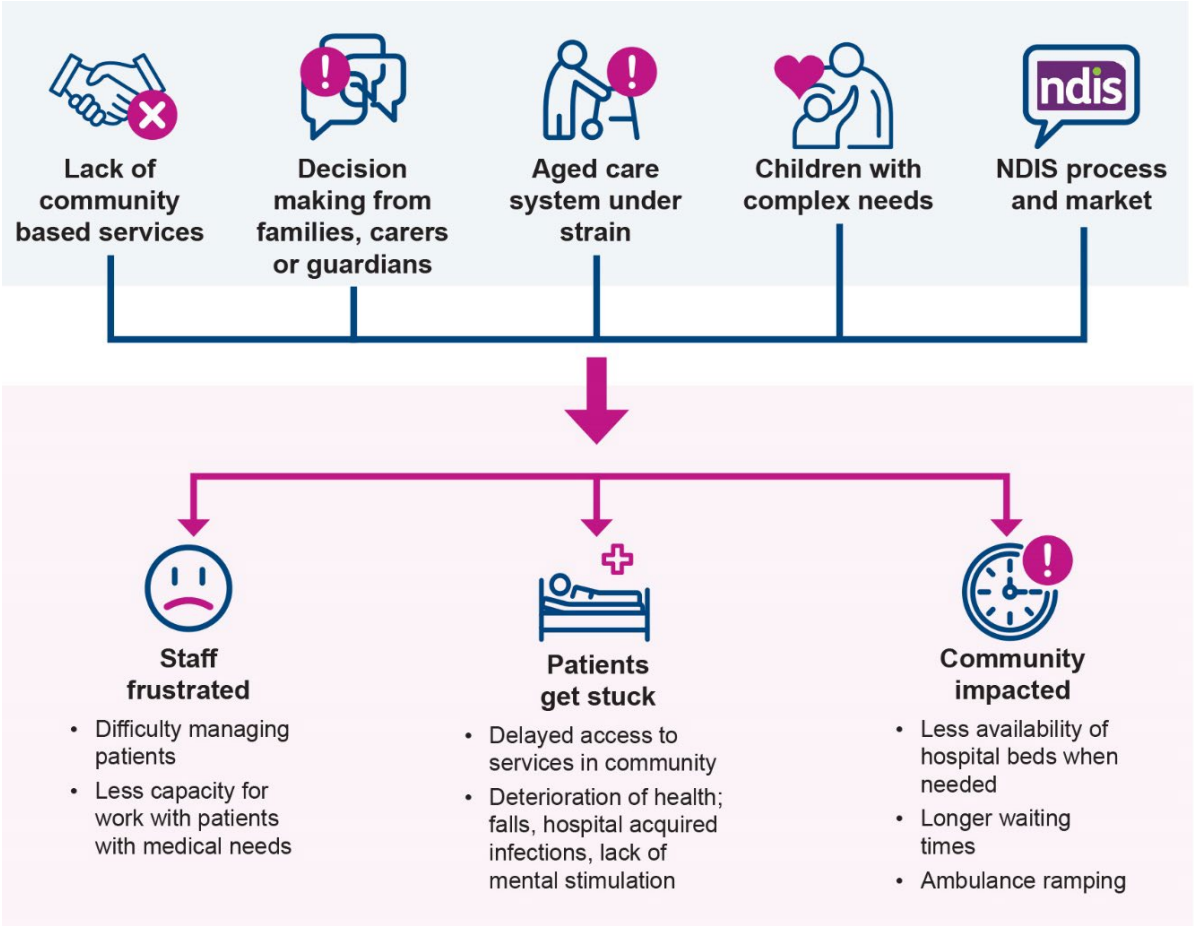
Despite these initiatives, the needs and barriers of long stay patients, particularly those coming to hospital with no other support options, are not fully understood. The Department needs this understanding to underpin collaborative and coordinated initiatives with HSPs and other entities to help long stay patients. This also impacts the ability of WA Health to work with others to direct resources to where they will have most effect. Robust analysis and a strategic understanding are essential given that funding and responsibilities cut across multiple State and Commonwealth entities, and sustained improvement requires coordinated action. Without it, expensive hospital capacity will continue to be used inefficiently and patients will continue to stay in hospital longer than they need to.

Findings

Hospital stays beyond medical necessity can impact both patients and hospital staff

Staying in hospital beyond necessary can have a profound impact for both the patient and hospital staff. Long stay patients can stay in hospital for days, weeks, months, or years longer than necessary. The most common reason for this is a lack of available services and includes (Figure 1):

- patients waiting for NDIS funded supports
- patients waiting for services or programs in the community, such as appropriate housing or mental health services
- patients waiting for aged care places to become available
- families, carers, or guardians taking time making decisions on placements, or the time it takes to educate families on caring for patients with complex needs
- social admissions, where patients enter hospital as there is nowhere else for them to go in the community. This includes where families or service providers can no longer care for a person.



Source: OAG

Figure 1: Factors leading to long stay patients and impacts

We visited six hospitals and spoke to staff about long stay patients. Each hospital spoke of very complex patients with multiple, chronic conditions or requiring specialised care. They also described patients being brought to hospital as a means of dealing with a social crisis, or where service providers have run out of funding. This also happens where carers need respite or where aged care homes do not have enough staff to care for residents. This is pronounced in regional areas, where WACHS is the provider of last resort. Sometimes, patients can be admitted to hospital multiple times over a period of months or years. This puts additional pressure on hospitals and hospital staff, which may already be struggling due to staffing shortages.

Long stay patients often do not have enough stimulation and activity, leading to reduced physical, mental and emotional wellbeing. When patients are stuck in beds, they are missing out on receiving services in the most suitable environment. Their capacity and opportunity for connecting within the community is reduced because they are removed from their home environment and regular social engagement with family and friends. Extended hospital stays may also increase the risk of hospital acquired infections and falls. Hospital is often not the most appropriate place for these patients, causing further challenges to recovery or reintegration into the community.

To be discharged safely, some patients need to be able to access care in the community. The absence of local supports can extend a hospital stay or force people to consider moving far from home to receive care they need. The absence of necessary services in the community, or enough of the right services, can lead to people experiencing longer stays in hospital.

Not having the right volume and mix of community services was mentioned by nearly all stakeholders during the audit. This was particularly so for people with disability or mental health conditions. Three years ago, we identified the lack of community services in our 2019 performance audit of adult mental health services.[2]

People staying longer than necessary in hospital also increases the pressure on hospital staff. Beds become blocked to other patients who also need to access them. Some of these patients also have significant behavioural issues that require more staff involvement. Despite these challenges, hospital staff remain focused on patient flow. At a hospital level, there are positions and processes aimed at discharging patients. For example, regular multi-disciplinary committees focus on identifying and addressing the barriers to discharge for individual patients. Hospital discharge coordinators and allied health staff also work to find solutions for complex patients.

The Department does not fully understand the number of long stay patients, but snapshots show it is significant

The Department has a limited understanding of the number of long stay patients in its system. WA Health monitors patients in hospital through its systems. But while WA Health can report on patients, it lacks the ability to report on how many of its current patients remain in hospital when they are medically ready for discharge.

