
New South Wales Auditor-General's Report
Performance Audit

**Visiting medical officers and
staff specialists**

NSW Ministry of Health



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The roles and responsibilities of the Auditor-General, and hence the Audit Office, are set out in the *Public Finance and Audit Act 1983*.

Our major responsibility is to conduct financial or 'attest' audits of State public sector agencies' financial statements. We also audit the Total State Sector Accounts, a consolidation of all agencies' accounts.

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Performance audits are reported separately, with all other audits included in one of the regular volumes of the Auditor-General's Reports to Parliament – Financial Audits.

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In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled **Visiting medical officers and staff specialists: NSW Ministry of Health.**

Peter Achterstraat

Peter Achterstraat

Auditor-General

14 December 2011

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Visiting medical officers and
staff specialists
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Executive summary

2

NSW Auditor-General's Report
Visiting medical officers and
 staff specialists
 EXECUTIVE SUMMARY

Background

In the NSW public hospital system, senior doctors are generally either staff specialists or visiting medical officers (VMOs).

Staff specialists are permanent or fixed term employees working full-time or part-time in the public health system. VMOs are doctors generally working in private practice who are in addition engaged as independent contractors in the public health system.

Both public and private patients are seen at public hospitals. Private patient income is important to public hospitals to supplement funding from the NSW Government.

This performance audit assessed whether NSW Health is managing VMOs and staff specialists well. We sought to answer the following questions:

- does NSW Health adequately deploy VMOs and staff specialists to best meet demand?
- are payments made for agreed and delivered services?
- is treatment of private patients within public hospitals appropriately managed?

Conclusion

We found that hospitals are generally able to deploy their VMOs and staff specialists to be at the place and time required. However, a hospital's ability to manage supply and demand at a local level is limited. This limitation will become more critical with the current national health reforms when public hospital funding will depend on their ability to set and meet activity targets and priorities.

NSW Health cannot be sure that all payments made to VMOs are for agreed and delivered services. Across the hospitals visited we found:

- limited checking of VMO claims for payment
- limited quality information on staff specialist activities
- limited hospital-level analysis of trends or inconsistencies in activities and treatments.

VMOs cost hospitals over half a billion dollars per annum. A sample of hospitals estimated that ten to 18 per cent of VMO claims for payment contained errors leading to over- or under-payment, so the inability to adequately verify their claims represents a major risk.

We saw no evidence that private patients were given any advantage in priority over public patients in public hospitals, but were concerned that only a few hospitals visited analysed priorities to ensure that this was not happening.

Supporting findings

Does NSW Health adequately deploy visiting medical officers and staff specialists to best meet demand?

All hospitals maintain rosters to ensure that staff are available to meet demand. Hospitals in metropolitan areas deploy both staff specialists and VMOs, while those in rural and remote areas are largely dependent on GP VMOs. However, many smaller hospitals require locums to fill short term vacancies (e.g. for leave).

VMOs have to account for their time, but we were unable to obtain any estimate of what activities a typical staff specialist performs, or how many hours they spend doing so. Some hospital staff complained that staff specialists sometimes were not available despite it being a time when they were meant to be on duty.

Are payments made for agreed and delivered services?

Verifying and processing VMO claims for payment is largely manual and labour-intensive. Staff at some hospitals visited had developed considerable expertise in analysing activities and verifying VMO claims. However staff at others did not have the skills, systems or resources. Analysis and exception reporting are not highly developed and better practices are not shared widely between hospitals or local health districts.

Improvements in supporting systems are needed by:

- electronic invoicing with automated cross-checking
- improved rostering of activities to better utilise all doctors
- more extensive use of benchmarking to detect inconsistent VMO claims for payment or anomalies in clinical priorities allocated to patients.

Some changes to industrial awards and determinations may need to be considered when these are next negotiated to deliver these improvements.

Many hospitals visited had long-standing vacancies for directors of medical services. These doctors provide a bridge between the clinical workforce and hospital administration. Without them hospitals can have difficulty verifying the appropriateness of treatment of VMO claims.

Staff specialists are entitled to training, education and study leave and funding for approved courses. All hospitals visited complained that the necessary approval processes represent a substantial paperwork burden. Some hospitals had inadequate or non-existent record keeping which could lead to doctors taking more leave than they are entitled to.

Is treatment of private patients within public hospitals appropriately managed?

All hospital staff interviewed emphasised that patients must be seen in order of clinical priority, whether public or private.

Some hospitals demonstrated the capacity to analyse data and detect inappropriate clinical priority given to patients. Others did not do so. We found one isolated example of patients being given inconsistent priorities. This had been rectified before the audit commenced.

The VMO determinations do not give any guidance in what is and is not appropriate in treating private patients in the public health system. The determinations only mention private patients in the context of professional indemnity insurance, and VMO contracts do not include the word private.

Recommendations

To ensure payments are made for agreed and delivered services

1. We recommend that by June 2013 NSW Health expedites current improvements in VMoney and related systems to:
 - eliminate manual data entry (page 17)
 - improve access by hospital staff to VMO payment management reports (page 17).
2. We recommend that by June 2013 NSW Health:
 - develops consistent guidelines and procedures for verifying VMO claims for payment (page 16)
 - ensures that there is more effective scrutiny of VMO payments to ensure that they are being made in accordance with NSW Health Policy Directives (page 16).
3. We recommend that by June 2013 NSW Health develops the use of benchmarking studies and analysis to assist local health districts to detect inconsistent VMO claims for payment or anomalies in clinical priorities allocated to patients (page 18).
4. We recommend that by June 2013 NSW Health assign unique identifiers to VMOs to ensure that there are no overpayments for duplicated services (page 17).
5. We recommend that by June 2013 NSW Health seeks improvements to reduce administration costs of staff specialists' training, education and study leave (page 21).

To ensure appropriate timeliness and quality of care for patients

6. We recommend that by June 2013 NSW Health provides a more explicit basis for VMO entitlements to treat private patients in public hospitals (page 20).
7. We recommend that by June 2013 NSW Health uses the provisions of the staff specialist award to develop performance agreements for each staff specialist to describe their activities in detail (page 19).
8. We recommend that by June 2013 NSW Health builds director of medical services capacity by encouraging doctors to choose medical administration as a career path, such as by training through the Royal Australasian College of Medical Administrators (page 18).

To ensure effective management of the hospital budgets

9. We recommend that NSW Health, after appropriate consultation with the Australian Medical Association, amend the model VMO contracts to impose stricter controls over the submission of VMO claims (page 16).

Response from NSW Ministry of Health



Mr Peter Achterstraat
Auditor General
Audit Office of NSW
GPO Box 12
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Your Ref: PA6490
Our Ref: D11/1170-2

Dear Mr Achterstraat

Performance Audit: Visiting Medical Officers and Staff Specialists

Thank you for your letter dated 2 November 2011 providing a copy of the final report for the Performance Audit 'Visiting Medical Officers and Staff Specialists, NSW Health'.

The Ministry of Health welcomes the opportunity provided by the Performance Audit to consider the way the NSW public health system manages Visiting Medical Officers (VMOs) and Staff Specialists.

