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PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Review of Auditor-General's Audit on Managing Acute Patient Flows

Melbourne—28 April 2010

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Ms F. Thorn, Secretary,

Mr L. Wallace, Executive Director, Hospital and Health Service Performance, and

Ms F. Diver, Director, Performance, Acute Programs and Rural Health, Department of Health.

The CHAIR—I declare open the Public Accounts and Estimates Committee hearings on the review of the Auditor-General's audit findings and recommendations 2008, addressing the following audit: *Managing Acute Patient Flows*.

On behalf of the committee, I welcome Ms Fran Thorn, Secretary, Department of Health; Mr Lance Wallace, executive director, hospital and health service performance; and Ms Frances Diver, director, performance, acute programs and rural health. Members of the public and the media are also welcome. In accordance with the guidelines for public hearings, I remind members of the public that they cannot participate in the committee's proceedings. Only officers of the PAEC secretariat are to approach PAEC members. Departmental officers, as requested by the secretary, can approach the table during the hearing. Members of the media are also requested to observe the guidelines for filming or recording proceedings as they would as if they were in the Legislative Council committee room.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days of this hearing—within two working days of receiving the transcript, in fact. It may not occur for three or four weeks, actually. In accordance with past practice, the transcripts and PowerPoint presentations will then be placed on the committee's website.

I will now pass to the secretary for any opening comments. Committee members will ask questions relating to the audit findings and recommendations. I ask that all mobile telephones be turned off.

Ms THORN—Thank you, Mr Chair. The first point I would like to make is that patient flow is one of the three pillars of thought, of both the department and health services individually and collectively, of how we go about managing the public hospital system in Victoria. 'Patient flow' in some ways is a metaphor for 'access'. The other two, of course, are quality and safety, and then the third is prudential financial management. Thinking about patient flow, it is important that you remember it is one of three tasks that we are required to do at any given time, and these are balancing tasks. Probably from the perspective of health services, quality and safety, if you gave anything an edge, would be there. That is something that they take very much into account when they are thinking about issues of patient flow and how to achieve the most optimal patient flow. But it is influenced by a range of factors: demand, capacity, patient pathways, health service processes and, as I said, quality and safety.

We have been working on ways in which we can assist the health services with patient flow from a number of perspectives: through additional investment in hospital capacity; development of substitution and diversion models of care; reforming processes to increase efficiency and improve experiences; and, of course, a performance management framework which takes a series of key performance targets and monitors what is happening across the system. The second page there has a diagram that tries to—

The CHAIR—This is produced by Barry Jones, is it!

Ms THORN—I did think it was open to accusations of 'noodle nation'. It is an attempt to show that patient flow is not the same as designing an assembly line for the manufacture of an inanimate product. We are dealing with patients who turn up in a relatively disorderly fashion—that is, they turn up when they feel the need. They primarily present through an emergency department, but there are a fair proportion who come in via elective surgery, and a small number who come in for direct medical procedures. But in that process they can be going in any number of directions and the majority of patients will go to a number of places. So this is merely to show that for any given patient, depending on the acuity of their need, they could have up to about nine different forms of transfer or flow through the hospital before they are discharged and, hopefully, go home in a much better state of health.

I do not want to labour the point, because it is very easy to say, 'Well, things are too complex and therefore it's too hard to change.' That is not in fact our approach. It is merely to say that this is a very dynamic environment and one in which it is particularly important to get the involvement of clinicians. If clinicians are not interested in what it is that either we or health service managers are interested in putting into place in order

to achieve what would seem to be more efficient patient flow, then there is probably no point in us starting. They are in fact going to have to carry it out, and if they do not agree with it, if they do not think it is a good way of dealing with patients, then we may as well not start.

I turn to the ways in which we are assisting. Firstly, there is investment in additional capacity. Growth in investment in the health system in Victoria—the public hospital system—has increased by an average of about eight per cent per annum for the past 10 years, and that is compounding.

The CHAIR—So what is the increase in the patients?

Ms THORN—And there is a commensurate increase in the number of services provided.

The CHAIR—So that is eight per cent as well?

Ms THORN—They have about matched each other. I am not quite sure if it is precisely eight per cent, but there has been a significant increase in the number of separations, so we are treating more people per thousand.

Mr WALLACE—Sorry, I just need to clarify. Eight per cent is price as well as growth.

The CHAIR—It is both?

Ms THORN—Yes.

The CHAIR—So that applies to both.

Mr WALLACE—So patient and inpatient growth is about four per cent and price is the remainder.