The Department is currently reliant on retrospective point in time snapshots. It has not yet established the collection of more reliable and complete information on long stay patient activity. The point in time snapshots are surveys of some of the long stay cohorts, which are conducted at both a Departmental and HSP level to better identify and understand the people stuck in hospital.

[2] Office of the Auditor General, *Access to State-Managed Adult Mental Health Services*, OAG, Perth, 2019 p. 24.

While these snapshots are useful because they provide insight into the people impacted, the information is static and only provides insight at that point in time. These snapshots do not indicate long-term trends in the cohorts most heavily impacted by being stranded in hospital. This means that the Department cannot rely on these numbers to make decisions on where best to allocate resources to resolve the issue or to assess how efforts to address the problem are working.

The Department has not yet established methods to collect consistent and complete data on long stay patients

At a system level, the data that is available on long stay patients is limited and unreliable. The Department is reliant on point in time information rather than live system data and trend analysis to gain insights into long stay patient activity. The point in time data is only available retrospectively, as it is based on when a patient is discharged, or separated, from hospital.

As a result, any analysis can only be done after the patient has left hospital and little is known about what is happening across the system at any one time. So, someone who has spent years in hospital may be excluded from the data if that person has not yet left hospital. Only considering people who have left hospital makes it harder for the Department to proactively manage long stay patients in real-time and observe trends in long stay patient activity for people who remain in hospital.

The lack of a medically ready for discharge flag inhibits the ability of WA Health to have an overall view of the system. When a patient no longer needs care in a hospital, there is no way for these patients to be consistently recorded across the system, making it difficult to determine the scale of the issue within WA Health. Other flags do exist, such as one that indicates if a patient is an NDIS recipient, but these are not consistently used. For other cohorts of long stay patients, for example, social admissions or people without other support options, there is no data flag. The inconsistent use of flags has left gaps in the data which means WA Health cannot reliably measure the problem.

WA Health does not have visibility over the NDIS status of a participant and making decisions or plans is more difficult. It also means WA Health's estimates of NDIS patients in hospital may underestimate the total population. WA Health does have an agreement with the NDIA, but this is currently limited to the sharing of intellectual disability specific NDIS data on behalf of the Telethon Kids Institute. Outside of this, data sharing arrangements with the Commonwealth regarding the NDIS are still being negotiated. Although it has been almost five years since the NDIS transition agreement between the State and Commonwealth was signed, there is still no policy in place to facilitate information exchange between WA Health and the Commonwealth. This increases the risk that WA Health cannot make plans in line with the actual impact of this cohort on the system.

Without reliable data, the Department cannot develop useful performance indicators or monitor its progress in resolving the underlying issues leading to people being stuck in hospitals. So, the Department cannot know the true scale of the problem or whether it is getting better or worse. It cannot effectively prioritise solutions and cannot guarantee that any investment made targets the fundamental issues that contribute to the problem.

Moving 486 long stay patients waiting for NDIS and aged care services to more appropriate settings could have allowed over 14,000 more people to access a hospital bed

Although they do not form a system wide long stay patient data set, recent NDIS and aged care cohort snapshots show that there are significant efficiency gains to be made from patients being in more appropriate care settings. When these snapshots are examined together, it indicates that at various times 486 people were stranded in WA hospitals while they waited for NDIS or aged care services. On a basic analysis, if these patients were in

more appropriate accommodation it could have freed up capacity to allow over 14,000 more people to access a hospital bed.

When the average length of stay is just under three days, patients with an extended hospital stay of a week or even ten days can have an impact. In the snapshots, the people waiting for NDIS and aged care services stayed in hospital for a total of over 40,000 days after they were medically ready for discharge. According to the Australian Institute of Health and Welfare, the average length of stay in a public hospital in WA is 2.8 days.[3] On this basis, the total approximately 40,000 bed days would have provided capacity to treat over 14,000 more patients with an average length of stay (see Appendix 1 for further information).

Snapshot 1: Long stay patients waiting for NDIS services May to December 2021

Since December 2020, the Department's Chief Allied Health Officer (CAHO) has been running monthly reviews of patients in hospital, medically ready for discharge, but waiting for NDIS funded services to become available to them. Social workers and hospital discharge coordinators identify these patients. They send spreadsheets with their information to the Department on a specific day each month. These reviews also identified key discharge barriers for patients, including accommodation, funding and NDIS plan reviews.

The CAHO reports identified that between May 2021 to December 2021, there were an average of 116 patients waiting in hospital for access to NDIS funded services. On average, patients without a mental health diagnosis stayed 112 days longer in hospital than needed. Those with a mental health diagnosis stayed 356 days longer than medically necessary, which is nearly three times longer. Collectively, they stayed 29,584 extra days in hospital.

Snapshot 2: Long stay patients waiting for aged care services July 2021 to June 2022

WA Health has visibility over the numbers of patients in hospital awaiting aged care in the metropolitan area through the Patients Awaiting Aged Care System used by hospital sites, HSPs and the Department. These patients have been assessed as medically ready for discharge and have undergone an aged care assessment. Between July 2021 and June 2022, the Department's monitoring identified an average of 209 patients medically ready for discharge but waiting for aged care in metropolitan Perth hospitals. These people stayed a total of 2,404 days longer in hospital than necessary.

Between July 2021 and March 2022, in regional WA, WACHS reported there were an average of 161 patients awaiting aged care who collectively spent 7,976 days longer than necessary in hospital. The collective wait time for people awaiting aged care services in the regions is significantly higher than their metropolitan counterparts (50 days and 11.5 days respectively).

Scarcity of staffing and aged care places are key drivers of this difference. Additionally, wait times have been exacerbated by safety and quality issues raised in the *Royal Commission into Aged Care Quality and Safety* and the COVID-19 pandemic, which have

[3] Australian Government, Australian Institute of Health and Welfare, Admitted patients - Australian Institute of Health and Welfare (aihw.gov.au), AIW, Canberra, accessed 12 September 2022.

led families to delay seeking medical care for older people. COVID-19 outbreaks in aged care facilities have also limited the ability to increase capacity in aged care.

