

CORRECTED VERSION

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospitals performance data

Melbourne — 18 August 2009

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Ms C. Broad
Mr M. Guy
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Dr D. Edey, chair, Victorian faculty, Australasian College for Emergency Medicine.

The CHAIR — I declare open the Legislative Council's Standing Committee on Finance and Public Administration public hearing. The hearing today is in relation to the inquiry into Victorian public hospital performance data. Specifically the committee is examining the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.

I welcome Dr David Eddey, chair, Victorian faculty, Australasian College for Emergency Medicine. For the information of witnesses and the committee, I point out there are a number of substituted members today.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard, and witnesses will be provided with proof versions of the transcripts in the next couple of days.

Dr Eddey, I invite you to make an introductory statement if you wish, and the committee will then proceed to questions.

Dr EDDEY — Thank you for the opportunity to appear before this inquiry. The ACEM Victoria faculty represents emergency medicine specialists working in the health system in Victoria. Faculty members are therefore at the front line of clinical medicine in Victorian public hospitals as well as performing other roles in health management and research, and they are employed with other bodies such as Ambulance Victoria. Our members are well placed to relate firsthand experience of conditions within the public hospital system in Victoria.

Our submission has outlined our experience with demand, quality of care, resourcing, access and data quality. The study we performed in 2007 specifically outlines our experience with data reporting. The appended 'Access block and overcrowding — a literature review' outlines the causes and effects of access block. The ACEM has taken the lead on this issue and in September 2008 hosted an access block summit in Melbourne.

This review concluded:

In summary, there are not enough available beds to meet demand. This results in access block and ED overcrowding. This is associated with significant mortality and human suffering. It has been proven that GP patients do not cause access block or ED overcrowding, and persistence of this belief is detrimental to finding real solutions. Access block has a huge impact on the health system but can be addressed by increasing the capacity of the system, most directly by increasing available beds (at all levels of care). Key performance indicators should be developed with agreed nationwide criteria implemented and collected at all levels. This is an issue that requires national leadership from all levels of government, professional organisations and academia. Only when all stakeholders agree that the problem is systemic and hospital-wide can solutions be implemented.

Our interest in data quality and integrity arose from our daily experience with access block and overcrowding, specifically because what we were experiencing did not correlate with the published performance data. Our study demonstrated that there was significant variation in how rules were interpreted, how data was reported and the measures taken to manipulate data.

The faculty is of the view that the manipulation of ED data to falsely give the impression of enhanced ED performance to achieve KPI funding, to enhance the standing of a particular health service or the health system in general or to avoid health service or individual performance scrutiny is dishonest and unethical.

The Victorian faculty of the ACEM supports the concept of KPIs when used to genuinely improve process and patient outcomes. However, if KPI performance data is manipulated or not reported or interpreted accurately, it cannot be used to drive real improvement in the system and achieve better real outcomes for our patients and our health services.

Many positive things have come out of KPIs. Emergency clinicians, health services and DHS have been working collaboratively in exploring and developing new models of care, ways of working and other innovative approaches to these issues. Access to beds and the flow of patients in a health service is now an issue for the whole health service and system, rather than just the ED. On the whole, process within EDs and hospitals has improved significantly but has not been able to make significant inroads into overall performance due to continually rising demand and competition for beds from other sectors of the system.

It remains to be seen if there will be any real change in data-reporting integrity as a result of these issues being brought to public notice. Some of my colleagues were still being pressured to manipulate data a week after the publicity surrounding the surgical waiting list at the Royal Women's Hospital.

Recently there have been some changes in the VEMD business rules that will test the resolve of health services and the DHS to effect genuine change in the area of data integrity and performance reporting. I refer to the new definitions of 'time to treatment' introduced on 1 July 2009. The new rules specifically exclude the time that a patient is simply placed in a cubicle from being included in the calculation of the 'time to treatment' KPI. Clearly this will affect those hospitals which in mid-2003 took the opportunity to report 'time to cubicle' as the end of waiting time for triage category 2 and 3 patients. One would expect that if this is reported accurately and in the spirit of the rules, a number of hospitals will experience significant falls in their reported performance. A number of my colleagues have already reported discussions with their executives around this data from July 2009. Any fall in performance will not become public until July 2010 when current performance is published in *Your Hospitals*.

Clearly it is difficult for a health service, health department or government to report a fall in apparent performance. We need to recognise that this is due to the utilisation of more sophisticated patient-tracking software and increasingly stringent reporting definitions rather than a fall in real performance and take this as an opportunity to identify real problems and effect genuine change. Unless we do this it is likely that the same lack of data integrity will continue to be used to make the system look good and avoid the consequences of poor performance.

The community should expect that performance data accurately reflects what is really occurring in their public hospitals. Where suboptimal performance is demonstrated, rather than penalise a health service financially, as has been the practice until recently, this should be taken as an opportunity to ensure that it is able to operate at an acceptable level by ensuring that it has the systems and resources in place to enable it to meet the demands placed upon it.

Similarly, the minister should expect that health services and others within the system also act with integrity. Regardless of the reasons for data manipulation, it is highly unlikely that it is done by low-level staff operating on their own initiative with some altruistic motive to make their health service look better. Systematic data manipulation is almost certainly done on an institutional basis with direction from those with overall responsibility for the service.