I would also like to take this opportunity to acknowledge the Audit team for their professionalism and collaborative manner in which this Performance Audit was conducted. The Ministry is appreciative of the co-operation of the Auditors in negotiating achievable timeframes, given the complexity and diverse range of issues surrounding the management of VMOs and staff specialists.

The Ministry has indicated its support for the recommendations and advised that many of the recommended changes can be implemented, particularly in respect to the VMoney system.

The report includes a range of recommendations that will support NSW Health and the Local Health Districts in putting in place better systems to improve the processing and streamline the management of payment of costs of VMOs and Staff Specialists.

A number of the Report's recommendations have been accepted. Others of the matters dealt with in the Report arise from industrial instruments and agreements, which are not able to be unilaterally varied by NSW Health. However, they do provide a useful basis on which to seek to make those changes to current arrangements which the Audit Office has assessed would be appropriate and desirable.

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A more specific Ministry response to the recommendations is as follows.

1. To ensure payments are made for agreed and delivered services

1.1 Recommendation: *By June 2013 NSW Health expedites current improvements in VMoney and related systems to:*

- *eliminate manual data entry*
- *improve access by hospital staff to VMO payment management reports.*

Response: This recommendation is accepted. The development of the VMoney web application has commenced. A pilot of the application will commence in June 2012 and implementation of this application is to commence in September 2012.

1.2 Recommendation: *By June 2013 NSW Health:*

- *develops consistent guidelines and procedures for verifying VMO claims for payment*
- *ensures that there is more effective scrutiny of VMO payments to ensure that they are being made in accordance with NSW Health Policy Directives.*

Response: This recommendation is accepted. One of the benefits of the VMoney improvement should be an enhanced capability to monitor VMO payments and identify the prevalence of non-standard arrangements

1.3 Recommendation: *By June 2013 NSW Health develops the use of benchmarking studies and analysis to assist local health districts to detect inconsistent VMO claims for payment or anomalies in clinical priorities allocated to patients.*

Response: This recommendation is accepted. There is scope to review VMO payments data to identify broad trends in their service delivery. In the longer term, the increase in the numbers of medical administrators, recommended in this Report, will assist in implementing this recommendation.

1.4 Recommendation: *By June 2013 NSW Health assign unique identifiers to VMOs to ensure that there are no overpayments for duplicated services.*

Response: This recommendation is accepted. The VMoney web application will incorporate an Australian Health Professional Registration Agency (AHPRA) medical registration number for each VMO. This number will be the unique identifier for each VMO thereby reducing the risk of overpayments for duplicated services.

1.5 Recommendation: *By June 2013 NSW Health seeks improvements to reduce administration costs of Staff Specialists' training, education and study leave.*

Response: This recommendation is accepted. Staff specialists' training, education and study leave (TESL) entitlements are set out in an industrial determination that has been agreed between NSW Health and the Australian Salaried Medical Officers Federation (NSW) ('ASMOF'). They are therefore not able to be unilaterally varied. The Ministry of Health is holding discussions with ASMOF about issuing agreed guidelines in order to have a more consistent approach to the interpretation of TESL arrangements across NSW Health), which would address one of the matters raised in the Report. In terms of monitoring leave entitlements, *StaffLink*, the new Human Resources Information System which is being progressively deployed across NSW Health, has been configured to keep a record of TESL leave entitlement balances.

2. To ensure appropriate timelines and quality of care for patients

2.1 Recommendation: *By June 2013 NSW Health provides a more explicit basis for VMO entitlements to treat private patients in public hospitals.*

Response: This recommendation is accepted. The Ministry will raise this recommendation with the organisations which represent VMOs, the Australian Medical Association NSW Ltd and the NSW Rural Doctors Association.

2.2 Recommendation: *By June 2013 NSW Health uses the provisions of the Staff Specialist award to develop performance agreements for each Staff Specialist to describe their activities in detail.*

Response: This recommendation is accepted. The Staff Specialists (State) Award makes provision at clause 12 for a written annual performance agreement, and attaches the standard format to be used as an annexure to the Award. The Ministry will emphasise to public health organisations the need to specify the work expectations and requirements which apply to staff specialists consistent with the provisions of the Award.

2.3 Recommendation: *By June 2013 NSW Health builds director of medical services capacity by encouraging doctors to choose medical administration as a career path, such as by training through the Royal Australasian College of Medical Administrators.*

Response: This recommendation is accepted. The Ministry of Health has allocated funding of \$130,000 per annum for the position of a State Chair to co-ordinate and support training of medical administrators in NSW.

The Clinical Education and Training Institute has been commissioned by the Ministry to review and report on the current training and career pathways for medical administrators in NSW and make recommendations regarding training to meet the changing needs of the health system, both now and into the future.

The review will incorporate the following components:

- review the current training arrangements for medical administrators in NSW;
- review the role and career opportunities for medical administrators in NSW and the implications for training medical administrators in NSW;
- consultation with stakeholders about possible training structures/models including establishment of a formal networked training program;
- make recommendations regarding the implementation of a revised training program structure in NSW that meets the requirements of the Royal Australian College of Medical Administrators and the health service employers;
- Identify links and leverage opportunities between medical management training and management training in other medical and other health professional disciplines.

A report is expected in the first half of next year.

The Ministry notes that the Report recognises the important role that Directors of Medical Services can play in verifying VMO claims, communicating more generally with medical staff on clinically-related issues, and managing and ensuring the efficient provision of services by the medical workforce. These comments are supported, however it also needs to be acknowledged that clinicians appointed to the role of Department Head also have a role in ensuring that their Department use both workforce and other resources efficiently and provide advice to hospital managers on issues relevant to their Department.

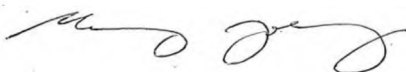
3. To ensure effective management of the hospital budgets

3.1 Recommendation: *That NSW, after appropriate consultation with the Australian Medical Association, amend the model VMO contracts to impose stricter controls over the submission of VMO claims.*

Response: This recommendation is accepted. The Ministry will raise this recommendation with the organisations which represent VMOs, the Australian Medical Association NSW Ltd and the NSW Rural Doctors Association.

We welcome the opportunity presented by this Performance Audit to seek to achieve greater efficiencies and effectiveness in the provision of services to NSW Health by VMOs and staff specialists.

Yours sincerely



Dr Mary Foley
Director-General

1 DEC 2011

Introduction

Doctors in the public health system

This audit deals with visiting medical officers (VMOs) and staff specialists.

Types of doctors working in public hospitals are shown below.

Exhibit 1: Doctors in NSW public hospitals

| Designation | Numbers of staff (as at June 2010) |
|---------------------------|---------------------------------------|
| VMOs | 4,594 |
| Staff specialists | 2,425 |
| Clinical academics | 184 |
| Career medical officers | 432 |
| Registrars | 2,955 |
| Resident medical officers | 1,586 |
| Interns | 656 |
| Total | 12,832 |

Note: all figures are full time equivalent except for VMOs, which are shown as the number of individual doctors.