Ms THORN—Yes, changes in the cost of delivery and then changes in demand, so increasing demand, and that is what has driven that growth in financing. But certainly where we have looked at demand, the growth in demand has equalled or exceeded our projections. The biggest, most recent investments, of course, were the recent package for beds where nearly 300 additional beds were funded; two big tranches of funding for elective surgery patients to increase throughput there, both in 2009-10 and another $45 million from April this year; and additional funding that has gone into emergency care. In addition to that, of course, there are a range of others. They are about increasing demand, and they also have elements of increasing capital in order to expand the capacity in order to treat more patients—or, in fact, redesign the treatment places so that they are much more contemporary and enable much higher throughput.

Perhaps as important as funding, although often not getting as much attention, are the models of care, where there has been ongoing innovation in the system for—well, probably forever, but I am just going to draw upon the last couple of decades for some of the main changes that have been implemented. The first of these is substitution—that is, different places where treatment can take place; more effective places for the treatment to take place. The first of these, of course, is Hospital in the Home. That has been running since, I think, the early 1990s. It has doubled in size. It relies on patients agreeing to be treated at home, but essentially they get a medical treatment service in their own home, similar to that which they would get in a hospital.

We have introduced observation medical units for reducing length of stay, which is certainly one of the biggest ways we can increase capacity and the patient flow; extended day surgery services; transition care; restorative care programs; a whole range of programs around emergency departments to speed up throughput of patients in those places; what we call the transit lounges is how we are speeding up the discharge process; acute inpatient care coordinators; post-acute care; medi-hotels; and day hospitals.

If you turn to the next diagram, this is just an example of a particular program that is significantly reducing the length of stay and has early indications of good outcomes for patients. This is the new approach to the geriatric medicine patient journey. It is worth starting with a few facts. Approximately 10 per cent of the current population in Victoria are 70 years and older, but 15 per cent of presentations to emergency departments are people who are 70 and older. About 30 per cent of transfers to ward are people who are about

70 years and older. Close on 60 per cent of total bed days are taken up by people who are 70 and older. So focusing on good care for older people is a clear priority for both achieving better outcomes for them and improving patient flow.

The traditional pathway for a geriatric medicine patient used to be approximately 40 inpatient days. They would start in ED, they would go into an acute ward and then, after a period of about 15 days, they would end up in a subacute inpatient ward. Now the approach that is being trialled in a couple of services is that, rather than putting them in an acute ward—there is plenty of research evidence that shows that this does not have a positive impact on an aged medical inpatient; they are not necessarily acute patients and it does affect their functioning if they go for an extended period of time into acute inpatient treatment—you put them firstly into an acute aged-care process which is really age-appropriate treatment and then into a program of restorative care so that you are preparing people to go home and focusing on what is needed around their care.

This is showing some very positive outcomes and we are hoping to expand that more broadly across the system. When you take into account the number of bed days that are being used by people who are 70 and older—and this is likely to increase in the next 10 years as the baby boomers start to hit that age—there is a significant patient flow advantage that could well be achieved there.

Then we turn to diversion, which is trying to stop people from being in hospital in the first place. The most important of these is HARP which has been around for about six or seven years now. It is about taking acute patients, chronic disease patients, who sometimes get notice—a frequent flyer—who we know are going to have inpatient experiences, and trying to reduce that by good treatment in the community. Early evaluation of this is showing a significant reduction in the number of inpatient experiences and ED experiences. It does not take it away entirely because these are people who have quite severe chronic illness, so the chances of saying, 'We'll be able to keep you out of hospital forever,' under current treatment regimes is unlikely, but it is significantly reducing the number of inpatient experiences.

Then of course there is Nurse-On-Call which is having a positive impact: it is not a huge proportion, but it is reducing the number of people who are turning immediately to ambulance or emergency departments as the first opportunity for treatment. That is also getting very positive responses in the evaluations that we are doing. We have also co-located after-hours GP clinics because many people who turn up for emergency department treatment would not be classified as an emergency and they are seeking primary care type treatment.

We have piloted a really interesting program called Outreach Services to Residential Aged Care Facilities to pre-empt the very frail elderly from coming into EDs and then in fact moving into inpatient experience. We have had 10 pilot sites and about 55 per cent of those altered the need for any ED presentation. So that is having a very positive impact and we are looking at how we can spread that further. Then there are some specialised programs around osteoarthritis hip and knee services, which are reducing call, where we are having treatment that does not require surgery or an inpatient experience.

We are also reforming processes, so we are making a smallish investment in the overall scheme of things: $5 million per annum to build and support health services in looking at their processes and working out how they can in fact achieve significant improvements. There has been a large rollout of training in this space, a very high level of take-up from the health services, and very high levels of sponsorship within the health services. The chief executives of those health services are personally taking a lead on this, which is having a big impact in the service. The clinicians are very actively engaged and we are at the stage now in the rollout where we can start looking at the results of individual projects. There are about 48 projects that have been selected by health services and four demonstration projects on particular areas that we wanted to look at and say, 'Are there things that arise from this that we can now systemise?'—for example, 'For the whole of the system, these are processes you should be seeking to improve.' That has got a lot of engagement.