In summary, it is evident that data manipulation has occurred, and this contributes to an overestimation of performance and the capacity of the system to meet demand. Whilst this might be expedient in the short term, it is short-sighted and does not contribute to genuine long-term system improvement. Most importantly, it does a disservice to the most important people in the whole system: our patients. We need to stop putting patients in virtual wards or other creative destinations that do not add to the patient experience and work towards ensuring that hospitals have both the staff and bed resources to meet demand in a timely fashion. Acknowledging that there are problems with performance results requires integrity and strength of character on the part of individuals, health services, DHS and government. Admitting you have a problem is the first step towards fixing it.

The CHAIR — Thank you, Dr Edey. You noted in your introductory comments that following the public issues surrounding data manipulation your members or colleagues continued to be pressured with respect to manipulating data. Can you expand on that?

Dr EDDEY — Within a week of that issue becoming public I had a call from one of my colleagues saying they were being asked to manipulate data to improve their waiting time performance.

The CHAIR — Can you tell the committee where that occurred, what institution?

Dr EDDEY — It was the eye and ear hospital.

The CHAIR — The eye and ear hospital. And what rationale was given for that? Was there any explanation as to why or the circumstances?

Dr EDDEY — I was not privy to the whole circumstance, but the director there was being pressured by their administration to change waiting times to make it look like patients had been seen in a shorter amount of time.

The CHAIR — Was that a practice that had been going on prior to the publicity surrounding data?

Dr EDDEY — I cannot speak specifically for the eye and ear hospital, but in general we have found that that sort of thing is a widespread practice, or was a widespread practice.

The CHAIR — Where else had it been occurring?

Dr EDDEY — I did my study, which was attached to my submission, almost two years ago. I cannot remember the specific hospitals, as it was all de-identified at the time, but a significant proportion of hospitals in some way manipulated their data, either the waiting times or by manipulating data to make it look like patients had left the department and gone to an inpatient bed when in fact they still remained within their emergency departments — so-called ghost wards.

The CHAIR — Notwithstanding the government's comments around this issue and the appointment of the office of data integrity et cetera, your evidence is that this is still occurring, and occurred immediately after the publicity?

Dr EDDEY — I have not surveyed my members since this has become public, but we would plan to do that. I would hope that new definitions of data and, as I said, much more sophisticated software would make this harder to do.

I can give you an example. I spoke about the new business rules for VEMD. Some of those performance KPIs specifically look at waiting times and how you calculate how long a patient has been waiting to be seen. There is at least one new computer software system in the state which is quite sophisticated and actually tracks every entry into the system. You can actually change data on it — you can change times and retrospectively changed things — but it records absolutely everything because it is all password protected. It may be that you do have to wind back a clock by a minute or something, because often people do see patients before they get to the computer to say they have seen them so that is fine, but it records that and records it in the background and you can audit it and follow it.

On much older systems you could record anything and there was no audit trail kept, so there was no record of it being changed. For some systems you could just change times willy-nilly and there would be absolutely no record. The only way you could really compare was if you got the emergency department notes out and compared them to perhaps the admission notes, and if the time was handwritten in them, you could compare them. I think that is what the Auditor-General has been trying to do but it was very easy to fudge those figures.

Similarly, just putting someone in a cubicle and rebadging it as an inpatient bed was a relatively widespread practice — so-called ghost wards — and again unless you were actually on the ground, there would be nothing on the computer to know, to suggest that that had happened, whereas some of these new computer systems are very sophisticated and keep track of every change. They are password protected so every time you want to change something you have to put your password in so we know who has done what and all that sort of thing.

The CHAIR — What was driving the creation of the so-called ghost wards referred to — cubicles being designated as inpatient beds?

Dr EDDEY — That is a matter of debate. Again, it is reporting performance, and the consequences are bad for them. Clearly there was, until recently, money attached to good performance. Similarly, if you were an underresourced, poorly performing department or health service, you did not get any money, and what money you might have got was totalled up and distributed to the good performing systems at the end of the year. There were significant financial imperatives — although some people would disagree with me — to performing well. Perhaps in some health services it would be hundreds of thousands of dollars in performance bonuses. That is probably a very small proportion of the overall operating budget, but when budgets are very tight, \$100 000, \$200 000, \$300 000 can buy a lot of resource, especially if it is reinvested in a clinical area.

The ghost wards were basically directed at achieving these KPIs. The KPI to get patients who are admitted to an inpatient bed out of your emergency department within 8 hours — or 80 per cent of them out within

8 hours — is a good KPI. It focuses the whole system on moving patients through the system. The easiest thing to do is not to buy beds but to fudge the figures. That was our argument: that the incentive for genuine improvement is lost if you fudge the data and make the system look good and say, 'We are fine'. Clearly if the system is not performing and you need to invest in geography, infrastructure, resource — either staff or beds or both — that is expensive. But it does not help anyone — certainly it does not help our patients — if you say that the system is working fine when in fact it is not.

Creating ghost wards, rebadging a cubicle and saying it is a short-stay unit when it is not or that this is an intensive-care bed in the emergency department and this patient, although they are in the emergency department, has technically gone to intensive care does not help anyone. It underestimates the problem and underestimates the capacity of the system. It had the potential for health services to make money out of it, from the bonus system. More importantly, I suspect this desire to make data look good is still ongoing because, even though there are no performance bonuses attached to it now, there is still the problem of performance scrutiny by the department of individual health services and their boards. I suspect that is probably a very potent driver of people to get their data to look good.

The CHAIR — I assume from what you are saying that when ghost wards were created it was not junior doctors in emergency departments who designated that this bed was now an inpatient bed.