Source: NSW Health and Audit Office research

Visiting medical officers

VMOs are doctors generally working in private practice who are in addition engaged as independent contractors in the public health system. VMOs usually have five year contracts with local health districts and on average spend about ten hours per week working in the public health system. VMOs also participate in on-call rosters to provide services after hours.

VMOs more commonly work in procedural specialties where treatment is in discreet episodes of care rather than for chronic or continuous care. However, they can also fulfil some management responsibilities such as working as heads of hospital departments.

Exhibit 2: VMO appointments by specialty 2009–10

| Specialty | Sessional | Fee for service | Total |
|------------------------|--------------|-----------------|--------------|
| Anaesthetics | 1,269 | 74 | 1,343 |
| General practice | 322 | 937 | 1,259 |
| General surgery | 242 | 353 | 595 |
| General medicine | 231 | 184 | 415 |
| Obstetrics/gynaecology | 297 | 105 | 402 |
| Psychiatry | 358 | 0 | 358 |
| Orthopaedics | 163 | 181 | 344 |
| Ophthalmology | 131 | 103 | 234 |
| Paediatrics | 181 | 30 | 211 |
| Emergency medicine | 164 | 18 | 182 |
| Urology | 85 | 70 | 155 |
| Ear, nose and throat | 99 | 44 | 143 |
| Cardiology | 99 | 35 | 134 |
| Radiology | 132 | 1 | 133 |
| Others | 872 | 232 | 1,104 |
| Total | 4,645 | 2,367 | 7,012 |

Note: this table shows the number of VMO appointments. This exceeds the number of VMOs (4,594 individual doctors as shown in Exhibit 1) because some VMOs hold contracts with more than one hospital.

Source: NSW Health

In all major city hospitals VMOs are sessional: they are paid an hourly rate. At most other hospitals VMOs are paid per treatment delivered (fee for service), and at the remainder (around one-third of all hospitals) they can choose to be either fee for service or sessional. The amounts they are paid are specified in state wide arrangements.

VMOs working in NSW public hospitals earn on average \$119,000 per annum treating public patients but earnings vary widely depending on hours worked and treatments delivered. In designated public health facilities VMOs receive higher payments under the Rural Doctors Settlement Package.

Some VMOs also earn income from treating their own private patients in the public hospital. The VMO can charge the private patients whatever he or she likes.

In addition to income earned from services provided in the public hospital, a VMO's total income will also include earnings from practice outside the public hospital.

Staff specialists

Staff specialists are permanent or fixed term employees working full-time or part-time.

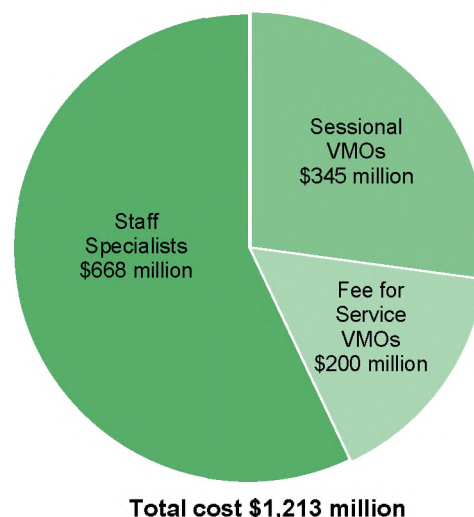
The staff specialists' determination allows them to undertake private practice. Staff specialist remuneration in the public health system ranges from \$198,212 to \$390,528 per annum. Staff specialist remuneration includes a component based on revenue from earnings for services they provide to private patients in the public hospital. These private patients are invoiced by the public hospital on behalf of the staff specialist. The revenue from private patients is either paid into a trust account from which the staff specialist is paid an agreed proportion of remuneration, or it is paid directly to the local health district which in turn pays an allowance to the staff specialist.

Staff specialists generally work in a different mix of specialties than VMOs. While VMOs are more likely to be surgeons, staff specialists are more likely to be working in emergency departments and providing services such as psychiatry and geriatrics.

As well as treating patients, staff specialists perform other functions within the hospital, including teaching, management, research and quality improvement activities.

The staff specialist determination also entitles them to a training, education and study leave (TESL) allowance. This is determined each year but is presently about \$29,400 per annum for study expenses plus 25 calendar days of special leave per year for full time staff specialists. These entitlements are proportionately less for those working part time.

Exhibit 3: Cost of VMOs and staff specialists to NSW Health in 2009–10



Source: NSW Health and Audit Office research

Working arrangements in different types of hospitals

How are hospitals staffed?

Smaller towns cannot generally support many specialist doctors because they do not have the number or variety of patients. Hence most doctors in rural public hospitals are general practitioner VMOs who otherwise work in local practices.

Some hospitals are highly dependent upon locums – doctors employed as casuals – to fill vacancies in their rosters, such as when doctors take leave. This audit did not examine the use of locums.

Rostering of doctors

Hospitals need to roster staff, including doctors, to ensure that they are available when needed. We saw a wide variation of rostering practices. In some hospitals doctors prepare the roster themselves to ensure coverage. In others the hospital administration staff prepare rosters. Doctors' rosters will include Registrars and other junior doctors as well as VMOs and staff specialists.

Exhibit 4: Number of VMO appointments and staff specialists by area health service 2009–10

| | Greater Southern | Greater Western | Hunter New England | North Coast | Northern Sydney Central Coast | South Eastern Sydney Illawarra | Sydney South West | Sydney West | Children's Hospital Westmead | Justice Health |
|-------------------|------------------|-----------------|--------------------|-------------|-------------------------------|--------------------------------|-------------------|-------------|------------------------------|----------------|
| VMOs | 597 | 668 | 903 | 1,112 | 958 | 941 | 1,044 | 612 | 91 | 86 |
| Staff specialists | 24 | 37 | 358 | 46 | 307 | 467 | 583 | 412 | 163 | 28 |

Note: this table shows the number of VMO appointments. This exceeds the number of VMOs (4,594 individual doctors as shown in Exhibit 1) because some hold contracts with more than one hospital. Since 2009–10 the above area health services have been reorganised into local health districts.

Source: NSW Health

The 2008 Garling report on acute care services in NSW public hospitals[‡] was critical of rostering:

[T]he vast majority of health professionals (except for nurses engaged in clinical practice) work in NSW public hospitals from Monday to Friday each week during business hours, whilst patients get sick, have accidents, need care, arrive, are treated and discharged 24 hours a day across all seven days of the week.

The report recommended extensive improvements to NSW Health's rostering including:

- to ensure the presence of an appropriate number and range of skills of these clinicians ... for 16 hours a day
- to ensure the availability of the services of these clinicians for seven days per week
- to ensure adequate coverage, whether by an on-call service or otherwise for the remaining eight hour shift for each day.

NSW Health is developing rostering software for all hospital staff to assist in meeting the recommendations of the Garling report. It is due for implementation in the first half of 2014.

[‡] Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals Volume 1; Peter Garling SC, 27 November 2008.

Implications of National Health Reform

Under the proposed national health reforms, NSW Health and local health districts will be required to undertake hospital workforce planning, performance management and development of local activity targets. This will necessitate more clarity in specifying what activities VMOs and staff specialists are expected to perform, at what times and in what locations.