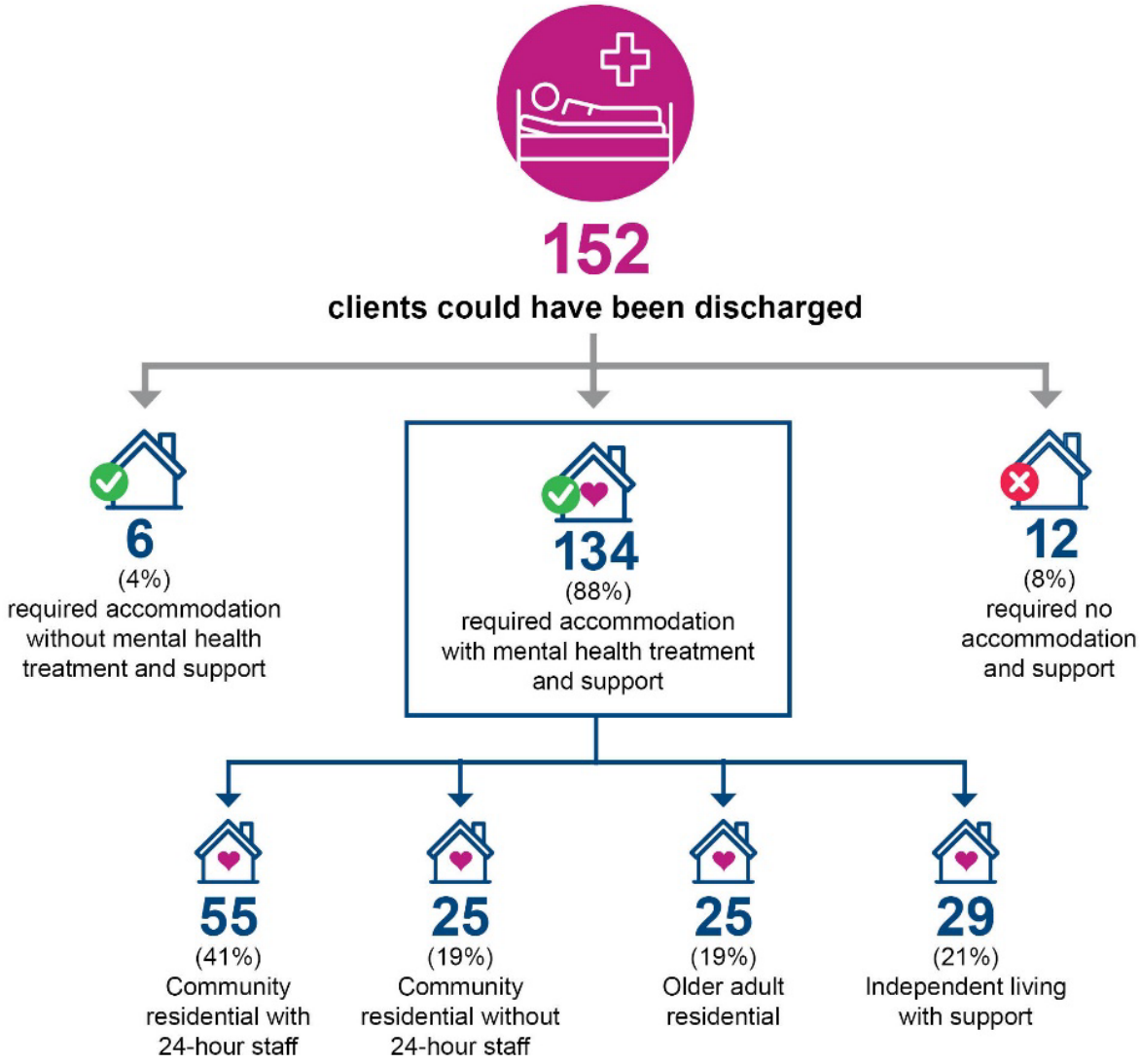
The data also allows for some basic analysis of cost efficiency. For example, hospital beds cost an average of $2,370 a day. Transitional NDIS and aged care beds cost $650 and $351 per day respectively. Assuming this is consistent across WA, this means that if these cohorts stayed in transitional accommodation, rather than a hospital bed:

- for the NDIS cohort, there could have been a $50.8 million reduction in the cost of their care
- for patients awaiting aged care in metropolitan areas, cost of care would have been $4.8 million less
- for patients awaiting aged care in regional areas, the cost of their care would have reduced by $16.1 million.

This is a total reduction of $71.8 million, from the $95 million spent on these patients. Transitional accommodation is cheaper because it does not have the cost overheads associated with hospitals. But it is also created for the purpose of enabling patients to receive care while planning for more permanent accommodation.

April 2021 data showed that 25% of mental health beds were occupied by people medically ready for discharge but waiting for community services including accommodation

The MHC drives information gathering on mental health long stay patients. It conducts a yearly survey of mental health inpatients at public hospitals medically ready for discharge but awaiting access to community services. The most recent snapshot, in April 2021, found that 152, or 25%, of the 675 mental health inpatient beds were occupied by patients medically ready for discharge. Nearly all of these patients could not be discharged as they did not have access to the necessary community services including accommodation (Figure 2).



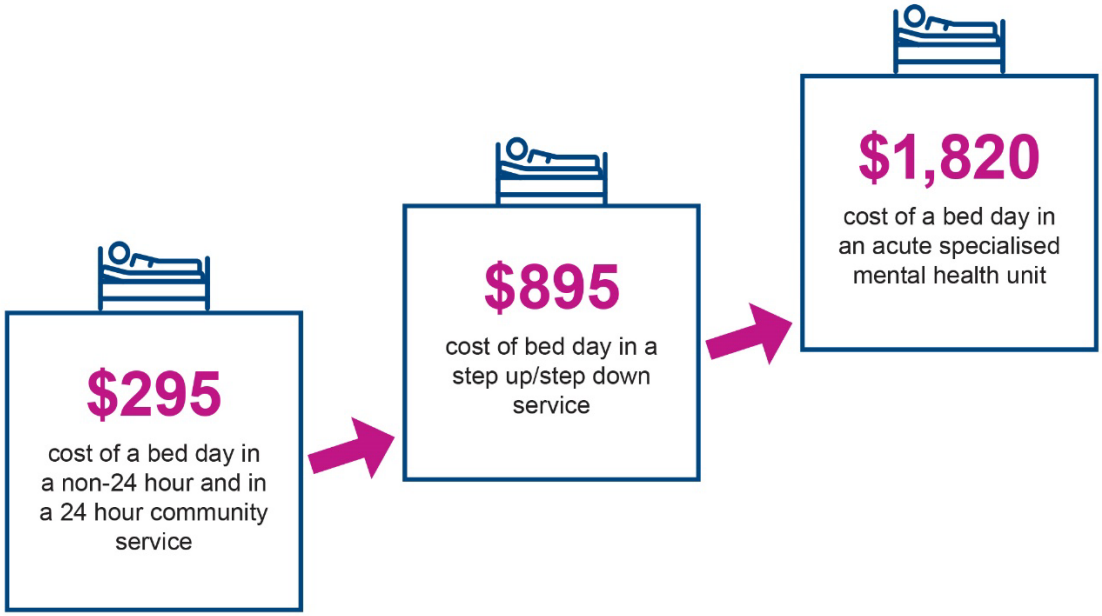
Source: OAG based on Mental Health Commission information

Figure 2: Results from the 2021 Mental Health Inpatient Snapshot Survey

The survey does not collect information about the extended length of stay of patients or any overlap with patients identified in NDIS surveys conducted by the Department of Health. However, moving these people to transitional mental health accommodation would be more appropriate to their needs, free up capacity for more acute presentations and is significantly lower cost than a hospital bed (Figure 3). This aligned with findings in our 2019 audit on adult mental health.[4]

To compare the cost of care for these patients, we have applied a similar process as for the NDIS and aged care cohorts. If each of the 152 patients stayed in the step up/step down service, compared to a specialised mental health unit, the cost would be $49.6 million per year, compared to $100.9 million per year.

[4] Office of the Auditor General, *Access to State-Managed Adult Mental Health Services*, OAG, Perth, 2019 p. 25.