Dr EDDEY — No, or junior clerks manipulating the data. Very junior staff would have a very limited concept of what all the KPIs mean. Certainly senior medical staff, senior nursing staff know about them. My members would be very averse to doing it unless there were some direction to do it.

The CHAIR — Direction from?

Dr EDDEY — From their hospital executives. It is quite possible that some of this occurred outside the emergency department; hospitals would have data units that would send the data on to DHS. That can be done and the data can be cleaned up and changed in the background.

The CHAIR — I would like to ask you about one of the systemic issues. You noted in your introduction the impact the changed business rules will have on hospitals that started reporting time to cubicle in 2003. Your paper on hospital data indicates there was a spike in performance for that reason.

Dr EDDEY — For those hospitals.

The CHAIR — For those hospitals. Why was that allowed to go unchecked? If suddenly all these sample hospitals had a spike in their performance in 2003 because they changed to reporting on time to cubicle rather than time to actual treatment, why did the DHS not intervene and ensure consistency in the data?

Dr EDDEY — DHS makes the rules. DHS and — I forget the name of the committee — the Health Data Standards Committee make the definitions and implement the business rules. A body of people would have got together and discussed what the data definitions were and changed them. In my study I have made reference to the meeting where that occurred. Someone had the idea that a nurse doing an ECG, for example, constituted the beginning of treatment. That is fine if the nurse can actually treat the patient, but a nurse doing a set of observations does not remotely constitute treatment. Certainly my faculty members were concerned about that at the time. I guess that is one of the things that started our going down this path of examining data collection and manipulation. For hospitals to suddenly rise in their performance from 50 per cent or 60 per cent to 95 per cent and keep it there overnight, literally, is extraordinary. It is only explained by that change in the data definition.

The CHAIR — There was no response from DHS, noting that suddenly a group of hospitals were performing so much better because they changed the basis of their data collection? It did not raise any concerns with DHS? Nothing was communicated back that suddenly it had this sample that was performing differently?

Dr EDDEY — No, not that I am aware of. And I think some of the attitude amongst health service executives was if they are doing it, we will do it as well so we do not look bad. You can do it if the rules say you can do it. If it makes you look good, people will do it. Not all hospitals have done it. I am aware of one health service that has made a conscious decision not to implement that rule. It is public data on the Your Hospitals website; you can plot it all out and graph it and you can see who is doing it and who is not. Eastern Health does

not use time to cubicle to mean waiting time. This was before 1 July and the new business rules. They consistently said, 'We will have time to clinician', and if you look at their performance, it is consistently below hospitals that are very similar to them.

The CHAIR — Why would DHS not want consistent data across all health services?

Dr EDDEY — I cannot speak for DHS.

The CHAIR — Thank you. I am conscious of the time. Mr Viney?

Mr VINEY — No, I am right at the moment, thanks.

The CHAIR — Thank you.

Mr HALL — First of all, thank you, Dr Eddey, for the information you have provided to us today. To what extent are your members aware of independent auditing processes being undertaken to check data entry?

Dr EDDEY — We are aware of it in that the hospitals would be notified of it. Individual hospitals which are about to be audited get notified, and I would assume that those hospitals that are audited would tell their departmental directors or other staff that they are about to be audited. We discussed these issues in our faculty meetings and were aware of the audit processes that have been implemented.

Mr HALL — Are they satisfactory in terms of your view?

Dr EDDEY — Some of them, yes. There are very simple things like actually physically inspecting things that are called short-stay units or whatever. It had not been done before but that is being done certainly for some health services. As I said before, I think it is not difficult to manipulate the data and hide it. Medical documentation is notoriously lean on accurate dates and times — you know, when people write in notes.

Mr HALL — So the auditing processes employed by the independent auditors do not necessarily overcome the data manipulation which you claim happens.

Dr EDDEY — No, I do not think so. Like I said, the computer record, certainly in the older systems, is completely untrackable.

Mr HALL — You made mention of short-stay units. Can you just tell us quickly what they are, how they actually operate and whether they have been effective in terms of reducing demand on emergency departments?

Dr EDDEY — It is interesting. They are currently doing a review of short-stay medicine in the state, and I had them visit my hospital yesterday. Short-stay units are technically wards, as in proper beds, separate from the emergency department, perhaps contained within or adjacent to an emergency department, where patients who probably require extensive work up and perhaps monitoring and decision making go for prolonged periods of time — usually 12 or 24 or sometimes more hours. They are usually low acuity things but things that you just need to make decisions about. It means that patients are in a much better environment. They cannot be too sick because they are not like intensive care units; they are very basic wards with nursing staff and medical staff attached to them. Those patients who require long stays in EDs to get sorted out can go to some of these beds with the hope that at the end of 12 or 24 hours they will just go home or get placed or whatever.

They do take patients out of trolleys and into much better environments and free up space in clinical areas. One of the problems is that we know some hospitals use them as holding bays for admitted patients. If a short-stay unit is operating pretty well, less than 20 per cent or 15 per cent of patients would get admitted to an upstairs bed, so to speak, but we are aware that some hospitals have extraordinarily high rates of admission, like 50 per cent or 60 per cent, so they are not being used as a short-stay, they are just being used as holding bays. They are wards; they are not really virtual wards.

The issue with a virtual ward is when the patient is actually in a cubicle in the ED but counted as being in a ward so they are off the books from the point of view of staying in the ED. There have been some creative solutions around that — like intensive care beds in some hospitals and just rebadging cubicles and calling them another unit. From the accounting point of view they are effectively counted as being admitted to an inpatient bed whilst they have remained in the ED.