Further reforming of the process has been a project which is looking at variation. This is really getting down to the nitty-gritty of why there is variation in treatment for the same DRGs across the system. It is a benchmarking process that 27 of the services have agreed to go in together. They have looked at three periods. Each of them who are part of this takes a selection of DRGs. If they are an outlier, they measure themselves against the best practice and work out how they can improve, so for a range of things we are seeing quite

significant reductions in length of stay to the medium or to the excellent level as a result of that process.

We have been leading the development of clinical service networks. These are, again, groups of clinicians across the health services who operate in the same practice area, who come together to work out what is the best and most effective way of effecting a good patient journey for particular conditions. We have clinical networks in cancer/renal, emergency care and maternity and newborn services. They are the first. We have now got a cancer clinical network and there is a cardiac clinical network—sorry, they were in that group—who are beginning to get particularly good results. Again, the importance of having clinician-led change is particularly important in the system. People who work in health services will listen to what the clinicians tell them about good practice and the very strong focus the clinical networks is achieving better coordination, a better patient journey or flow, and better outcomes for people in the treatment process.

If we turn to the kinds of things that were discussed in the Auditor-General's report, health services every day have to balance competing demand. There is the demand both for emergency—for example, people presenting and there has been a significant growth in the number of presentations in what we call the 'more emergency levels', so categories 1, 2 and 3—and people who have scheduled surgery, otherwise known as elective surgery. And, yes, it is true that we know that at any given day or any given week there is going to be a certain level of emergency demand and we know that X number of them will be cardiac arrests or various other forms of well-known conditions. We just do not know what day it is going to be on, whether they are all going to come at the same time, at different times; and when somebody turns up with a cardiac arrest, you down tools and you treat that. You do not say, 'Well, it would be more convenient for us to do this this afternoon,' for example. It is not quite so simple to balance demand for elective and emergency treatments, although we have been putting in place centres that are solely for the throughput of elective surgery in order to reduce that demand. But health services are very much focused on how that can be managed over any given period and are constantly working on ways in which that can be improved.

Then we turn to bed management techniques. The Auditor-General made reference to the piloting of a new bed management tool; after having surveyed what was being used around the country and elsewhere, we thought the one that was being used by New South Wales Health offered a very good system. There are now seven health services implementing this bed management system and seeing some good results from that in terms of managing patient flow. A number of other health services have different bed management systems that they are looking at. This of course will be evaluated and, depending on the evaluation, we will be looking at a broader rollout of that system.

Another key issue is the transfer of patient care—the push-pull discussion in the Auditor-General's report—and this is managed in different ways, depending on the health service that you approach, because they will have developed, over time, approaches that actually work for them. There was a recommendation that we should provide a guideline for the whole of the system as we do in areas such as discharge planning. Having looked at that, we decided in the end that it would be of such a high level as to be not particularly useful, so the sort of work we are conducting with health services relates to transfer of care issues depending on the kind of treatment being received, so how that might happen at different times in the patient journey. This is something we continue to look at, but at this point in time a single guidance for the health system on transfer of patient care we do not think would be particularly useful. If you wish to hear more about that, Frances can talk about that for us.

Finally, discharge protocols: again, we have worked with the system to develop a set of discharge protocols. There is a suggestion that we ought to look at initiatives in what are called criteria led discharges in order to get more timely discharge, particularly for those health services where you are talking about not necessarily having in-house, full-time medical staff. There are a whole range of practices that drive the decisions around discharge, not the least being the needs of the patient, but also their carers and the kind of care that they are going home to. This does complicate the issue of criteria led discharge guidelines. We are looking at this, but this is something that we very much have to work through with clinicians themselves, and at this stage clinicians are not showing a great deal of enthusiasm for going down this track. So this is a program of work that we will continue, to see if there is ongoing merit in it. At this stage the clinicians are putting forward very good reasons why they are a little nervous about doing it. Patients, as I said, are all going home to different situations and there is still a strong desire for the treating clinician to have a final look and a final say before people go home. So we do not rule it out, but it is something we are working on with the clinicians

themselves. Thank you.

The CHAIR—Thank you very much. We will probably go over some well-worn philosophical tracks this afternoon, but I might take up where you left off in terms of discharge. I know on page 59 and following in the Auditor-General's report, there is analysis. 6B is the discharge performance by time of day: hospitals 1, 2, 3, 4, 5, plus state-wide. First, have you got any more recent figures beyond 2006-07, or even some longitudinal analysis, even if it is state-wide, which could show any impact of moving the curve?

Ms DIVER—Not with us today. We can certainly provide it.