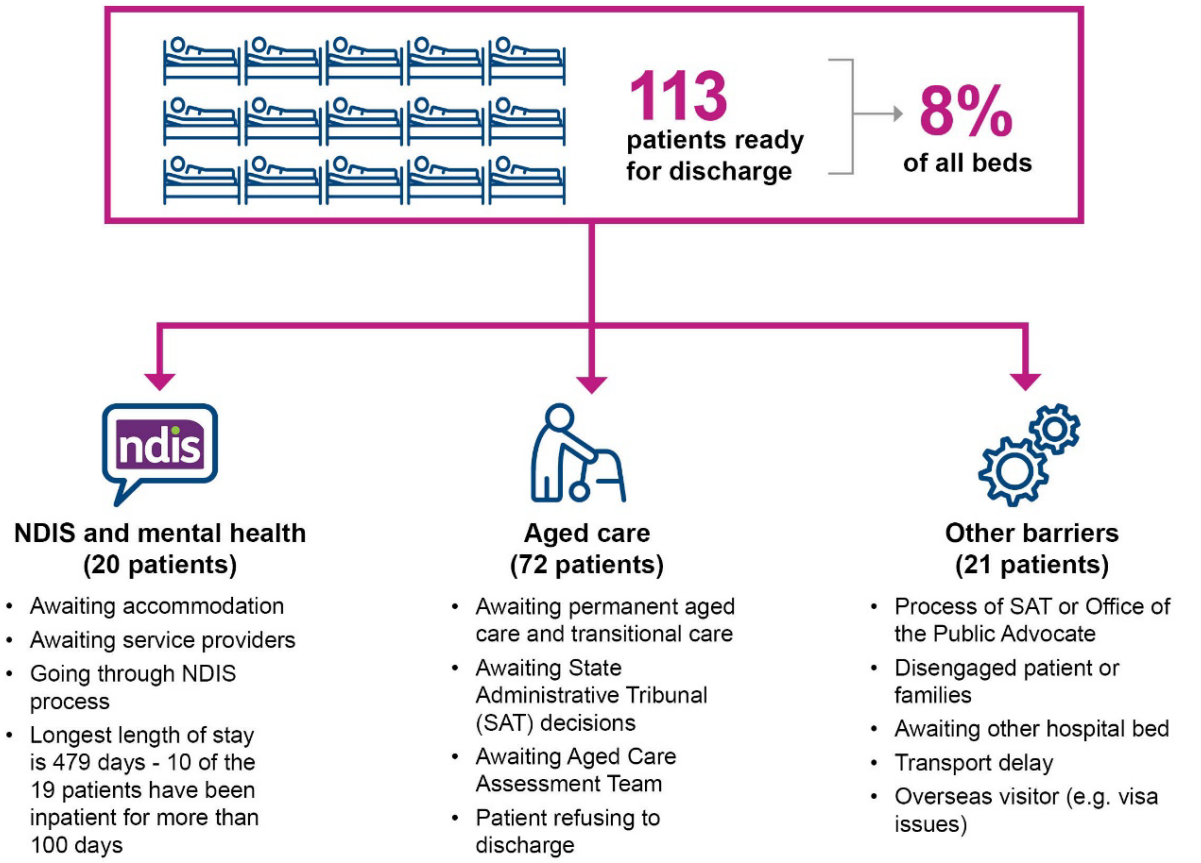
Source: OAG using information supplied by Mental Health Commission

Figure 3: Comparison of the cost of state based adult mental health services

Recent snapshots at HSPs show long stay patients occupy at least 6.5% of hospital beds

Recent estimates from HSPs suggest that at least 6.5% of patients in hospital beds no longer need hospital care. During the audit, both EMHS and SMHS began projects to identify patients staying longer than medically necessary in their respective hospitals. They also assessed the key discharge barriers for these people stuck in hospitals. Clinicians identified and recorded patients through regular surveys. Both HSPs have found similar proportions of patients in hospital medically ready for discharge, with at least 6.5% identified in snapshots between May and September 2022. More systematic attention to the findings could assist to form a detailed view of the problem and start to address the causes.

For example, on 26 May 2022, SMHS found 113 patients medically ready for discharge in hospital beds. As SMHS has 1,452 beds, this means that 8% of all beds were being used by patients who did not need to be there. Most patients fit into the aged care, NDIS and mental health categories, though other discharge barriers were also identified (Figure 4). WA Health believes this particular result was inflated due to pressure on the aged care system during the COVID-19 pandemic. Between 12 July 2022 and 6 September 2022, SMHS identified an average proportion of 6.89% of long stay patients in its hospitals.



Source: OAG based on SMHS information

Figure 4: Results from SMHS survey of long stay patients on 26 May 2022

Similarly, the EMHS survey from 29 August 2022 found 99 patients who were medically ready for discharge in its hospitals. EMHS has 1,491 beds, which means that 6.6% of beds were occupied by patients who did not need hospital care. The main cohorts identified were aged care (46%), NDIS (26%), other non-NDIS accommodation (17%) and other barriers, such as awaiting home modifications and family disengagement (11%).

Similar proportions of long stay patient numbers recorded at both HSPs suggest the issue is significant and multifactorial, beyond the aged care, NDIS and mental health cohorts. Recognising the dimensions of the problem and finding ways to measure it more systematically is an important step. These are point in time estimates in individual health services in metropolitan Perth. It is also resource intensive and reliant upon the participation of indidvidual staff at hospital sites. However, they provide a good starting point in understanding the total population of long stay patients in a health service.