Treatment options

A patient generally has a choice of being treated in different ways:

- as a public patient in the public hospital
- as a private patient in the public hospital
- as a private patient in a private hospital.

Exhibit 5: Differences between treatment of public and private patients

| Type of patient and hospital | Waiting time | Choice of doctor | Choice of single room | Does the patient pay? |
|-------------------------------------|--------------------------------------|--|-----------------------|-----------------------|
| Public patient in public hospital | Depends on clinical need | No, treatment may be provided by a junior doctor supervised by a VMO | No | No |
| Private patient in public hospital | Depends on clinical need | Yes | Yes, if available | Yes [†] |
| Private patient in private hospital | Almost immediate: usually a few days | Yes | Yes | Yes [†] |

[†] Patient expenses for accommodation, medical, and other services will be offset in full or part by Medicare benefits and any private health insurance held by the patient.

Source: NSW Health and Audit Office research

The size of the private hospital system is significant. In 2009–10 private hospitals provided care for 38 per cent of all patients and had 24 per cent of the total number of hospital beds.

Exhibit 6: Comparison of public and private hospitals activity 2009–10

| | Separations/ admissions | Same day separations/ admissions % | Beds | Occupancy rate % |
|---------|-------------------------|------------------------------------|--------|------------------|
| Public | 1,598,991 | 43 | 19,662 | 88.3 |
| Private | 988,304 | 68 | 6,378 | 88.9 |

Source: NSW Health and Audit Office research

The table below shows the costs of three typical procedures as a public patient in a public hospital.

Exhibit 7: Costs of typical surgical procedures for public patients in public hospital

| Operation | Total cost to hospital | Payment by hospital to fee for service VMO | Payment by hospital to fee for service Anaesthetist | Patient pays hospital |
|-----------------------|------------------------|--|---|-----------------------|
| Gallbladder surgery | \$5,400 | \$501.50 | \$152.40 | Nil |
| Removal of a cataract | \$3,579 | \$731.80 | \$114.30 | Nil |
| Hip replacement | \$24,817 | \$1,267.90 | \$190.50 | Nil |

Source: NSW Health and Audit Office research

The costs to the hospital shown above include items such as salaries and wages for doctors, nurses and other staff, payments to VMOs, workers compensation and superannuation, drugs, food, medical and surgical supplies, repairs, maintenance and depreciation etc.

The public hospital charges for private patients in 2009-10 are \$493 per day if they have a single room or \$294 per day in a shared room. Private patients will also be billed for services provided by VMOs or staff specialists. Staff specialists bill at the Medicare Benefit Schedule rate, but VMOs are free to decide how much to charge for their services. Fees vary because doctors take into account their particular costs in delivering services and may have differing views about what represents a reasonable return for their time and skill.

Key findings

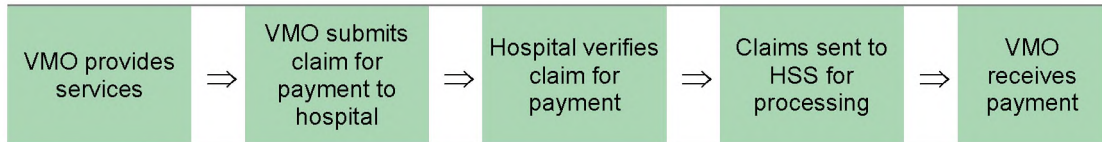
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NSW Auditor-General's Report
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KEY FINDINGS

VMO claims for payment

Inadequate processes for verifying VMO claims

VMO contracts are with individual local health districts, and VMOs submit claims for payment to hospitals for work they perform on public patients. Each hospital's staff verifies its own VMO claims, which are then sent to NSW Health Support Services (HSS) for data entry and submission for payment.

Exhibit 8: Verification of VMO claims for payment



Source: Audit Office

Interviews with hospital staff revealed numerous problems with VMO claims verification and processing.

All claims for payment from VMOs are in hard copy, and some are even handwritten.

Exhibit 9: A handwritten VMO claim

| HEALTH SUPPORT SERVICES NSW HEALTH | Author: Vmokey ISO Working Party Email: QualityAssurance.ServicesCentre@nsw.health.nsw.gov.au Approved by: Director Operations & Business Support | Document ID: 2008:VMO0068 Version: 1 Modified: 23/7/09 Published Date: 23/7/09 | OFFICE USE ONLY Claim Form No: _____ Entered: _____ Checked: _____ | | | | | | | | |
|---|--|---|--|-----------------------------|--------------------------------|----------------------|------------------------|-----------------------|-----------------------------|-------------------------------|--|
| SESSIONAL VMO CLAIM FORM <small>Separate Claim Forms to be completed for each month Please refer to VMO Hintsheet for completing this Claim Form</small> | | | | | | | | | | | |
| Health Service: <u>AREA HEALTH SERVICE</u> Facility Name: <u>HOSPITAL</u> Facility Code: _____ | VMO Name: <u>D</u> Specialty: <u>PHYSICIAN</u> Month Worked: _____ | | | | | | | | | | |
| Routine Hours Only | | | | | | | | | | | |
| HSSC use only | Service Type & Committee Meetings | Start Date | Start Time 24hr clock (HH:MM) | Finish Date | Finish Time 24hr clock (HH:MM) | Hours worked (HH:MM) | Hours deducted (HH:MM) | No. Patients Attended | Total Payable hours (HH:MM) | No. of reads (Radio.vmo only) | Cost Centre <small>(Enter Cost Centre if different to the designated Cost Centre provided by your Health Service)</small> |
| | MS | 23/9/10 | 16:30 | 23/9/10 | 21:00 | 22:30' | - | - | 22:30' | | |
| | MS | 23/9/10 | 08:30 | 23/9/10 | 09:00 | -30' | - | - | -30' | | |
| | R | 23/9/10 | 09:00 | 23/9/10 | 10:00 | 1:00 | - | 1 | 1:00 | | |
| | MS | 23/9/10 | 10:00 | 23/9/10 | 10:45 | -45' | - | - | -45' | | |
| | R | 23/9/10 | 11:00 | 23/9/10 | 15:30 | 4:30' | - | 8 | 4:30' | | |
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| | R | 23/9/10 | 09:00 | 23/9/10 | 15:45 | 6:45' | - | 12 | 6:45' | | |
| | R | 26/9/10 | 09:00 | 26/9/10 | 13:00 | 4:00' | - | 5 | 4:00' | | |
| Service Types: R= Rouse, T= Theatre, M= Meeting, C= Committee Meetings, H= Clinical Planning, NS= Peer Review O= Out Patient, D= Consult, A= Administration of a Dept, M= Hospital Patient Management Please complete Agreed Committee & Post Graduate Education Form | | | | | | | | | | | |
| Certification: I certify that the information provided (including the patient's details) is a true and accurate record for the period and that no claims are made for "Rostered On-Call" hours provided at the same time at another hospital. | | | | | | | | | | | |
| Doctors Name: <u>D</u> <small>(Please Print Name)</small> | | | | Doctors Signature: _____ | | | | Date: <u>30/9/10</u> | | | |
| CLAIM RECEIVED BY: <small>(Please Print Name)</small> | | | | Date: _____ | | | | | | | |
| CLAIM CHECKED AND PAYMENT APPROVED | | | | | | | | | | | |
| Authorised By: _____ <small>(Please Print Name)</small> | | | | Authorised Signature: _____ | | | | Date: _____ | | | |

Source: NSW Health and Audit Office research

NSW Health has no state wide policy or guidelines for verification of VMO claims, and relies on the integrity and effectiveness of local processes.