The CHAIR—That would be good, because in looking at the text, particularly on page 59, it does seem that most planned admissions occur early in the morning, the theory being that beds should be available at that time, but only 16.8 per cent of patients are discharged before 10, and the range before midday was 18.2 to 27.4 per cent. Whether it is that the clinicians do not quite finish their rounds before nine o'clock, or what—

Ms THORN—I might ask Frances. I actually asked precisely the same question—

The CHAIR—It sticks out a bit, doesn't it?

Ms THORN—when I was discussing this, and I shall ask Frances to give you the same reply she gave me about why it is that the clinicians cannot do everything at once.

Ms DIVER—Getting discharges earlier in the day is a focus for health services—10 am discharges and getting medications ready in time. There is a balance between medical review and criteria led discharge. Should the patients wait for a medical review immediately prior to discharge? And medical staff often have a conflict of their own workload: 'Am I going to theatre?' and, if so, to start theatre on time. 'Am I going to the emergency department to review patients for admission?' 'Am I reviewing discharges?' So each health service works out their local arrangement to see which is the best flow. That is why we have implemented things like discharge lounges or transit lounges so that patients can be transferred to another point of care awaiting their medical review or their discharge medication, so sometimes the time that they discharge from hospital does not reflect the time they actually empty the bed. That is one component of it. But there is an enormous amount of effort going into trying to bring that time forward in the day so that there is a better match between the patients awaiting a bed in ED and the patients in the—

The CHAIR—Has that been successful? I guess this goes back to my first question. Is it showing that there is an improvement? From an unscientific and casual analysis, it does seem that there is great scope here. We discussed this morning with the Auditor-General how to understand the fact that there is very high bed usage here—although you can have sort of more than one person in a bed successfully, of course, in any individual day. It is 355, which is higher than any other state.

Ms DIVER—There are examples where the Redesigning Hospital Care Program is redesigning discharge processes, where there are local improvements, so we can show it is shifting in individual local circumstances and we have got individual examples. Whether that converts into a state-wide shift in the curve, I have not got that information with me today.

The CHAIR—Okay. We are obviously interested in this.

Mr WALLACE—Perhaps I could also add to this.

The CHAIR—Yes, please.

Mr WALLACE—With a number of these things there are trade-offs involved.

The CHAIR—I know. We understood that, yes.

Mr WALLACE—Other parts of the A-G's report indicates that tighter transfer from ED would be good, and also an understanding of what patients are coming into ED, what conditions they have and where

they will transfer to. So the same physician may be attending ED and looking at improving that flow, rather than discharging and approving that flow. So there are trade-offs between those.

The CHAIR—That is fair enough. In respect to transfers from ED, he did make the point that wards did not seem to have the same priority in terms of their receptivity—organising for receiving people from the emergency department—as did the emergency departments, with the anxiety they felt in trying to place people.

Ms THORN—That is an observation that the Auditor-General made. If we asked a range of health service managers the same question, they would probably say that is not true, that each part of that patient flow is trying to balance a number of competing issues around getting someone ready for discharge versus receiving the next load of patients. I think it would be hard to go down the track of saying that there is, within this flow, a total disconnect between the two. It is just that you cannot get it precisely correct.

The CHAIR—I know. The Auditor-General was describing bottlenecks rather than necessarily disconnects. To be fair, we did ask him what was the evidence, what was the basis, for the statement that was made in the report—what I have just described—and the answer was that they had a whole range of interviews with staff in hospitals.

Ms THORN—Yes.

The CHAIR—Obviously, from our point of view and looking at what we recommend, we are trying to come up with some key things and discharge figures did show—and I accept the hospital operates 24/7, Frances, but there are some critical times and there seems to be an understanding both by yourselves and the hospital services that that is the case.

Ms THORN—One other point I would throw into this is to take into account the age of many of the patients who are in the hospital as inpatients. They are not young and, even though one of the things that seems to happen to you as you get older is that you sleep less, it does not necessarily mean that you are going to move that much faster in the morning. So there are a range of patient factors. We do not accept that this cannot be improved, because we do think it can be, but we also do need to take into account patient preferences and how they are going to feel about the discharge experience.

The CHAIR—Right. Richard.

Mr DALLA-RIVA—I have got to put this on the record. The complex process that you have got there, I did read this when I was going through the notes—the Redesigning Hospital Care Program inaugural bulletin. If you have got it there, have a look at it. There is a big picture-mapping exercise for Peninsula Health and, if you read it, if you can understand that, that is worse than 'noodle nation'. That is magnificent. I tender that as evidence No. 1.

The CHAIR—That looks like Michael O'Brien.

Mr DALLA-RIVA—That is just terrible.

Ms THORN—I presume we provided it.

Mr DALLA-RIVA—That is magnificent, as she refers to the notes provided for *Hansard*.

Ms THORN—It is very complicated, yes.