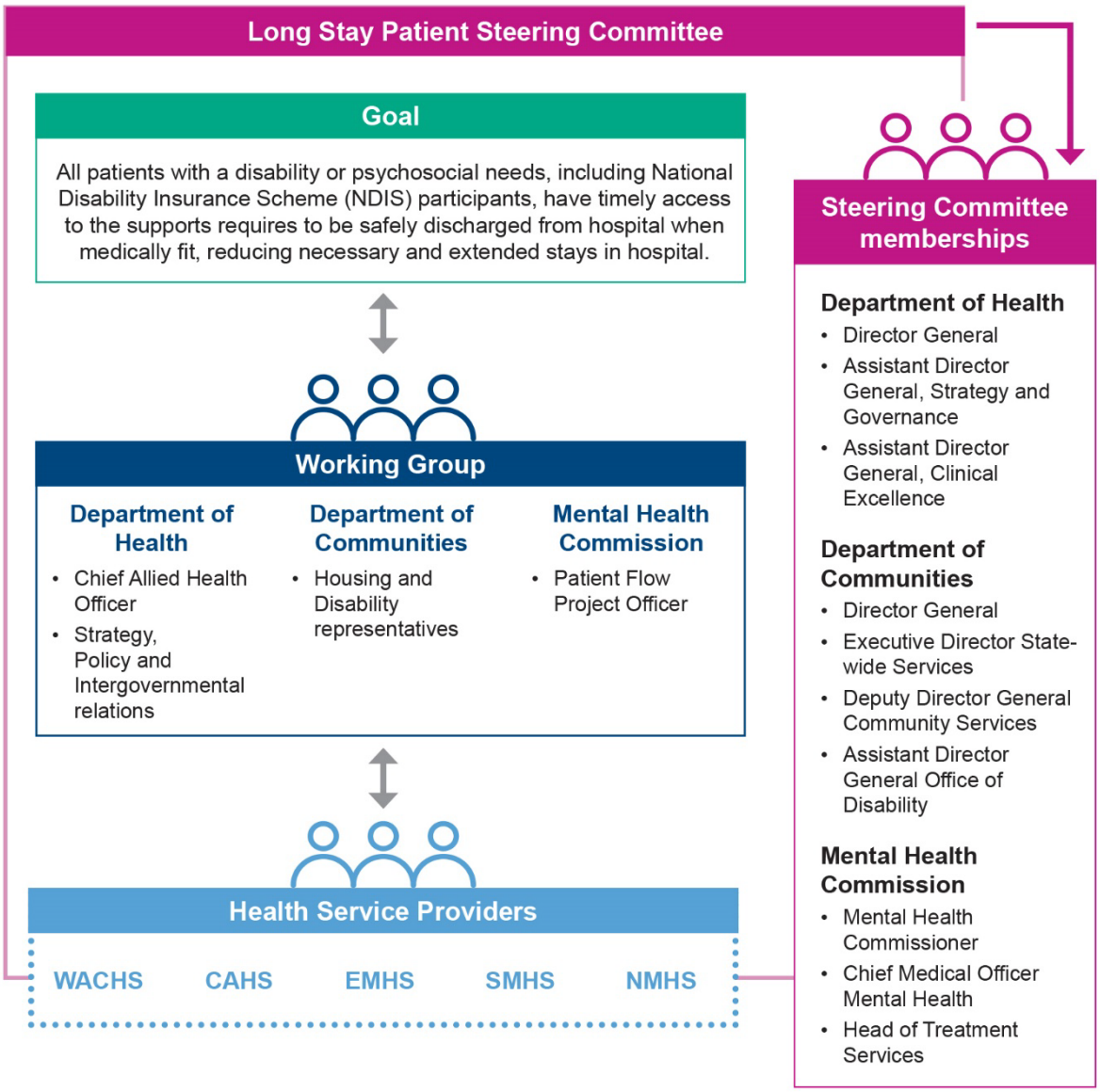
Entities are now collaborating to manage long stays, but sustained progress needs a more strategic approach

Case management has shown success for patients, but system wide progress is slow

The Department's Long Stay Patient Steering Committee (Committee) and its Working Group (Working Group) were established in March 2021. They have found solutions for individual patients waiting for NDIS supports and helped them to access existing services. However, the Committee has taken only limited steps to ensure that the systemic issues

leading to long stays are addressed and lasting system wide changes are secured. The work the Committee and Working Group has done to understand the key issues for NDIS patients and advocate for NDIS policy changes has been a promising first step in the process.

The Committee includes representation from senior members and key staff of the Department, MHC and Communities (Figure 5). The Committee meet monthly and Working Group twice weekly to case manage individual patients. Patients are identified through monthly (manual counting) audits of hospitals, but hospitals can also refer complex patients on an 'as needs' basis. Mental health patients, many of whom are part of the NDIS cohort, are also a focus of the Committee and Working Group.



Source: OAG based on Department of Health information

Figure 5: Long Stay Patient Steering Committee and Working Group

The Working Group has focussed on identifying suitable NDIS providers, finding interim accommodation and modifying properties. This has shown success in discharging some long stay patients. For example:

- since 1 July 2021, the Working Group provided case input or consultation for at least 115 patients experiencing delayed discharge

- the Department reports that, by the end of May 2022, the Committee had approved $726,839 to support 38 NDIS recipients leaving hospital
- $75,025 has been spent on interim supports to support the discharge of nine patients from Graylands Hospital. Two of these individuals had experienced delays of up to eight years.

The Committee and Working Group have now had an impact for some individual patients. But there is little evidence to suggest a system wide improvement on the size of the problem. For example, between March 2021 and March 2022, the patient turnover of the NDIS cohort shows that 377 long stay patients were discharged. But 379 new patients were identified over the same period. As the number of these patients in the system remained stable over the year, this suggests that the underlying causes of the issue have not been effectively addressed.

Entities identified the transition of disability services from State to Commonwealth as a key driver of long stays. This may have left service gaps, but there is little evidence that these gaps have been documented and actions taken to address them in a systematic way. We have previously found a lack of clarity on the agreement of roles and responsibilities between NDIS and mainstream services.[5]

The Working Group is attempting to influence broader strategic change. In November 2021, it conducted an accommodation needs audit, which identified the forms of housing and support long stay patients needed. Seventy one percent of NDIS long stay patients with accommodation needs required a high level of support (12-24 hours per day) within a care facility or formalised community living arrangement. The critical next step is these gaps being addressed. Given responsibility is dispersed across several State entities and the Commonwealth, this will not be easy, but the effort is necessary to achieve long-term improvement.

The Department has advocated for the Commonwealth to help address challenges facing patients awaiting the NDIS. Promisingly, progress between the State and the Commonwealth has recently been made.[6] This includes an intent by both Commonwealth and the State for:

- quicker timeframes for NDIS decision making
- embedding NDIS staff in hospitals to find discharge solutions
- improved information sharing between Commonwealth and State, including patient information and expected medically ready for discharge dates.

The Department believes that this development is an important step in resolving some of the issues leading to NDIS long stay patients. Some of the more challenging aspects, including service gaps in the community, may be more difficult to overcome in the short term.

It is not clear how the recent investment of $74.1 million will achieve sustained system wide reductions in the number of long stay patients

WA Health's approach to reducing the number of long stay patients is hampered by the absence of a strategic plan and measures to coordinate and track initiatives to reduce the number of long stay patients. There are a range of initiatives across WA Health to try to help long stay patients and $74.1 million funding was announced on 2 May 2022 to extend them.

[5] Office of the Auditor General, *WA's Transition to the NDIS*, OAG, Perth, 2020, pp. 24 – 25.

[6] ABC News, NDIS Minister Bill Shorten announces plan to free up hospital beds as WA backlog revealed, 13 September 2022.

But these are not part of a system wide plan, and the timing and extent of impact that the initiatives and funding will deliver is not clear.

While State entities working together to provide intensive case management has helped individuals, and there is acknowledgement across WA Health that long stay patients have a significant impact, key elements of a strategic approach are not yet in place. There is no consistent definition of a long stay patient. This makes it difficult to set performance indicators. Targets have generally not been set, either in terms of the acceptable number of long stay patients or their extended time in hospital. The only exception is the aged care cohort, for which there is a target for patients to wait less than 14 days. The roles and responsibilities of HSPs, the Department, Communities and the MHC are also not clearly defined. This undermines the effectiveness of programs because they are not delivered in a coordinated way (see examples below).

Case study 1: Examples of ad hoc initiatives related to long stay patients

From Hospital to Home (Disability Transition Care Pilot)

- Since November 2021, the Department, in collaboration with HSPs, have run a 12-bed venue for hospitals to discharge individuals who are medically fit, for up to 18-weeks of transition care while long-term support arrangements are secured (primarily through the NDIS).
- Between November 2021 and 20 June 2022, 22 patients have been discharged from hospital.
- Nine patients have moved from the disability transition care pilot into safe long-term community-based support arrangements.
- The pilot is being evaluated by an external agency.