Mr HALL — So a decision may have been taken that they need an acute bed but they might be sitting there for 12 hours or more while waiting for a bed to become available.

Dr EDDEY — Yes.

Mr HALL — Therefore for that 12-hour period, for example, that is their virtual ward. Is that the sort of thing you are talking about?

Dr EDDEY — Yes. That is how a virtual ward works.

Mr HALL — In respect of the bed block issue, you mentioned in your submission and again this morning it being one of the most significant causes for overload in the emergency departments. Have you seen any sort of evidence of real investment in additional beds to overcome this particular issue in hospitals throughout Victoria?

Dr EDDEY — We are working towards it. Certainly Australia-wide the number of beds has not kept up with demand. Recently in Victoria there have been increasing beds. There was a beds pact — I cannot remember the exact numbers of beds — but certainly for some hospitals that has made a difference; for others it has not. It is not just about beds in the ED. You can build huge EDs but it does not sort out the problems. With some it is acute beds upstairs beds for sick patients, but for some it is to unblock the drain effectively — that is, downstream beds in rehab and subacute care and even nursing home beds — so you can take patients who no longer need to be in hospital and place them in appropriate care out of the acute setting, so it is not just inpatient beds — it is beds across the whole system.

Mr HALL — What is your view about ambulance bypass? Does that assist or exacerbate the problem in EDs?

Dr EDDEY — In general people do not like it. I work in a hospital that does not go on bypass, because of its geographical location. It is a very short-term answer to a crisis in a particular department. It does not help anyone in the long term. It means that the St Vincent's patients end up at the Royal Melbourne and the Royal Melbourne patients end up at Western, so you end up with this chain reaction of hospital after hospital after hospital going on bypass when one goes on bypass.

Mr VINEY — Are you on the road to Damascus, Mr Hall? You did not have that view in the Kennett government period.

The CHAIR — Mr Viney, you will get your chance.

Mr VINEY — Bypass never occurred in the 1992 to 1999 period?

The CHAIR — Order! Dr Eddey?

Dr EDDEY — It is a very short-term solution to one hospital's problem which frequently spreads the problem further. People do not like doing it. When they do it they are at crisis point. It is not always in the best interests of the patients, because the wrong patient can end up at the wrong place quite easily.

Mr HALL — I have one last question, and it concerns elective surgery. Has the expenditure that has recently occurred — there has been a blitz, as we know, on elective surgery — had any impact at all on emergency departments?

Dr EDDEY — Yes. I think winter last year was the blitz on elective surgery. Emergency department work used to be a bit seasonal; it is more perennial now. Certainly there is a peak of attendances in winter with winter problems. Unfortunately if you combine that with a blitz on elective surgery, it means access to beds for patients coming through an emergency department was at a premium this time last year. One of the issues is that surgical work is quite seasonal as well. Hospitals tend to wind down their surgical operating over summer. I quite like summer, because access is usually good; there are more free beds in the system. This has a specific impact on intensive care beds over winter if elective surgery ends up in intensive care. If it is all done over winter when there are all the medical demands on intensive care beds, access to intensive care beds is very difficult. That is pretty traditional. If you could spread the elective surgery workload across a year a bit more

and reduce some of the peaks and troughs, it would probably make things easier to manage, but you would have to get people to work in summer holidays.

Ms HARTLAND — I am interested in a comment you made before in regard to ghost wards and rebadging. Does that not come up in the audits that are done — that is, that suddenly a cubicle in an emergency department has gone from being a cubicle in an emergency department to a bed in a ward?

Dr EDDEY — No. The only thing you change is you say, ‘The patient is admitted to’ — whatever you want to call your group of cubicles. Unless you actually go into the patient record and see that ED nursing notes were going for hours after they said the patient was admitted, you will not pick it up. That is an extraordinarily tedious process to go through, and you have to know what you are doing.

Ms HARTLAND — In terms of seasonal issues, I am quite interested in what you were just saying about doing a blitz in winter when you obviously need ICU, especially this year with swine flu. Did you find that last year’s heatwave also had a major impact on the ED, and do you expect, because we can only presume it is going to get worse, that during summer you will have to gear up in a different way?

Dr EDDEY — Summer work is a bit different than winter work. It used to be that winters were always very busy and you would have a winter peak but now it seems to be much more constant. I think it depends where you work as well. Certainly in places which have big seasonal changes in their population get very busy over summer. With the heatwave, a lot of hospitals were under pressure with heat-related conditions. I guess it is like the flu; it is just a different time of year.

Mr DAVIS — Dr Eddey, thank you for your submission and also for your evidence today. It has been most informative. I want to pick up on some comments made to Mr Rich-Phillips and flowing out of some discussions we had with DHS officials yesterday. The *Proposals for Revisions to the Victorian Emergency Minimum Dataset for 1 July 2009*, a document dated October 2008, changes the definitions, it seems to me, across the system for these time-to-care arrangements. That has now been in place for a month basically; a month and a bit. I wonder if you might reflect on what that will mean for patients coming through the system, how it will be recorded and the impact that that might have on the data that is reported, and finally — one other thing — what it will do to the comparability of data backwards?

Dr EDDEY — From a patient’s point of view, you would not notice anything different. If all things remain unchanged, this is purely a way of recording events in the emergency department and reporting them. It used to be that time to treatment was recorded from when you arrived — —

In some hospitals it was permitted that you could count time to a cubicle or first seen by the nurse in the cubicle effectively. That meant that if your computer system recorded your arrival time and the time you got put in a cubicle, that was reported as treatment being commenced. That is clearly not the case in the vast majority of cases.