Mr DALLA-RIVA—I want to get to the issue that came out of the meeting today with the Auditor-General and that was, I think it was indicated, the block, the process. From my observation, if you look at the emergency department being created, there is a perception there. One of the things that the Auditor-General's report, on page 3 and then on page 4, specifically talks about is managing acute inpatient admissions. In your presentation you looked at the issue of the push-and-pull strategies. It seemed to me that the one concern was that we have the emergency departments getting clogged up—not the right word but

patients coming in, pushed in. But then when they get to the ward, the pull strategy or the pull from the wards is somewhat resistant, and that was the feel that I got this morning from the Auditor-General and from the report. He uses the words in here 'to improve the "pulling" culture within wards', and then he also talks about some of the issues on page 40:

> Ward staff had a more passive approach that often contributed to delayed admissions and longer emergency department waits.

It gets down to an issue of management, I guess. I am somewhat concerned with your response to the key initiatives of transfer of patient care. Maybe I will get some clarification, but you are not going to put some protocols or guidelines in about changing the culture of the wards that are not receiving inpatients? For me as a layperson looking at it, it appears to me that the bottleneck is at that join there: lots in the emergency and this process here gets slowed down. I think that is what the Auditor-General is getting at, but he calls it 'culture'. 'Culture' to me indicates a management issue rather than a process or something else.

Ms THORN—If I can just pick up on the point: where we were talking about guidelines, they were high-level guidelines about discharge, not about the push or pull between ward and emergency department. You are quite right: the issues that the Auditor-General talks about are partly planning. So I know that there are going to be X people coming out of elective surgery who will be coming into the ward today. On average, we will get this many people out of an emergency department. How much can we plan to juggle that? How much can we be more ready for that versus I am sitting here and I am waiting for someone to ring me and tell me that there is someone on the way?

On one of the slides, there is talk about the process, and I am going to get the term wrong, but it is basically pre-booking. It is the giving of advance notice to wards from emergency departments, which is being used in a number of hospitals. But there is the issue also of a management culture around this: a view that people within the hospital see themselves as part of a flow, not discrete parts of a business that get connected by the patient, rather than seeing themselves as a patient journey. We would say that is something that we would always be looking at over time and that all management in the health services are looking at. It is clearly getting a lot of attention in our Redesigning Hospital Care Program. I know that one of the largest health services is looking at the transfer from EDs to wards; in fact, I went and saw what they were doing and had a long conversation with the clinicians who are leading it. They are in the very early stages.

But what comes out of this is the sort of thing we are looking forward to say: 'Is this transferable across the whole system?' 'Are there going to be some guidelines about how you manage process that might come out of this?' But, equally, the message from that and other projects that Frances and Lance might like to talk about further in the Redesigning Hospital Care Program all point to the importance of senior management paying attention to these issues. When the CEOs and the director of medical services start asking questions about these things, there is no doubt that you can get more active interest played to it. That is why you have that rather frightening diagram. That is an example of where one health service is sitting down and saying, 'Okay, what happens here? What is it that we can do to make this a less discontinuous process?'

I am sorry if I sounded like I was rejecting the idea of any guidelines. I am not. We certainly think out of the Redesigning Hospital Care Program we will get areas where we can try and spread different practices much more broadly. But the point you make about senior management interest in this is critical. Lance can talk about the work he does, as certainly can Frances in her arm-wrestling with health services about performance and Lance in his meetings with CEOs, and certainly these are issues that are raised with board chairs as well as issues around patient experience.

This is a relatively new way of thinking about how we go about health services, by and large. People have been focused on issues—and quite rightly—of qualitative care: did somebody get the best surgery or the best medical intervention? It is pretty modern to start saying, 'Yes, but how did the patient experience this?' I know that sounds amusing.

Ms HUPPERT—Talkback radio has been dealing with that for some time.

Mr DALLA-RIVA—But, yes, you are right. It is a management issue. I apply this to the old retail days: you would aim to get the throughput. Somebody walks past the department store, and you try to pull

them into your store to maximise your sales.

Ms THORN—We are trying to divert them.

Mr DALLA-RIVA—But the feeling I get is that the door-greeter there has basically said, 'Oh, look, we might be just a bit full.' I know that is not the intention, but then it becomes a management issue, so I would be interested in the experiences of the CEOs.

Mr WALLACE—All I would do is make one major observation: timely treatment in ED is really important, but it is not the most important thing. The most important thing is the quality of health care outcome. So if you waited an extra 15 minutes outside an ED or you were waiting an extra hour in the ED and you got a really good quality of care outcome, that is probably more important to you than timely treatment. There is a balance here. If we gave the capacity for ED physicians just to place people for the remainder of their treatment in whatever ward was available whenever they chose to do that, the question is: would that get you the very best quality of care? The ED is stabilising somebody, is initiating some treatments, but their major treatment will be done on a ward under the supervision of a ward physician, and you just need those two people working together to make sure you get the right quality of care outcome overall.