Mental Health Homeless Pathways Project

- Since early 2019, the project has been operating across the Royal Perth Bentley Group (EMHS) to improve service delivery to mental health patients experiencing homelessness.
- Project identifies patients who are homeless and their support needs, providing discharge planning advice and connecting people to housing and community support.
- The evaluation showed that of the 23 people housed for at least one year:
    - mental health inpatient days had decreased from over 3,000 to 68 days
    - cost had decreased from $4.8 million to $103,000
    - cost per person had decreased from $208,000 to $4,500.

NDIS Linkage Team

- Aimed to improve outcomes for patients engaging with NDIS processes while admitted to Fiona Stanley Fremantle Hospitals Groups (SMHS).
- Incidence of discharge delay was reduced, from an average of 34 days in Q1 2021 to 10 days in Q4 2021.

- There were 10 patients who presented to emergency for non-medical reasons (NDIS related social presentations) who were successfully discharged home and prevented from being admitted to hospital.

MHC Patient Flow Project Officer

- The MHC has funded a patient flow project officer to assist in a coordinated approach to addressing long stay patients in HSPs. The Project Officer is a member of the Long Stay Patient Working Group and works across the HSPs mental health services to assist in discharging patients whilst also identifying and reporting on systemic barriers and issues that need addressing.

NDIS Interface and Navigation Team

- The WACHS NDIS Interface and Navigation Team provides NDIS expert knowledge, clinical leadership, coordination and advice to assist WACHS regional teams to navigate the NDIS process, and to establish and develop pathways or processes that support efficiencies in patient flow and outcomes for WACHS patients with disability.

As part of the 2022-23 Budget, the State Government announced that $74.1 million would be spent managing long stay patients. This mainly consists of extending existing initiatives. The Department has not shown evidence that the funding for these initiatives is tied to an assessment of the mix of services needed. In addition, little is known about the needs and barriers of the other long stay cohorts.

The $74.1 million is aimed at getting long stay patients out of hospital and includes:

- $59.5 million for 120 aged care beds to help transition older patients out of hospital, of which $40 million of this funding is provided by the Commonwealth Government. These beds were previously temporarily funded, but this funding makes them permanent
- $7.7 million (across the 2022-23 and 2023-34 financial years) for disability transition care beds. This is to provide additional pilots in metropolitan Perth, following an initial 12-bed pilot program in operation since November 2021, in cooperation with a private residential care provider
- $5.8 million for a Long Stay Patient Fund (across the 2022-23 and 2023-24 financial years) for support measures tailored to the needs of individual patients experiencing barriers to being discharged from hospital
- $1.1 million for an additional five Transitional Accommodation Program places for adults with complex care needs. This is not a new program and funding is for an existing contractual arrangement under this program, relating to transitional care for younger people with complex care needs.

At the time of our report, the Department has not provided specific demand-based modelling to support each funding initiative, or how the funding will lead to enduring improvement in the management of the issue. In addition, the Department has not shown evidence that the solutions in this funding package were aligned to detailed assessment of the service gaps that lead to long stay patients. For example, the Department has not shown how the initiatives will lead to a sustained reduction in the number of long stay patients, or the time these patients stay in hospital longer than medically necessary.

Eighty percent of the funding is for transitional aged care beds. The aged care cohort is a significant part of the long stay issue. As a result, these beds may alleviate some of the pressure it adds. While occupancy has been variable through COVID-19, WA Health expect

utilisation to reach ninety percent average occupancy by mid-2023. With an average occupancy of 90 per cent and a growing older adult population it is likely that these beds will not satisfy the demand for the older adult transition beds. Yet, there is no evidence that this specific number of beds is what is needed or how the beds will be distributed throughout metropolitan and regional WA based on demand. As challenges in the aged care sector are more complex than simply bed capacity, including not enough staffing, the impact of this initiative is unclear.

Recommendations

WA Health should commit to and drive systematic management of long stay patients through:

1. defining ‘long stay patient’ to ensure the issue can be understood, measured and reported

   Implementation timeframe: Dependent on national work

   WA Health response:

   The creation of a universally accepted and understood definition of Long Stay is fundamental to the ability to measure and manage long stay patients across all health services. The complex nature of many patients experiencing extended length of stay, a lack of consensus regarding the notion of ‘readiness for discharge’ and the potential impacts of identifying as such, makes defining and measuring this cohort of patients challenging.

   There is currently significant cross-jurisdictional work underway on defining long stay and discharge delay and ensuring the issues can be understood, measured and reported. For example, the Department of Health (Department) is a part of the National Disability Insurance Scheme (NDIS) Hospital Discharge Delay Data Working group, comprising representatives of health, disability and social service agencies from all jurisdictions. This group will provide advice on a nationally agreed minimum dataset and consistent definition of discharge delay. Further, the Department supports national work by the Australian Institute of Health and Welfare (AIHW) to develop a suite of key performance indicators on interface issues between hospitals, primary care, aged care, and disability under the auspices of the National Health Reform Agreement.

   The Department will continue to contribute to national discussions on consistent definitions and datasets and implement changes as required.

   Mental Health Commission response:

   Agreed. The Mental Health Commission (MHC) concurs there is a need for an agreed definition of 'long-stay patient'; and that this category of patients need to be reported consistently by Health Service Providers (HSPs) and tracked centrally to gain reliable systemwide data. The MHC suggests that this should be a functional definition around fitness for discharge rather than based on length of stay as some mental health inpatients are appropriately placed in hospital for a longer period.

2. identifying and implementing a way to collect, monitor and report on long stay patients

   Implementation timeframe: December 2023

   WA Health response:

   The Department will continue to support work occurring at the national level to develop a minimum dataset for discharge delay. WA Health will also continue to monitor long stay patients through the Long Stay Steering Committee and the Long Stay Working Group. During the next six months, the Department will examine interim measures which may be utilised to monitor and report on long stay patients.

   In the medium term, the introduction of a data flag for ‘medically ready for discharge’ and identification of why the patient is not able to be discharged will enable standardised system wide understanding and reporting of key trends and issues for an evidence based, targeted approach to resolving the issues. Improvements will also be

made to the Transition and Aged Care Services database, including the addition of data from the WA Country Health Service to improve monitoring and collection.

Mental Health Commission response:

Agreed. The MHC is committed to working alongside the Department of Health to support the implementation of this recommendation. The Independent review of the WA Health System Governance Report (August 2022) proposes the establishment of a State Health Operations Centre and states that "improved access to real time data on acute hospital capacity and patient flow would enable the System Manager to coordinate capacity load share across the system includes" (Recommendation 36).

3. collaborating with Communities and the MHC, to identify and monitor long stay patient needs, barriers to discharge and work together to address these in a systematic way

Implementation timeframe: July 2023

WA Health response:

The Department is already working in partnership with the Department of Communities and Mental Health Commission to solve individual problems, as well as working with the Commonwealth, Aged Care and Disability sectors on potential solutions for people who are unable to exit hospital.