The other part of the definition was who could provide treatment. I think everyone has accepted that purely being put in a cubicle, being connected to a monitor and having your blood pressure and pulse taken does not constitute treatment. The new definitions say treatment can be provided by the doctor coming to assess you. A lot of hospitals have systems where a doctor might see you very quickly after arrival and say, ‘You have got a broken leg. Here is an X-ray, some pain relief and a splint and get you moving’, and we accept that, so a doctor or a nurse practitioner who is approved to treat certain conditions and they operate effectively as independent practitioners. Some departments have primary care physiotherapists who deal with musculoskeletal problems and other people like mental health clinicians who work in emergency departments, so they can start treating a patient.

The other part of the definition was about placing the patient on an approved clinical pathway. That is a very nebulous definition. Some hospitals would have some approved clinical pathways, but the hope that you could place every patient on an approved clinical pathway the minute they arrive is unfounded in that emergency medicine is largely dealing with undifferentiated problems which could be — —

Mr DAVIS — Presenting symptoms and so on.

Dr EDDEY — Yes. It is easy if someone has clearly got a broken hip; that is easy. If you present with something like shortness of breath or abdominal pain, there could be myriad problems causing it. In general, nurses cannot say, ‘Oh, you are short of breath; I will put you on the short-of-breath pathway’, because they might be doing completely the wrong thing. So to put someone on an approved pathway you need to make a diagnosis — —

Mr DAVIS — A provisional diagnosis of some sort.

Dr EDDEY — Yes. Although there are some very experienced nurses, some who work as nurse practitioners, in general a regular nurse probably is not equipped to examine and diagnose most of these conditions. The huge number of undifferentiated patients sent to emergency departments really need to have a proper diagnostic process — a history and examination and a working diagnosis made and investigations and treatment commenced. Putting people on a pathway — if you get it wrong — is fraught with danger.

I could give an example in my own hospital where this was done a few years ago. We actually stopped using pathways because a patient was put on a pathway when everyone accepted that was what the patient had got and a few hours later we realised the patient did not have what he was on the pathway for, and the patient had a very bad outcome. Unless you get it right, approved clinical pathways are fraught with danger.

Sure, simple things are easy. A splinter in the finger? A clinical pathway is not a problem. Undifferentiated headache, neurological symptoms, shortness of breath, chest pain, abdominal pain — the things we see lots of — are not amenable to — —

Mr DAVIS — So there is potential clinical risk if people are put on pathways prior to a proper diagnosis in the case of that large, undifferentiated group of — —

Dr EDDEY — Yes, especially if they are allowed to remain on the pathway for hours until seen and are perhaps getting no treatment or the wrong treatment or the wrong investigations.

Mr DAVIS — Although the statistics would look better.

Dr EDDEY — Because that ticks the box that treatment has commenced. That is why — —

Mr VINEY — How often would there be people left on the pathway for hours?

Dr EDDEY — It is conceivable.

Mr VINEY — A lot of your paper is theoretical. What I am interested in is the facts; I am not interested in the theory. Of course your theory will work — —

Dr EDDEY — I can tell you, if they are not put on a pathway, they may wait hours as in 4, 6, 8 or 12 hours to see a doctor — —

Mr VINEY — I am asking how often would that happen in your hospital.

Dr EDDEY — In my hospital?

Mr VINEY — Yes. How often does that happen?

Dr EDDEY — That a patient would wait 6 hours to be seen?

Mr VINEY — Yes — having been put on a pathway without a doctor having overseen it.

Dr EDDEY — I do not use pathways for that reason.

The CHAIR — Mr Viney will have his opportunity.

Mr VINEY — Great, more theory.

Mr DAVIS — The other point about this is the impact on data comparability to previous years. Will the data in the new system be comparable to those places that use the traditional definitions?

Dr EDDEY — No.

Mr DAVIS — So there will be no — —

Dr EDDEY — That spike that occurred in mid-2003, I would expect those hospitals to return to that baseline. There have been lots of improvements since 2003, so certainly I do not anticipate that the hospitals that are performing in the high 90 per cents for those KPIs would continue to do so if this is done, as I said, in the spirit of the rules.

Mr DAVIS — And these new DHS rules that have been put out to start from 1 July this year, are they in sync — I am looking for the right word here — with the national health data dictionary — the Australian Institute of Health and Welfare definitions — or are they different?

Dr EDDEY — They are more in sync with the college of emergency medicine's definitions. We have spent the last couple of years trying to bring it back to what is an accepted definition from a professional body. The DHS performance KPIs are based on our triage guidelines and triage categories, so I think they are in sync.

Mr DAVIS — The other point that you mentioned to Mr Rich-Phillips was about certain computer programs that would track patients. Are there particular proprietary brands that we should know, the names of the programs and so forth, that are used for this?

Dr EDDEY — Look, there are probably a number of very sophisticated programs on the market. My hospital and a number of other health services in Melbourne have been through the process of selecting a new one recently. We have implemented one called Symphony, which is a UK-based program. It has now been taken up by Southern Health on three campuses. Royal Melbourne is about to start using it, and Eastern Health I think is going to implement it. We looked at a range of other vendors as well and the later, more sophisticated ones have auditable trails of data changing so that any data changing that is done has a record kept of it.

Mr DAVIS — Whereas the previous data on the older system could be changed — —

Dr EDDEY — There are lots of vendors around, or several. The system that my hospital and a number of other hospitals used had no safeguards so you could change it and there was no record that it had been changed.