I could agree with you: if you look at any single factor, you would basically say 'yes'. If what you are trying to achieve is faster ED throughput, obviously allow ED just to push patients wherever they want in the health service. But when you are balancing the quality outcome with the ED time, you have to have a bit of a balance there. There may be two physicians in the health service who do not have entirely the same opinion about the appropriate balance there, but from our viewpoint and the CEOs', we are trying to work collaboratively with people to make sure that the person gets the right quality of care outcome. I think quality of care outcomes have been pretty good in this state. There is all sorts of data that, yes, we have done fairly well on quality of care and I think it is this collaborative arrangement that helps us get there.

Ms DIVER—The only point I would add is that one of the solutions to ED bottlenecks, as you are describing them, is the whole-of-hospital response. The solution to ED is partly in the ED, but the solution is also outside the ED, and I think quite a lot of effort in recent years has been put into understanding that actually the solution to those ED bottlenecks lies in the wards. Whilst EDs count in minutes and wards count in hours—an extra 10 minutes at the front end or an extra hour ensuring a safe discharge—where is the relative balance?

Just going to the spaghetti charts, the process maps, one of the things that I think the Redesigning Hospital Care Program has done is to do the patient journey throughout the hospital. You get the ED people, the medical inpatient ward, the subacute people, the physios, all in the room, so the whole journey is mapped and that is why it looks like spaghetti. If you just get the ED people in the room or if you just get the ward in the room, it does not look so bad, but it is actually getting that flowthrough. I think that is helping the whole hospital engage in the patient's experience, not just their bit of the experience, and that is why the maps look pretty ugly.

Mr DALLA-RIVA—I had to go to Epworth recently. That is where I go, because I can afford it and that is my choice, and I try not to clog the other system. So my view is that I go there and I pay for it. Having said that, I did note that they had allocated a separate room now in their emergency department, and I found that they had a doctor or a GP solely responsible for what could be done at a GP's office, even though I had X-rays and other things done. Is that something that has been trialled? For me, that is about removing the bottlenecks. Then the ED has responsibility for their throughput—no longer pushed out, because they can pull somebody out of the system themselves.

Ms THORN—Yes, straightaway. Quite a few health services have a co-located GP clinic service or they will have, themselves, almost like a GP service, for patients who have got a bit of a cold or who do not need the full gamut of treatment that the majority of patients in ED get, which is a very full suite of services. So there are a whole range of hospitals making different attempts to take these people to one side and give them very quick treatment.

There is another phenomenon that I do not think we have spoken about before. We did some research a couple

of years ago, mainly led by New South Wales and we collaborated on it, where we looked at what was the changing pattern of attendance at the emergency department. What we saw was a relatively new pattern, with not just a younger cohort, but particularly a younger cohort, realising that EDs provide a full service. So you might have to wait a couple of hours, even four hours, but if you turn up with a book and your iPod and you are happy to sit there and keep yourself entertained, every test that you need will be done, whatever you think is wrong with you will be thoroughly checked out, and you will not have to go and make an appointment to see anyone else; it will all be done for you. We have certainly noticed that, and also patients with higher levels of acuity presenting than in the past.

As Frances says, the sorts of things that you observed at the Epworth are more and more common in emergency departments in the public hospital system, but they still have very high levels of demand, and the demand tends to have very peak periods: late afternoon to about 11 o'clock at night. If you really want very fast treatment, the best time to go is at about three in the morning.

Mr DALLA-RIVA—But I wasn't go-kart racing at 3 a.m.!

Ms THORN—No.

Ms HUPPERT—I wanted to go to a more high-level question, which is really the flavour of the Auditor-General's report and the flavour of your responses, and that is to do with the philosophical issues that the chair raised earlier about subsidiarity. The question is: yes, you agree in principle with the recommendations, but they are implemented by the health services and you do not monitor the implementation, you monitor the outcomes. It seems there are quite a lot of points where your answer is, 'The department does not specifically monitor implementation of the recommendations by the health services.' But clearly you are looking at the outcomes.

A matter raised by the Auditor-General this morning was that that point is understood, but that there would be value in monitoring implementation processes because then there would be able to be seen if, in particular, health services were not performing as well in the implementation, and that waiting for the outcome is perhaps too late. I understand the concept of the independence of the health services. They are independent. They manage their own operations, but the point raised was that there might be better results.

The CHAIR—There is a gap.

Ms HUPPERT—Yes, that there is a gap, and that there would be better results if there was some more performance valuation.