The Department will utilise the existing Long Stay Steering Committee and the Long Stay Working Group which is attended by the Department of Health, Department of Communities and the Mental Health Commission. The Department will consider membership refresh to ensure all relevant service systems are included or engaged. The Department will support thematic analysis of barriers to discharge in this context.

The Department acknowledges that a cross agency approach is required to find solutions that meet the needs of this cohort. For example, creation of accessible and affordable housing solutions is fundamental to the ability to efficiently discharge high risk groups such as inpatient mental health patients in addition to reducing risk of admissions as a result of psychosocial stressors (ie homelessness). In addition, WA Health needs to work with other community service providers and NGOs to provide seamless discharge pathways for patients. However, it must be noted that service providers such as residential aged care facilities experience significant recruitment challenges.

The Department will also continue to advocate the Commonwealth Government for appropriate community supports.

Mental Health Commission response:

Supported. The MHC is committed to the cross-agency Long Stay Program.

4. working together to identify best practice and share lessons in a coordinated and regular way, across hospitals, HSPs and the Department.

Implementation timeframe: July 2023

WA Health response:

The Department will review existing system-wide forums which can be utilised to share learnings in a coordinated way and establish a program of work to facilitate this.

Health service providers (HSPs) have taken a service wide approach to the coordination of long stay patients and have positions in place to support this function. HSPs have developed networks of lead clinicians who communicate regularly to

discuss NDIS related long stay issues, sharing of resources and support generally around management of complex patient situations. It as an important forum for advocacy and representation of the issues relating to the impact of NDIS discharge delay on health services.

Mental Health Commission response:

As the Mental Health System Leader, the MHC will continue to utilise the Governance mechanism of the Mental Health Leads Sub-Committee of the Mental Health Executive Committee to identify areas of innovation, strengths and best practice across the system; and to ensure these are disseminated across the relevant attendees from the Department of Health (System Manager) and each of the Health Service Providers.

Response from WA Health

There is a long history of issues at the interface between health and social care systems, including disability and aged care, and substantial focus has been given to addressing these concerns through interjurisdictional forums. Over the last decade, the WA health system has been navigating the seismic shift to market led models across social service settings, including the NDIS. The challenges associated with long stay patients and interface issues between hospitals and social service systems is experienced in every state and territory.

In the last two years significant work has been undertaken to partner across agencies, governments and sectors to understand the drivers for, and impact of, long stay patients and to design pilots and programs to address these issues. This has included the Emergency Access Program, led by a Ministerial Taskforce, to reduce hospital demand pressures and secure more appropriate forms of care for long stay patients. Health service providers (HSPs) have also made considerable efforts to enhance the focus on discharging medically cleared patients who no longer require hospital care. The Department has led or supported much of this work.

The Department agrees with the premise of the report, acknowledging there are patients in hospital that no longer require hospital care but are unable to be discharged. The reasons patients may not be able to exit hospital are multi-factorial. The Department will continue to work with other government agencies and service systems to influence decisions beyond the remit of the health system, such as NDIS and aged care decision making, accommodation, social care workforce and addressing market failure. Acknowledging the challenging cross-agency, cross-sectoral and cross-government nature of long stay issues, the Department will develop a dedicated long stay program management framework to oversight the long stay program of works, initially focused on long stay patients that should be supported through Commonwealth NDIS and aged care systems.

It should be noted that work is occurring in the national context, as currently there is no standard national definition of long stay and discharge delay data items recorded across jurisdictions and national reporting requirements require consistent data collection practices. Accessing data from the National Disability Insurance Agency (NDIA) would also be a significant step forward in identifying patients that are likely to experience discharge delays. The Department originally instigated the commencement of data sharing negotiations with the NDIA in 2019. This process has been significantly delayed and in 2021 was superseded by a whole-of-government head agreement which continues to progress agency specific schedules for data exchange.

Work on discharge delay in other jurisdictions indicates that systematic monitoring, early escalation of discharge barriers, and developing capacity of clinical teams to understand discharge options are essential to change. HSPs have been actively improving local processes and rolling out education, training and enhanced monitoring of long stay patients. As System Manager, the Department does not operationally manage each program HSPs deliver. Subject to the identification of appropriate long-stay patient outcome measures, relevant performance measures and targets could be considered for inclusion in the Performance Management Policy.

Response from Mental Health Commission

The Mental Health Commission (MHC) appreciates the work of the Office of the Auditor General for completing this performance audit of the Management of Long-Stay Patients in Public Hospitals. The MHC agrees and supports the findings and is committed to working

with the Department of Health as the System Manager to implement the recommendations as required.

The MHC is committed to the ongoing cross-agency Long Stay Program and, in the development, and delivery of initiatives to support long stay patients to be discharged from hospital, and to live a satisfying, hopeful and contributing life within the community.

Response from Department of Communities

Communities will continue to work collaboratively with the Department of Health to implement the recommendations as appropriate, including recommendation 3.

Audit focus and scope

The objective of this audit was to assess if WA Health (the Department of Health and Health Service Providers) and other State government entities (Mental Health Commission and Department of Communities), have an effective system for managing long stay patients who no longer require hospital care.

We based our audit on the following criteria:

- Does WA Health understand the extent and impact of long stay patients?
- Is WA Health effectively reducing the number of long stay patients?

As part of this audit we:

- reviewed documentation related to the management of long stay patients
- analysed available data from the Department of Health, Health Service Providers and the Mental Health Commission
- interviewed key staff at audited entities
- visited hospitals across metropolitan and regional WA
- spoke to staff from the Mental Health Tribunal and the Health and Disability Services Complaints Office.

This was an independent performance audit, conducted under Section 18 of the *Auditor General Act 2006*, in accordance with Australian Standard on Assurance Engagements ASAE 3500 *Performance Engagements*. We complied with the independence and other ethical requirements related to assurance engagements. Performance audits focus primarily on the effective management and operations of entity programs and activities. The approximate cost of undertaking the audit and reporting was $325,000.

Appendix 1: Additional information on NDIS and aged care snapshot data

During the audit, we found that WA Health had no system to report on the total number of people in hospital who were medically ready to be discharged. It instead has manual reports and other data that, when pieced together, reveal an insight into people in hospital arising from the wait for two key services, the NDIS and aged care.[7] There are limitations, as the data is sourced differently and based on averages from different time periods. However, it does allow us to give an example of potential efficiencies that could be achieved in the system.

Snapshot 1: Long stay patients waiting for NDIS services May to December 2021

The Department of Health manually tallies patients in hospital, medically ready for discharge, but waiting for NDIS supports. Hospital staff identify these patients once monthly and send the list of patients to the Department. There are two categories of these patients – those with a mental health diagnosis and those without a mental health diagnosis.

From May to December 2021, WA Health counted an average of 68 NDIS patients with a mental health diagnosis who spent an average of 356 days each in hospital.

From May to December 2021, WA Health counted an average of 48 NDIS patients without a mental health diagnosis who spent an average of 112 days each in hospital.

Snapshot 2: Long stay patients waiting for aged care services July 2021 to June 2022

WA Health uses its Patients Awaiting Aged Care System in the metropolitan area to capture patients who have been assessed as medically ready for discharge and have undergone an aged care assessment to determine the service they need.