VMO claims for payment are hard copy

Some hospitals rigorously verify VMO claims for payment. Staff check them against hospital and operating theatre rosters, electronic medical records and the patient administration system. We saw examples of VMO claims in which every particular – date, patient name, whether public or private, procedure carried out – had been checked and verified. We saw examples of advice to VMOs rejecting or correcting some claims for reasons such as:

- more than one consultation had been charged on the same day for the same person
- the payment claimed for aftercare is already included in payment for the initial consultation
- the patient was not in the hospital on the day claimed
- the claim had already been paid.

However, several hospitals acknowledged that they could perform only minimal checks on VMO claims for payment because of the tight deadline for submitting VMO claims to HSS, lack of resources and difficulty of accessing information against which to verify claims.

Verification is labour-intensive, with claims being checked against other hard copy records to confirm that the service claimed for was actually delivered. Electronic claims and the ability of other systems to communicate would offer opportunities to automate and speed up verification.

Some doctors submit claims for payment irregularly or late, sometimes 12 months late or longer. While hospitals can in theory accrue for these, receiving an unexpected claim for several hundred thousand dollars strains cash flow. NSW Health has advised that the VMO determination contains a deadline for submission of claims for payment, but it is unclear whether this deadline is enforceable.

The audit team had access to relevant internal audit reports during planning for the audit. While these had identified and in some cases rectified problems, we found that many still existed. We also saw differing approaches and levels of activity by different VMOs.

Exhibit 10: Internal audit findings on VMO claims verification (2010 and later)

Weak and inconsistent processes for verifying VMO claims

Hospitals reviewed employed different processes for verifying claims for payment by VMOs, with some less effective than others. There were numerous examples of inaccurate or inappropriate claims found.

Lack of adequate approval of payments

Some claims were not signed by the VMO. Checking and approval by hospital staff was not clearly separated and was sometimes ineffective.

Lateness in VMOs submitting claims

One VMO had not submitted a claim since 2009, and the hospital accrues an estimated amount monthly. The amount owed to the VMO probably exceeds \$800,000.

Failure to comply with policy

VMOs at a principal referral hospital are remunerated under fee for service arrangements despite a NSW Health Policy Directive that sessional contracts apply. This has been in place for over a decade but there is no documentation on the terms of the agreement and no history on how it was authorised. Excess costs are estimated as at least \$150,000 per annum.

Source: NSW Health and Audit Office research

Inadequate
verification of
VMO claims

Some doctors
submit claims
irregularly or late

Recommendations

We recommend that NSW Health:

- develops consistent guidelines and procedures for verifying VMO claims for payment
- ensures that there is more effective scrutiny of VMO payments to ensure that they are being made in accordance with NSW Health Policy Directives.

We recommend that NSW Health, after appropriate consultation with the Australian Medical Association, amend the model VMO contracts to impose stricter controls over the submission of VMO claims. This could include making a failure to submit claims within a certain time limit mean that the claims are discounted or ultimately need not be paid.

Problems with processing of VMO claims for payment

After verification, VMO claims for payment are entered into the VMoney system operated by HSS.

HSS has two independent centres at Parramatta and at Newcastle. These two centres have different VMoney systems, and hence development and maintenance costs are duplicated.

VMO claims for Parramatta are sent by courier in hard copy for data entry. Hospital staff within Hunter New England Local Health District enter VMO claims directly into VMoney. Manual data entry represents a significant workload and would be expected to generate errors.

VMoney calculates each VMO's fees from his or her claims based on a set of rules related to when and where VMOs work. These rules are applied by the system which sends this as payment data to NSW Health's finance system.

Some hospital staff complained about availability of management reports to assist them in verifying VMO claims for payment.

NSW Health has advised that it is developing improvements to the VMoney system. These are intended to include a web-based portal for data entry which will eliminate some manual processes and interface with other systems to facilitate verifying patient details. A pilot system is planned for the fourth quarter of 2011, and the final phase will integrate the new VMO payment system with the automated rostering system in 2014.

Exhibit 11: Risks of losses with inadequate verification of VMO claims for payment

The risk to the hospital of inadequate verification is that they may be paying for services they did not receive. As NSW Health pays VMOs over \$500 million per annum the financial impact of inadequate verification can be significant.

We attempted to estimate the risk of inadequate verification. Hospitals checking VMO claims thoroughly found and rectified errors in between ten per cent and 18 per cent of all claims processed. It is likely that this error rate would also apply in hospitals which are unable to thoroughly check VMO claims.

Many of the local health districts visited had difficulties adequately verifying VMO claims for payment. One of the benefits of the VMoney improvements should be an enhanced capability to deal with VMO overpayments. The business case noted this, but did not quantify any resultant cost savings. NSW Health maintains that it would be difficult to do so.

Source: NSW Health and Audit Office research

HSS branches
have different
VMoney
systems

Errors found in
ten to 18 per
cent of VMO
claims for
payment

Recommendations

We recommend that NSW Health expedites current improvements in VMoney and related systems to:

- eliminate manual data entry
- improve access by hospital staff to VMO payment management reports.

Inconsistencies in VMO numbers

The number of VMO accounts processed by HSS Parramatta was found to exceed the number of VMOs by around 30 per cent because some VMOs have contracts with multiple hospitals. In addition some VMO code numbers were found to be shared by several VMOs.

With so many multiple contracts for an individual VMO it is difficult to verify that a VMO has not claimed payment from different hospitals for overlapping services, such as being on call at multiple hospitals at the same time.

Difficult to verify that VMOs have not submitted overlapping claims

Recommendations

We recommend that NSW Health assign unique identifiers to VMOs to ensure that there are no overpayments for duplicated services.

Analysis of treatment and VMO billing patterns

Hospital staff observed that some VMOs claimed different payments for what appeared to be similar patient treatments. One hospital noted that some VMOs were claiming for an unusually high number of emergency caesarean sections, while others did not. VMOs are paid \$780.35 for a normal caesarean and \$1,567.60 for an emergency caesarean. Staff at that hospital were able to extract data to show that while most doctors claimed about half of their caesareans as emergencies, a few claimed that 100 per cent were emergency. It is possible that some normal caesarean sections were being billed as the higher cost emergency procedure.

Some hospitals appeared to use such analysis of data to explore apparent inconsistencies in practice, while others did not demonstrate this capability.

Exhibit 12: Anomalies in rates of surgery

The management of an area health service found that an unexpectedly high number of patients required a particular surgical procedure.