Ms THORN—There probably would not be a week go past where I do not have a conversation with Lance or Frances or someone about, 'Why can't we do this faster?' and we have made a very deliberate choice in the governance model we have, which is to fully engage the health services in the process. We could choose to go down, dare I say it, a New South Wales type track where you have a very centrally managed system and just say, 'Here is our fiat. You will do it.' Our view is that that is not particularly effective. This means that we are going to take longer to institute some change. Our experience is showing us, however, that that is reaping the benefit of the change sticking. So it is the change that people decided they want. They see the evidence. They see it in front of their eyes, as they work it themselves, and then they go on with it.

On the issue of implementing, and the things that the Auditor-General says, it is not entirely correct to say we do not implement it and do not monitor implementation. A very large part of Frances's time, and of her staff and other staff within the department, is spent in constant connection with the health service around the implementation of a range of these change programs and really being partners in the process of implementation, watching and being engaged in how it happens and, where necessary, redesigning it as it goes along.

So if we give the impression of being hands-off, that is not what it feels like when you sit inside the department. The department is very actively involved with health services in the implementation of change, but where I say we are probably different from other systems is that we do not presume that we have necessarily the fiat or the mandate to say, 'You must do this.' We also are open to the view that we may not

have had the best idea and we are prepared to go through a process with health services where we trial, test, redesign and then see it stick over time.

Ms HUPPERT—There was an interesting issue raised this morning which was the Auditor-General's view that the boards of the health services see themselves as the equivalent of public companies—boards of public companies with those types of responsibilities—whereas, due to the funding model, maybe they should see themselves more as directors of a proprietary limited company which is a subsidiary of the health department. I am not saying whether or not we adopt that view, but I thought it was an interesting issue to explore.

Ms THORN—It is an interesting issue. I would be surprised if they saw themselves as entirely akin to the boards of private companies. I often talk to chairs and, indeed, I sit on the—as far as possible and, if I cannot, Lance does—interview panel for all directors or potential directors. One of the key questions we pursue with them is their understanding of the governance model and the relative players in it. We are very careful to make sure that people who come on understand that, yes, these are independent statutory authorities but they are bodies that are wholly owned by the government. They have a single shareholder and they are, therefore, subject to operation within government policy; not dissimilar to a department but at more arm's length. So I would be very surprised if there were too many directors who thought they were entirely like the board of a private company. In some ways it is splitting hairs: are they a wholly owned subsidiary of a single shareholder? Is the department a holding company and they are wholly owned subsidiaries? They are nice similes but they do not necessarily fully get to the issue of what is different about them being public health providers and the understanding of the boards of their responsibilities, vis-a-vis that of the department.

Ms HUPPERT—I think that is taking up a lot. Richard was talking before about council issues. I guess the view that you are putting is that the current governance structure means that the boards and their networks and the hospital staff are more likely to own change and therefore deliver on change.

Ms THORN—We would feel very strongly about that. If it were such a bad system, I am not quite sure why everyone is insisting that the rest of the country adopt it. We are totally addicted to it. We think it works. It just sometimes moves at a slightly slower pace in order to institute change and we also make the trade-off of what you would call 'individuality', so there will be a lot of difference in how health services choose to go about things. What we do not want to see is difference in outcomes and that is probably where we do spend a lot of our time: why is this health service versus that health service having quite a different set of outcomes?

The CHAIR—It goes back to Lance's point.

Ms THORN—So you have a trade-off. You say, 'Would we like everyone to be exactly the same, or would we prefer a model that is much closer to the needs of both the patients and the communities they serve?' That takes into account also the workforce that they are dealing with. So we live with variation and we live with—albeit, impatiently—sometimes a different pace of implementation.

Ms DIVER—It is probably worth mentioning that there is underlying that devolved governance model a very sophisticated relationship management that is occurring and that, whilst health services have their own self-determination and there is variation—and variation actually breeds innovation as well; sometimes the bright ideas come from the difference—there is also a relationship management that is managing performance, that is collaborating on policy and is, in a number of ways, working at various levels in organisations to get the change owned by the organisation. So it feels like it is their idea sometimes and they start owning it. It is not that we sit in 50 Lonsdale Street, develop policy and say, 'Go forth and implement and we'll see you and measure your eight-hour performance at the end of the month.' It is much more that, 'We collaborate with you on policy. We develop some guidelines. We might issue some self-assessment guidelines and then we might come and visit you afterwards to see how did you go on your self-assessment?' and then, 'Now, how can we help you get better?' I think that component of the relationship and the collaborative work between the department and health services is sometimes missing from an understanding that it is not just completely hands-off, long leash, they go forth and do as they wish. I think there is a lot more collaboration and partnership work that is going on.

The CHAIR—We might come back to that later. Robin?

Mr SCOTT—In relation to recommendation 5.2 and the electronic bed management system, if I understood you correctly when you were speaking to your presentation, there are two issues: one is that you have got here:

> Revised evaluation framework currently being developed to determine whether a statewide rollout would enhance performance.