Mr TEE — I will start by following up the discussion with Mr Davis in relation to the definition of treatment or clinical pathways and so on. Clearly I am no expert in these matters, and I suspect neither is Mr Davis. The evidence that we had yesterday was that there are experts in these matters — the department gave us evidence that they were working on these definitions with the appropriate people, and I assume that is the appropriate vehicle to try and work through these definitions. The evidence was that those discussions had been going on for six months and that as decisions were made and agreements were reached with appropriate professionals those definitions, whether they were around treatments or so on, would be rolled out. Are you aware of those discussions?

Dr EDDEY — Yes. There is an emergency clinical network which is convened by DHS and involves practitioners across the emergency medical system, and they would be looking at pathways of care and that.

Mr TEE — And essentially the evidence was that the experts, as opposed to Mr Davis and myself, were looking at particular presentations so that there were different pathways essentially for differences in how the patient presented in terms of their condition, and they were looking for both the definition but also what that meant for those particular pathways.

Dr EDDEY — As I said, there are some conditions that would be amenable to pathways: easy to diagnose, easy to treat, do it from the front when the patient arrives.

Mr TEE — I suppose the point I am making is that — —

Dr EDDEY — That is what they are working on.

Mr TEE — Yes, that is right, and that is the appropriate — —

Dr EDDEY — Yes. A child turns up and clearly has got asthma, has had asthma all its life and needs a well-recognised drug regime that can be implemented by the nurse who sees the patient. That is quite reasonable but, as I said, the danger is that you get it wrong and the patient presents with an undifferentiated problem. You cannot have a pathway for every symptom: that is the problem.

Mr TEE — What did you call that network?

Dr EDDEY — I forget the acronym for it but it is the emergency clinical innovation network, I think.

Mr TEE — And they approved those issues.

Dr EDDEY — Yes, and the college supports that. As I said, we have been working quite well with DHS in a very collegiate manner towards improving things.

Mr TEE — The other aspect I think Mr Hall raised is the number of beds and whether or not there have been any improvements there. Again, you would be aware of the \$300 million or \$320 million which has been allocated for, I think, about 100 emergency beds and I think there are 160 subacute beds — —

Dr EDDEY — Yes; I cannot remember the breakdown.

Mr TEE — But again that would obviously make a difference in terms of the treatment of potentially thousands of patients or the conditions of patients who would be able to be processed — —

Dr EDDEY — Yes, so extra beds are important and they have helped. Certainly at times in the middle of winter, extra intensive care beds, extra mental health beds; it all helps. But, as I have said, the whole system is not just about beds; it is about step-down beds and improving the way hospitals work and how they flow patients — —

Mr TEE — Sorry to cut you off, but on that issue we had evidence yesterday about short-stay units, medi-hotels, hospital in the home, day surgery and 24-hour procedure units, again ways of clearing through emergency units as quickly as possible.

Dr EDDEY — All those things — the hospital in the home, day surgery and short stays — have made big differences. Compared to 20 years ago — fantastic. But, as I said, all these things have not kept up with demand, and that is one of the problems.

Mr TEE — In relation to that, you say 20 years ago but even 10 years ago the hospital budget was \$3 billion. It is now \$7 billion, so we have had a more than doubling of the budget for hospitals in less than sort of 10 years.

Dr EDDEY — I will take your word for it

Mr DAVIS — But less beds.

Dr EDDEY — Yes. Things that used to be done as a four-day stay in general surgery are now done as an afternoon stay. Medical practice has changed a bit as well.

The people who really suffer from a lack of beds are the people who end up stuck on trolleys in emergency departments. They are often the elderly patients who do not have acute problems: they do not need their heart attack fixed or their heart failure fixed, they just need to be in hospital for whatever period of time and there is no bed for them. They are the ones who really suffer the most — the medical patients with unexpected problems that suddenly arise and get to a hospital and wait hours to be seen and then wait hours, if not days, to get into an inpatient bed.

Mr DAVIS — Because of access block, largely.

Dr EDDEY — Because of access block.

Mr TEE — The Auditor-General in his report for 2008 — and I want to know if you would agree with this — basically said that current patient flow processes have allowed Victoria to achieve amongst the best

time-to-treatment and bed efficiency performance levels in Australia. Do you agree with the Auditor's assessment?

Dr EDDEY — From my experience talking to my colleagues interstate, Victoria is probably one of the better-off states, but I think we still have a long way to go.

Mr TEE — We are leading the country but we can do better. Is that what you are saying?

Dr EDDEY — Yes. And, as I said, if some of that is based on inaccurate data, then we may not be the best.

Mr TEE — I will come to the data in a second. It is a question of whether or not you are quibbling with the Auditor, and you are saying you are not.

Dr EDDEY — I travel around Australia regularly and my experience is that Victoria is probably not quite as bad as some other states.

Mr TEE — The Auditor says we are better. Do you agree or disagree with the Auditor?

Dr EDDEY — Half-full or half-empty — not as bad or better.

Mr TEE — He says we are better. You have a different — —

Dr EDDEY — I think there is still a long way to go.

Mr TEE — Obviously. I understand what you are saying; it is just whether or not we are the best or whether we — —

Dr EDDEY — The Victorian DHS, even though we have issues with its methods of data collection and all of that, has been very proactive in getting the system to work better. We have worked very hard with it, as have other professional bodies. The Australasian College for Emergency Medicine's relationship with DHS is extraordinarily good compared to some other states, and we would hate to see it become poisonous or this put our good relationship and the opportunity to really improve things at risk.