A study compared the rate of surgery in the local government area of the hospital in question with others using indirect age standardisation. This technique is used in health research for valid comparisons of rates in different populations, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

The study revealed that while indirect age standardisation predicted that 335 procedures would have been expected at the hospital in question, 530 procedures had actually been performed. The statistical significance was such that there was only one chance in a thousand that this could have happened by coincidence. The study concluded that the rate of surgery for the particular procedure performed in the hospital's local government area was very significantly different to the rates observed in the rest of the area health service.

This anomaly had been detected and rectified before this audit commenced.

Source: NSW Health and Audit Office research

Problems with priorities

Exhibit 13: Inconsistent priorities

The management of an area health service found that an unexpectedly high proportion of private patients awaiting a particular procedure were being given the highest clinical priority. The area's management analysed priorities given to public and private patients in public hospitals, and this revealed that one VMO had given higher clinical priority to his/her private patients than to public ones.

While 69 per cent of the VMO's public patients would have waited for a year to have surgery, only six per cent of his or her private patients would have waited that long. This inconsistency had been detected and rectified before this audit commenced.

Source: NSW Health and Audit Office research

Only a small number of hospitals we visited used analysis of rates of surgery or comparisons of clinical priorities to detect anomalies. It would be advantageous if such analysis were more widely used.

Recommendations

We recommend that NSW Health develops the use of benchmarking studies and analysis to assist local health districts to detect inconsistent VMO claims for payment or anomalies in clinical priorities allocated to patients.

Need for clinical expertise

Some hospital staff mentioned the absence of directors of medical services as a key reason for their inability to ensure that procedures conducted by VMOs were clinically appropriate. Some staff who were not doctors claimed that they lacked the requisite expertise and experience necessary for discussing clinical-related issues with doctors, whereas a director of medical services, who is a doctor trained in administration and management, is much better able to do so.

Shortage of directors of medical services

Few of the hospitals in our sample had a director of medical services. Some had been unable to fill director of medical services positions for long periods. NSW Health does not maintain records of such vacancies and was unable to quantify the shortages.

Directors of medical services can play an important role not just in verifying VMO claims for payment, but more generally in communicating with the medical staff on clinically related issues and in managing, and ensuring the efficient provision of services by, the medical workforce. To fill medical administrator vacancies, NSW Health needs to promote medical administration as an attractive career option in comparison with other medical specialities.

To provide an enhanced career structure for medical administrators, and to provide high level assistance to Chief Executives and Boards in respect of medical administration, NSW Health could consider establishing a senior level, district wide medical administrator position in local health districts which includes among its responsibilities managing the medical workforce.

Recommendations

We recommend that NSW Health builds director of medical services capacity by encouraging doctors to choose medical administration as a career path, such as by training through the Royal Australasian College of Medical Administrators.

Staff specialist availability

No systems to measure time spent by staff specialists on different activities

No hospital visited was able to provide any estimate of the proportion of time staff specialists are expected to spend on different activities. There are no systems by which the time spent on different activities by staff specialists can be measured.

Neither the staff specialists (State) Award nor the staff specialists determination give any indication of what duties staff specialists are expected to undertake or the time which they would be expected to allocate to them.

The Garling Report also referred to the difficulty of knowing in what activities staff specialists were engaged:

[S]ome staff specialists overexploit their right to treat private patients and are not sufficiently available to carry out public patient work.

The award requires each staff specialist to provide a signed monthly return showing any leave taken in the previous month. This has to be certified by the relevant hospital executive.

Both the award and determination are silent on the need to complete timesheets. According to the award, staff specialist performance agreements should include the nature of work to be performed during normal duties (clinical, teaching, administrative, research, quality improvement etc) and the amount of time that staff specialists will be released to undertake college and other professional association activities.

In addition to rights to engage in private practice as part of their employment, the award entitles full time staff specialists to engage in medical practice, paid employment or other business activities outside their employment with the approval of the employer. These activities by staff specialists are generally known as outside practice. Some hospitals have part time staff specialists, and they are required to notify the employer of any outside practice they conduct.

Involvement in outside practice if not properly supervised has the potential to conflict with staff specialist obligations to the employer. Some hospital staff interviewed claimed that at those times when a staff specialist should be on site, he or she may be unavailable, apparently due to carrying out outside practice activities. This was a particular concern with public hospitals situated next to co-located private hospitals where staff specialists are involved in outside practice.

The proposed rostering system being developed by NSW Health offers an opportunity to more clearly specify the duties of staff specialists, what they will be doing, where they should be and at what time. Better rostering of doctors would also assist local health districts to meet national health reform requirements.

Some staff specialists may not be available when needed

Recommendations

We recommend that NSW Health uses the provisions of the staff specialist award to develop performance agreements for each staff specialist to describe their activities in detail.

Lack of clarity of VMO private practice entitlements

Staff at many hospitals emphasised the importance of private patient income to their budgets. NSW Health's private patient fee income in 2009–10 was \$359 million, which represents 16 per cent of total non-government revenue.

Despite the importance of income from private patients to the public health system, the VMO determinations and model contracts provide no guidance on arrangements for VMO private practice in public hospitals, in contrast to the staff specialists determination. VMO determinations only mention private patients in the context of professional indemnity insurance, and VMO contracts do not include the word private.

VMO contracts in other jurisdictions, e.g. the ACT, give some details on treatment of private patients in the public health system and emphasise its importance:

[T]he Territory may make available for use of the VMO facilities for the care of his or her private patients, and encourages the VMO to participate in Territory programs aimed at increasing the use of private insurance by patients being admitted to Territory facilities.

More clarity in contracts between NSW Health and its VMOs would improve governance. This could include details of proposed private practice commitments, its location, working times, duration of work, any conflict with arrangements for public patients, charges for use of any public hospital facilities, reporting of private patient activities (if appropriate) etc.

Recommendations

We recommend that NSW Health provides a more explicit basis for VMO entitlements to treat private patients in public hospitals.

Burdensome training, education and study leave processes

Staff specialists also are provided with a training, education and study leave allowance (TESL) under their determination. Staff specialists are entitled to claim up to \$29,400 in TESL expenses and 25 calendar days of leave per year with pro rata entitlements for those working part time. Depending upon their private practice arrangements, some are directly paid by NSW Health and others draw their TESL allowance from trust funds derived from private practice earnings.

NSW Health staff advised that not all staff specialists take all of their TESL entitlement. While NSW Health was unable to provide any estimate of actual leave taken or the cost of TESL, total expenditure may be as much as \$60 million per annum.

Many hospitals visited complained about the amount of paperwork in administering this leave, including verifying appropriateness of courses and ensuring that individuals' TESL entitlements are not exceeded.

Internal audit reports by two area health services revealed significant problems with the TESL approval processes.

Exhibit 14: Internal Audit reports on training, education and study leave

Inconsistent TESL administration processes

Hospitals reviewed employed different processes relating to the processing and management of TESL.

Inconsistent interpretation of TESL policy

Differences in the interpretation of the policy were noted. For instance while some hospitals would not allow staff specialists to attend conferences outside their speciality, others did not reject a TESL application on this basis.