Between July 2021 and June 2022, the Department's monthly report identified an average of 209 patients in metropolitan Perth hospitals who were medically ready for discharge but waiting for aged care services. On average, these patients stayed 11.5 days in hospital beyond when they were medically ready for discharge.

Between July 2021 and March 2022, in regional WA, WACHS quarterly reporting identified an average of 161 patients in its hospitals awaiting aged care. On average, these 161 patients waited 50 days in hospital beyond when they were medically ready for discharge.

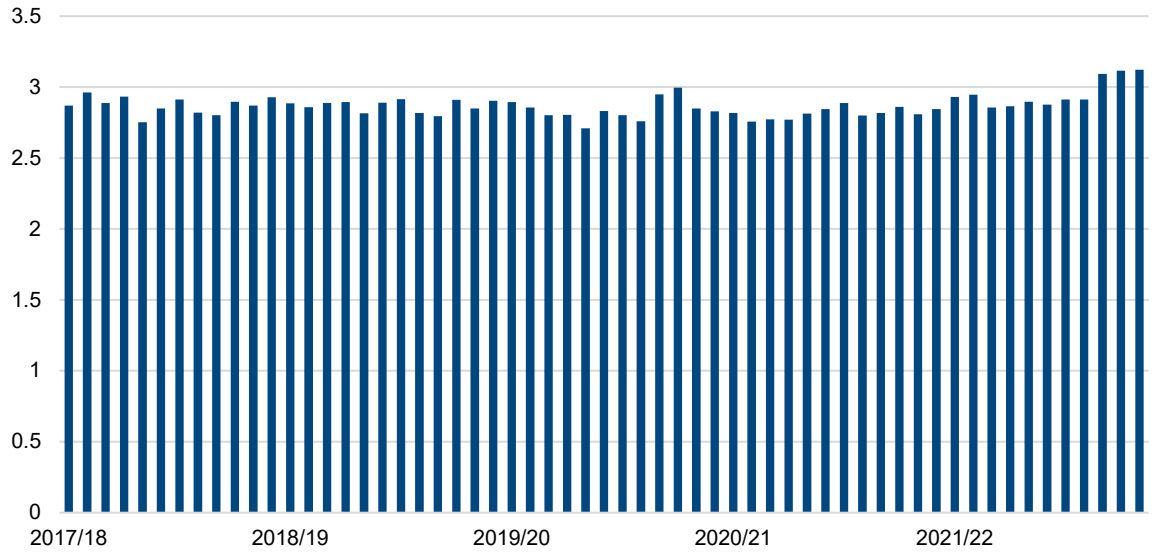
Estimated additional people that could have accessed a hospital bed if long stay patients had been discharged when medically ready

For illustrative purposes, we estimated how many additional people could have accessed hospital care if all the long stay patients identified in the snapshots had been discharged when medically ready. We did this by taking the total additional bed days occupied by the long stay patients and divided it by the average length of stay for patients in WA in 2020-21.

The average length of stay in a WA public hospital in 2020-21 was 2.8 days per patient. This is consistent with the average length of stay between 2017-18 and 2021-22 which has ranged between 2.7 and 3.1 days. In Australia, in 2020-21, the average was 2.9 days.

[7] The calculations used to arrive at this figure include the possibility of individual patients being counted twice, if they were transferred across between the NDIS and aged care categories. However, the NDIS snapshot focus on patients under 65, so the risk of double counting and overestimation is low, based on our review.

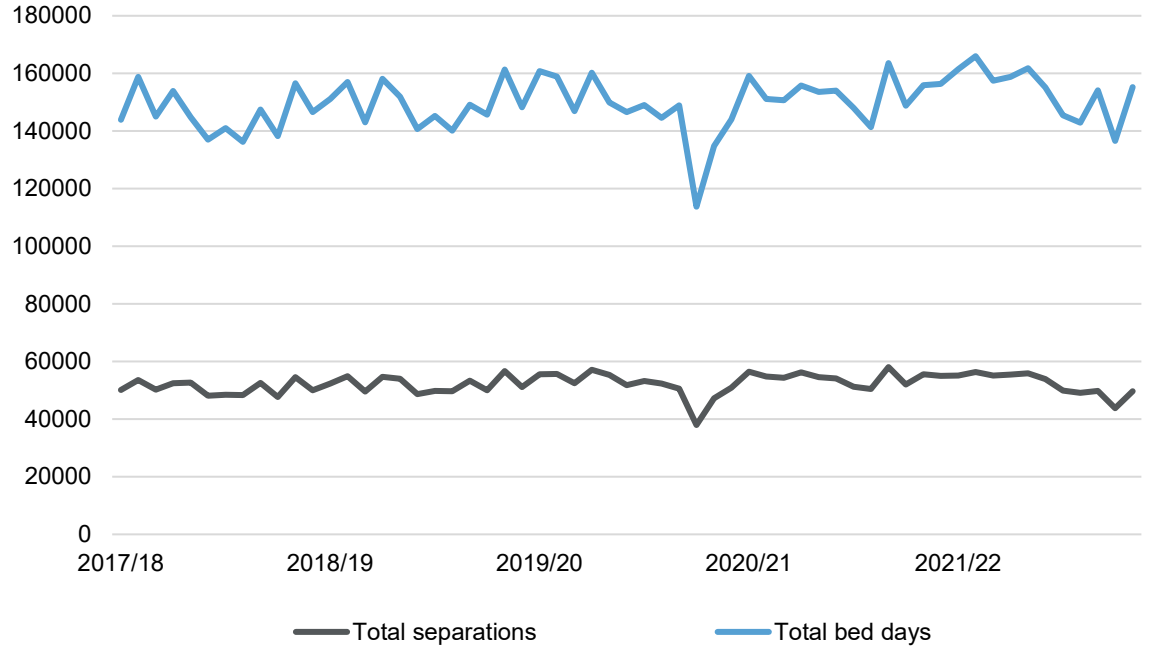
Average number of bed days per separations – 2017-18 to 2021-22 in WA public hospitals



Source: OAG based on data from the Department of Health

The average length of stay per separation is calculated by dividing the number of bed days patients were in hospital by the number of separations. A separation is recorded when a patient leaves hospital, so each separation represents a patient. The total number of bed days and the total number of separations were provided by WA Health and are shown below.

WA total bed days and separations between 2017-18 and 2021-22



Source: OAG based on data from the Department of Health

Auditor General's 2022-23 reports

Number	Title	Date tabled
8	Forensic Audit Results 2022	16 November 2022
7	Opinion on Ministerial Notification – Tom Price Hospital Redevelopment and Meekatharra Health Centre Business Cases	2 November 2022
6	Compliance Frameworks for Anti-Money Laundering and Counter-Terrorism Financing Obligations	19 October 2022
5	Financial Audit Results – Local Government 2020-21	17 August 2022
4	Payments to Subcontractors Working on State Government Construction Projects	11 August 2022
3	Public Trustee's Administration of Trusts and Deceased Estates	10 August 2022
2	Financial Audit Results – Universities and TAFEs 2021	21 July 2022
1	Opinion on Ministerial Notification – Wooroloo Bushfire Inquiry	18 July 2022

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