Mr TEE — It is one thing to say there are opportunities for improvement, but I suppose it is the benchmark we are starting from. The Auditor says we are doing well. I take it you are not particularly quibbling with that — whether your cup is half-full or half-empty. Is that right?

Dr EDDEY — I think Victoria is probably ahead of other states — I agree with you — but could do better.

Mr TEE — I am sorry if I missed part of this, but in terms of the material that you put forward which was then the subject of the Auditor-General's report, that material was September 2008?

Dr EDDEY — It was 2007 — our first study.

Mr TEE — Since then we have had the independent auditor review all of that material, make recommendations. As I understand it, essentially the recommendations have been acted upon. We have rolling spot audits, we have abolishment of the bonus pool, we have an automatic notification in writing to patients informing them of any changes to their surgery date. From my perspective it seems that we have a process in place that works: you have an auditor that can investigate, you have recommendations and you have a government that has responded. Is that your sense of how it has transpired?

Dr EDDEY — I think all of the things the Auditor-General has done are heading in the right direction. It would be good to repeat the study when we have time and just see if things have really changed. I suspect they have. I think there is much more awareness amongst hospital executives and clinicians of the issues, and they will probably be a bit more rigorous, especially with new rules and new data systems, in collecting and reporting the data.

Mr TEE — But, again, I suppose the point from my perspective is that an issue has been raised, someone independently has had a look at it and government has responded. The next stage is to ask: is that response adequate — that is what you are saying. We will need to wait for the data to come through to measure that in 6, 12, 18 months, 2 years.

Dr EDDEY — I look forward to it.

Mr TEE — Yes, and we can take some comfort from the fact that there is a process in place that seems to be working.

Dr EDDEY — Yes.

Mr VINEY — When I read through the paper that you presented, I guess the most common question mark was around where the evidence is, so I am going to ask you specifically about some of the things you suggest here. You say:

Similarly the minister should expect that health services and others within the system also act with integrity.

Are you suggesting he does not expect that?

Dr EDDEY — No, not at all.

Mr VINEY — So your experience is that there is a general expectation that the system operates with integrity?

Dr EDDEY — As a member of the public I would expect the whole system to act with integrity.

Mr VINEY — There is an implication in this sentence in your presentation that relates to data manipulation. There is an implication there. You were suggesting the minister does not expect that the system operates with integrity.

Dr EDDEY — He has not come out and said it. When the Royal Women's Hospital surgical waiting lists came to light, the executives of the Royal Women's Hospital said that was a low-level clerk acting on their own. I find that to be a fairy story.

Mr VINEY — You have then gone on in the same paragraph to say:

Systematic data manipulation is almost certainly done on an institutional basis with direction from those with overall responsibility for the service.

Can I ask you what your evidence is for that?

Dr EDDEY — I have no hard evidence. It is anecdotal evidence reported to me by my members.

Mr VINEY — Who would be making those directions, in your view?

Dr EDDEY — Hospital executives.

Mr VINEY — Systematically, across the system?

Dr EDDEY — In those hospitals that are doing it, yes.

Mr VINEY — So you think that all hospital executives are manipulating the data for what purpose?

Dr EDDEY — I spoke to this earlier. There is a number of reasons. One is performance funding. Two, there is a performance framework implemented by DHS which looks at your surgical waiting list performance, your emergency KPI performance and your business financial performance. There is a scoring scale. If you do not perform, there are certain levels of DHS intervention that occur — performance watch they call it. As a health service executive I guess your reputation depends on how well you do your job.

Mr VINEY — You guess or you know or you have evidence of? These are pretty serious allegations, so I am asking you to back up your allegations. You have an opportunity here to back up your allegations that the system is being manipulated deliberately by the senior executives of the various health services. I just want some evidence.

Dr EDDEY — To improve the data?

Mr VINEY — But I want some evidence.

Dr EDDEY — I cannot give you hard evidence about every department I surveyed. As I said, it was not a scientific study; it was anecdotal, but I have no reason to doubt that from what my members tell me the performance that they experienced was not the same as their hospital put out at the other end. The only way that can happen is if someone is directing people to make the data look good.

Mr VINEY — But you have no evidence that that is being done.

Dr EDDEY — I can speak for my own health service only. I have no direct evidence. I am told by reliable colleagues — —

Mr VINEY — So you are happy, basically, to impugn the professional reputation of the CEOs and senior administrators of every health service in Victoria, based on no evidence. Is that correct?

Mr DAVIS — You think they are all keystroke errors, do you?

Mr VINEY — You have had your go. Is that correct? You are prepared to impugn their reputation based on no evidence that you are bringing to this committee.

Dr EDDEY — There is evidence that the data has been changed, so the question is: who has changed it?

Mr VINEY — But your allegation is that it is systematic data manipulation on an institutional basis. I just want to know the basis of that allegation.

Dr EDDEY — Okay, I will give you an example: the creation at the Alfred hospital of emergency intensive care beds. When they are really under pressure and do not have an intensive care bed, they are allowed to rebadge an emergency cubicle as intensive care. The patient should be in intensive care, they are getting intensive care in emergency, but the box is ticked that they are admitted. That is done with Alfred hospital executive knowledge, and probably with DHS knowledge.

Mr DAVIS — So that is a virtual ward.

Dr EDDEY — That is a virtual ward.

Mr DAVIS — It is not a real ICU bed.