Lack of records or incomplete records

The records of TESL days and funding balances maintained by the hospitals vary, both in terms of actual records kept and the timeliness of the information. One hospital did not maintain any central records for the TESL funding taken by staff specialists, but relied on a senior member of staff maintaining a manual record.

Risk of leave taken exceeding entitlements

With the manual systems in place, errors in spreadsheet formulas and the lack of accurate and timely records held at these hospitals, there is an opportunity for staff specialists to obtain greater TESL entitlements. One area health service found that some staff specialists had negative TESL leave balances and/or funding entitlements, and estimated the potential over accrual by its staff specialists at 677 TESL days and \$740,000.

Inadequate approval of TESL applications

Some applications were found to be incomplete. In some the actual application was missing a conflict of interest declaration or appropriate sign off, and in others the application did not have an appropriate quote for travel costs. In all instances these applications were approved. Some TESL leave applications were not signed off by the appropriately delegated officer, and some applicants had approved their own applications.

Source: NSW Health Internal Audit reports

Internal audit
 revealed
 significant
 problems with the
 TESL approval

Poor
 record-keeping
 of TESL
 entitlements or
 actual leave taken

The TESL application and approval process utilised in the Illawarra Shoalhaven Local Health District was found in an internal audit to have strong controls compared to other hospitals. It was recommended as a significant improvement by senior management interviewed in other local health districts.

Other jurisdictions use different approaches to training, education and study leave. In Queensland, for example, staff specialists receive their entitlements in cash and self-manage their study requirements.

Recommendations

We recommend that NSW Health seeks improvements to reduce administration costs of staff specialists' TESL.

Some observations on Internal Audit

Internal Audit reports for the local health districts included in the sample for this audit had all identified deficiencies in processes for verifying VMO claims for payment. All had given examples of possible overpayments. Internal Audit reports provided by other local health districts also noted deficiencies leading to risk of overpayment of VMOs.

The document *Future Arrangements for Governance of NSW Health* does not mention the role of internal audit, nor does it give any indication of how NSW Health's Internal Audit function, formerly meeting the needs of eight area health services, will be able to provide an adequate level of service to the 15 local health districts.

The quality of internal audit reports made available during this audit has provided a reminder of the importance of this function to good governance. An internal audit framework for VMOs, developed in 2009 by NSW Health's Internal Audit Working Party, has given support and direction to local internal audit teams. The framework also offers an opportunity for some comparisons and benchmarking between practices and findings of internal audit teams.

The success of internal audit in addressing sensitive issues such as overcharging will depend on their ability to build strong relationships with local health district staff with the knowledge to identify potential problems that internal audit teams can then investigate. The benchmarking and analysis skills that some hospital staff used to identify anomalies could also be of significant assistance to local internal audit teams.

It is therefore most important that NSW Health continues to support local health district internal audit teams throughout the current change processes. The operation of Audit and Risk Committees and internal audit in local health districts will be of continuing interest to the Audit Office.

Appendix

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NSW Auditor-General's Report
Visiting medical officers and
 staff specialists
 APPENDIX

About the Audit

Audit objective and criteria

The objective of this audit is to assess if the service provided by visiting medical officers and staff specialists in the NSW public health system is well-managed and delivers agreed services using the following criteria.

Criterion 1: Does NSW Health adequately deploy visiting medical officers and staff specialists to best meet demand?

This considers how well NSW Health (at Local Health District (LHD) or hospital level) has identified the demand for services to be provided by visiting and salaried medical specialist staff, including number of anticipated patients and procedures by specialty, location, timing or seasonality of demand, and availability of medical staff to meet demand (currently working within NSW Health or otherwise).

Criterion 2: Are payments made for agreed and delivered services?

This considers contracts used to specify service requirements and payment, controls in place for managing service delivery, documentation and approval of payment claims, and any trends in payment across specialties, hospitals, LHDs or individuals.

Criterion 3: Is treatment of private patients within public hospitals appropriately managed?

This considers how medical practitioners' rights to private practice within the public hospital system are documented or agreed, how hospitals manage, authorise and approve rights to private practice, and any trends in their use across specialties, hospitals, LHDs or individuals.

Audit scope and focus and exclusions

The audit reviews the processes established by NSW Health for managing the use and costs of visiting medical officers and staff specialists. It also reviews the control of the use of rights to private practice.

Audit exclusions

The audit did not specifically examine the relative cost of VMOs and SSs and the optimal mix of these in each hospital.

Audit approach

We acquired subject matter expertise by:

- interviewing administrative NSW Health responsible for:
- policies on VMOs and SSs
- interviewing administrative and medical NSW Health staff at rural/ regional and metropolitan hospitals responsible for:
- managing VMOs and SSs
- verifying VMO payments
- interviewing Health Support Services staff responsible for processing payments to VMOs
- reviewing directives and policies on VMOs and SSs
- reviewing internal audit reports
- analysing data on specific procedures performed on patients.

To ensure that we were fully informed we wrote to a number of medical organisations advising them of the audit's objectives and criteria:

- Australasian College for Emergency Medicine
- Australasian College of Dermatologists
- Australian and New Zealand College of Anaesthetists
- Australian College of Rural and Remote Medicine
- Australian Healthcare & Hospitals Association
- Australian Medical Association (NSW)
- Australian Salaried Medical Officers' Federation NSW

- College of Intensive Care Medicine of Australia and New Zealand
- Health Consumers of Rural and Remote Australia
- Health Services Union of Australia
- Royal Australasian College of Medical Administrators
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (NSW Regional Office and Committee)
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Psychiatrists, New South Wales Branch
- Royal Australian and New Zealand College of Radiologists
- Royal Australian College of General Practitioners
- Royal College of Pathologists of Australasia.
- Rural Doctors Association of NSW

Some of these organisations subsequently provided us with submissions.

Audit sample

We visited public hospitals in both rural and regional and metropolitan area health services, now local health districts (LHDs).

- Hunter New England LHD
- Southern NSW LHD
- Murrumbidgee LHD
- South Eastern Sydney LHD.

Our LHD selection was based on obtaining a mix of small, medium and large hospitals in different LHDs.

Audit selection

We use a strategic approach to selecting performance audits which balances our performance audit program to reflect issues of interest to Parliament and the community. Details of our approach to selecting topics and our forward program are available on our website.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Audit Standards ASAE 3500 on performance auditing, and to reflect current thinking on performance auditing practices. We produce our audits under a quality management system certified to International Standard ISO 9001. Our processes have also been designed to comply with the auditing requirements specified in the Public Finance and Audit Act 1983.

Acknowledgements

We gratefully acknowledge the co-operation and assistance provided by NSW Health and in particular our liaison officers. We also wish to thank staff who participated in our site visits and for providing valuable information on their region.

Audit team

Our team leader for the performance audit was Geoff Moran, who was assisted by Amelia Miller. Sean Crumlin provided direction and quality assurance.

Audit cost

Including staff costs, printing costs and overheads, the estimated cost of the audit is \$240,617.

Performance auditing

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NSW Auditor-General's Report
[Visiting medical officers and
 staff specialists](#)

PERFORMANCE AUDITING

What are performance audits?