Mr VINEY — I am just fascinated that you are able to make these allegations without being able to say, 'This is occurring in these instances on these occasions'. You have not done that. You have not come to us with that specific data. You said before that theoretically it is possible. I agree: theoretically, lots of things are possible. Theoretically, all sorts of things are possible. What I am suggesting to you is that if you are going to come to this committee with allegations about the improper conduct of the chief executive and senior administrations of all our hospitals in Victoria, you ought to do so on the basis of some evidence, some actual hard evidence.

Dr EDDEY — I do not have hard evidence from — —

Mr VINEY — That is fine; you do not have hard evidence. Can I just ask you, if we are going to work in theory, in the theoretical basis of the extra funding that has been put into hospitals over the last 10 years and the theoretical basis of the additional beds that have gone into the system and the changes, which you acknowledged, and improved processes — —

Mr DAVIS — There are actually less beds in the system today.

Mr VINEY — — of the management of the hospital system, in the last 10 years has the pressure on the emergency departments generally improved? Has there been a general improvement on pressure in emergency departments?

Dr EDDEY — No, it has got worse.

Mr VINEY — Not at all — no improvement, despite all of that investment? I have to say that your experience is not what has been reported to me by many others.

The CHAIR — Mr Viney, let Dr Eddey answer.

Dr EDDEY — If you surveyed, as I have, people who work in major metropolitan emergency departments, the problem is not getting better.

Mr VINEY — But emergency department medicine is always a high-pressured business, is it not?

Dr EDDEY — Yes.

Mr VINEY — And I am sure when you end a shift it is always pretty exhausting.

Dr EDDEY — No-one has complained about working hard. What we are complaining about is that we are trying to work in an environment where there are patients lying in corridors, spending hours and hours unseen in waiting rooms, mental health patients spending days in emergency departments in bright lights and noise whom we should not be looking after because we have done our bit — they need to be in an inpatient bed. There are 10 ambulances ramped out the door with patients lying in them for 2 hours before they can get in — doctors going out to ambulances in the street, in the ambulance bay to try and sort out problems that cannot be unloaded.

Mr VINEY — I understand all of those pressures; I have seen them all.

Dr EDDEY — Good.

Mr VINEY — But what I am asking you is: are you putting to this committee, based on any evidence at all, that none of those things have improved in the last 10 years?

Dr EDDEY — Process has improved, bed flow has improved, but the problem is that there are not enough beds in the system to keep up with demand. Demand continues to increase. All these things are fantastic and make the life of everyone better up to a point, but the point is: our patients are spending hours and hours and days in places they should not be, and that clogs up the whole system.

Mr VINEY — In regard to those critical issues you have identified such as mental health beds, when I was Parliamentary Secretary for Health I remember there were major issues associated with people who could not get nursing home places and so on, so you had backups in the system. Are you saying that none of the initiatives that have been put in place by the minister and previous ministers and the department have been addressing those critical issues?

Dr EDDEY — They are all designed to address the issues, but they do not keep up with the demand.

Mr VINEY — So there is still more to do is your essential evidence.

Dr EDDEY — There is still more to do, and — —

Mr VINEY — No-one has ever argued with that.

Dr EDDEY — My point about the data is that until you acknowledge there is a problem by having good data that actually demonstrates the problem you will never get to address it because there is no — —

Mr VINEY — Again, that is a theoretical position, isn't it? Who can disagree with that?

Dr EDDEY — No-one, hopefully.

Mr VINEY — No-one here is arguing against the fact that we need good data. What I am concerned about is you have made allegations in here that the data is deliberately manipulated without backing that up.

Mr DAVIS — So did the Auditor-General.

Mr VINEY — You have had your go.

Mr DAVIS — So did the Auditor-General. You know that.

Mr VINEY — I guess I am trying to just get to the nub of what you are trying to tell us. You are trying to tell us that there has been systematic manipulation of data, but you are not able to produce the evidence of that.

Dr EDDEY — As I said in my submission, people do not get up in their day-to-day jobs and say, 'My health service is doing this', because they will be sacked.

Mr VINEY — They will be sacked?

Dr EDDEY — Yes.

Mr VINEY — And you have got evidence of that, too?

Dr EDDEY — It is in their contract, and that would be well recognised. If I got up and said — —

Mr VINEY — Well recognised — you are going to a theoretical position. That is all right; I have no more questions.

The CHAIR — Allow Dr Eddey to answer.

Mr VINEY — I have no more questions.

Dr EDDEY — There are contractual issues about speaking in public about your health service as an employee of the health service. It would be in just about everyone's contract.

The CHAIR — Thank you, Dr Eddey. I think there are some more questions but we have run out of time; the next witness is here. On behalf of the committee, I would like to thank you for your evidence here this morning and also the college for its written submission and your paper on ED performance data. We will have a draft version of the transcript to you in the next couple of days for any corrections.

Ms HARTLAND — Can I just say before we finish that I really appreciate the evidence you have given today. Certainly under the Liberals health care was demolished and under the Labor Party it has had to be brought up to a standard. But I think what you are saying is that even with all of that work it is not quite there yet and only by being open and transparent can we actually know what is going on.

Dr EDDEY — Absolutely.

Mr DAVIS — Can I also thank Dr Eddey and flag that we may need to speak to him again on some of these matters. There are certainly many more questions I would like to put to you, but we are out of time.

Dr EDDEY — Thank you.

The CHAIR — We appreciate your attendance this morning. Thank you.

Witness withdrew.