Performance audits determine whether an agency is carrying out its activities effectively, and doing so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of a government agency or consider particular issues which affect the whole public sector. They cannot question the merits of Government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in the *Public Finance and Audit Act 1983*.

Why do we conduct performance audits?

Performance audits provide independent assurance to parliament and the public that government funds are being spent efficiently, economically or effectively and in accordance with the law.

Through their recommendations, performance audits seek to improve the efficiency and effectiveness of government agencies so that the community receives value for money from government services.

Performance audits also focus on assisting accountability processes by holding managers to account for agency performance.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, the public, agencies and Audit Office research.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing. They can take up to nine months to complete, depending on the audit's scope.

During the planning phase the audit team develops an understanding of agency activities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the agency or program activities are assessed. Criteria may be based on best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork the audit team meets with agency management to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with agency management to check that facts presented in the draft report are accurate and that recommendations are practical and appropriate.

A final report is then provided to the CEO for comment. The relevant Minister and the Treasurer are also provided with a copy of the final report. The report tabled in Parliament includes a response from the CEO on the report's conclusion and recommendations. In multiple agency performance audits there may be responses from more than one agency or from a nominated coordinating agency.

Do we check to see if recommendations have been implemented?

Following the tabling of the report in parliament, agencies are requested to advise the Audit Office on action taken, or proposed, against each of the report's recommendations. It is usual for agency audit committees to monitor progress with the implementation of recommendations.

In addition, it is the practice of parliament's Public Accounts Committee (PAC) to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report is tabled. These reports are available on the Parliamentary website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

Internal quality control review of each audit ensures compliance with Australian assurance standards. Periodic review by other audit offices tests our activities against best practice. We are also subject to independent audits of our quality management system to maintain certification under ISO 9001.

The PAC is also responsible for overseeing the performance of the Audit Office and conducts a review of our operations every three years. The review's report is tabled in Parliament and available on its website.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

Performance audit reports

| No | Agency or Issues Examined | Title of performance Audit Report or Publication | Date Tabled in Parliament or Published |
|-----|---|---|--|
| 219 | NSW Health | <i>Visiting Medical Officers and Staff Specialists</i> | 14 December 2011 |
| 218 | Department of Family and Community Services Department of Attorney General and Justice Ministry of Health NSW Police Force | <i>Responding to Domestic and Family Violence</i> | 8 November 2011 |
| 217 | Roads and Traffic Authority | <i>Improving Road Safety: Young Drivers</i> | 19 October 2011 |
| 216 | Department of Premier and Cabinet Department of Finance and Services | <i>Prequalification Scheme: Performance and Management Services</i> | 25 September 2011 |
| 215 | Roads and Traffic Authority | <i>Improving Road Safety: Speed Cameras</i> | 27 July 2011 |
| 214 | Barangaroo Delivery Authority Department of Transport NSW Treasury | <i>Government Expenditure and Transport Planning in relation to implementing Barangaroo</i> | 15 June 2011 |
| 213 | Aboriginal Affairs NSW Department of Premier and Cabinet | <i>Two Ways Together - NSW Aboriginal Affairs Plan</i> | 18 May 2011 |
| 212 | Office of Environment and Heritage WorkCover NSW | <i>Transport of Dangerous Goods</i> | 10 May 2011 |
| 211 | NSW Police Force NSW Health | <i>The Effectiveness of Cautioning for Minor Cannabis Offences</i> | 7 April 2011 |
| 210 | NSW Health | <i>Mental Health Workforce</i> | 16 December 2010 |
| 209 | Department of Premier and Cabinet | <i>Sick leave</i> | 8 December 2010 |
| 208 | Department of Industry and Investment | <i>Coal Mining Royalties</i> | 30 November 2010 |
| 207 | Whole of Government electronic information security | <i>Electronic Information Security</i> | 20 October 2010 |
| 206 | NSW Health NSW Ambulance Service | <i>Helicopter Emergency Medical Service Contract</i> | 22 September 2010 |
| 205 | Department of Environment, Climate Change and Water | <i>Protecting the Environment: Pollution Incidents</i> | 15 September 2010 |
| 204 | Corrective Services NSW | <i>Home Detention</i> | 8 September 2010 |
| 203 | Australian Museum | <i>Knowing the Collections</i> | 1 September 2010 |
| 202 | Industry & Investment NSW Homebush Motor Racing Authority Events NSW | <i>Government Investment in V8 Supercar Races at Sydney Olympic Park</i> | 23 June 2010 |
| 201 | Department of Premier and Cabinet | <i>Severance Payments to Special Temporary Employees</i> | 16 June 2010 |
| 200 | Department of Human Services - Ageing, Disability and Home Care | <i>Access to Overnight Centre-Based Disability Respite</i> | 5 May 2010 |
| 199 | Department of Premier and Cabinet NSW Treasury WorkCover NSW | <i>Injury Management in the NSW Public Sector</i> | 31 March 2010 |
| 198 | NSW Transport and Infrastructure | <i>Improving the performance of Metropolitan Bus Services</i> | 10 March 2010 |
| 197 | Roads and Traffic Authority of NSW | <i>Improving Road Safety: School Zones</i> | 25 February 2010 |
| 196 | NSW Commission for Children and Young People | <i>Working with Children Check</i> | 24 February 2010 |

| No | Agency or Issues Examined | Title of performance Audit Report or Publication | Date Tabled in Parliament or Published |
|-----|--|--|--|
| 195 | NSW Police Force NSW Department of Health | <i>Managing Forensic Analysis – Fingerprints and DNA</i> | 10 February 2010 |
| 194 | Department of Premier and Cabinet Department of Services, Technology and Administration NSW Treasury | <i>Government Advertising</i> | 10 December 2009 |
| 193 | Roads and Traffic Authority of NSW | <i>Handback of the M4 Tollway</i> | 27 October 2009 |
| 192 | Department of Services, Technology and Administration | <i>Government Licensing Project</i> | 7 October 2009 |
| 191 | Land and Property Management Authority Maritime Authority of NSW | <i>Administering Domestic Waterfront Tenancies</i> | 23 September 2009 |
| 190 | Department of Environment, Climate Change and Water NSW Environmental Trust | <i>Environmental Grants Administration</i> | 26 August 2009 |
| 189 | NSW Attorney General's Department NSW Department of Health NSW Police Force | <i>Helping Aboriginal Defendants through MERIT</i> | 5 August 2009 |
| 187 | Roads and Traffic Authority of NSW | <i>Improving Road Safety – Heavy Vehicles</i> | 13 May 2009 |
| 186 | Grants | <i>Grants Administration</i> | 6 May 2009 |
| 185 | Forests NSW | <i>Sustaining Native Forest Operations</i> | 29 April 2009 |
| 184 | NSW Police Force | <i>Managing Injured Police</i> | 10 December 2008 |
| 183 | Department of Education and Training | <i>Improving Literacy and Numeracy in NSW Public Schools</i> | 22 October 2008 |
| 182 | Department of Health | <i>Delivering Health Care out of Hospitals</i> | 24 September 2008 |

Performance audits on our website

A list of performance audits tabled or published since March 1997, as well as those currently in progress, can be found on our website www.audit.nsw.gov.au.



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