Can you let me know the time lines for that process? You also seem to allude to—apart from the seven where this is being trialled—bed management systems used in other health systems. Could you provide some information on that?

Ms DIVER—When the electronic bed management potential was identified and we looked at the New South Wales model—Royal Melbourne, Austin, Barwon already had their own models—we did a small evaluation at the Centre for Health Evaluation at the Alfred and compared the products; decided that the New South Wales bed board looked like a good option, but what we wanted to do was have it live in use, and compare it with what we have got available at the other health services that have developed local in-house products. So the three health services implemented it and we got very positive feedback from them. Other health services were very keen to implement it, so we have widened it and we have got another four health services on board. Now we are up to the stage of, 'Will we evaluate?' and I would expect that, in the next six months to 12 months, we will be able to give some results on whether we are going to go for one system: is it one-size-fits-all? Do we want individual different systems? What is the biggest opportunity for us?

Mr SCOTT—So that evaluation is a comparative as much as an absolute process.

Ms DIVER—Comparative, yes. Well, it will be both: are electronic bed management systems adding value?

Mr SCOTT—Yes.

Ms DIVER—What is the value that they are adding? What is that worth? Is this the best one? Is it best to have just one or is it okay for everybody to select their own?

Mr SCOTT—Okay.

Mr WALLACE—It is probably worthwhile mentioning that our philosophy on IT systems generally is that you can have core systems—we try to stay connected—but peripheral systems, where it is really internal process systems; there is a reasonable amount of autonomy and decision making. So the way our governance works, you are talking to whole services. We do not mandate unless we think that there is a systems benefit in mandating. So that is part of the normal process that we go through.

The CHAIR—Can I come back to subsidiarity? It is inevitable, isn't it? The Auditor-General clearly has a strong view in regard to the central function that you have and the independent, devolved, subsidiary boards—whichever way you describe it—and it is not just this particular audit where this has been an issue, because we had a big discussion about this when it came down to looking at the nursing homes. It was about the infrastructure.

Ms DIVER—It is a consistent theme across his audit, yes.

The CHAIR—There is a consistent theme. When we did the nursing home follow-up, we did not back the Auditor-General and we did not fully back you. We felt that there were issues and we tried to work our way through them in our report. But having discussed this with the Auditor-General this morning, one of the things we said was, 'Look, is it just a myth or is it a real issue here? Does some more work need to be done on it?' He put a very strong view that, 'Look, if I was a resource manager, I'd want to actually fill this gap.' If there are problems, you should be acting to fill that particular gap, rather than saying, 'I'm floating on the top.' I am not saying you are, but you are not helped probably by some of the statements you make here. 'We're not actually responsible for the implementation of it; we just look at the outcomes' gives the impression that there

is a gap. Is there a mythology there? Is there something which needs to be looked at? Should we be recommending that the State Services Authority, under the coordinating departments, DPC and Treasury and Finance, look at this? There may be some examples in the Department of Health, there may be some other things in other departments, and we do need to look at this in a more cogent sort of way, either to dispel mythologies or to improve the management of the public sector.

Ms THORN—The Auditor-General has a particular view of how he believes that the relationship of a department, acting on behalf of the government, ought to operate with health services, and I can understand the argument he is putting. What I would say is that it is not as simple as that sounds, and the comments Frances made before, which probably we do not put in writing as much as we might and ought to, do talk about a much richer and more sophisticated relationship that underlines the concept of the independence of the hospitals or health services.

On a day-to-day basis, the level of contact between individuals in the department and health services is very high. A day would not go by when Lance, for example, or Frances or any number of people are not in very detailed discussions with individual health services about a whole range of issues relating to performance, or them highlighting in advance problems that they can see emerging or—which is always much more fun—them coming to tell you about the good things that they are doing, and 'Why doesn't everyone else do this too?' So there is a very detailed set of ongoing discussions and interactions between the department at all levels and the health services and, indeed, the board chairs.

It is not hands-off, but neither is it directive, and I think it is best described as a collaboration amongst parties who recognise their different roles. Our role is that of—and I am sorry I ever coined this term, because it has now gone into much broader usage—system manager, looking at how the whole system operates and the performance of the system and how the individual elements of that come together. The actual delivery of the service is a responsibility of the board. In the end, yes, of course we have a shared responsibility for the delivery of the service, and the way we carry out that shared responsibility is in the process of policy development, then programmatic implementation, evaluation and obviously performance monitoring.

This is not something we do once or twice a year; it is something that would be happening on a daily basis with all health services. Then, depending on the matter that is being dealt with, the department or the minister may well issue directions to health service boards, saying, 'I expect these sorts of things to take place.' These then get written into the annual policy guidelines, and we do not necessarily want to weigh you down but we can certainly get you a copy. It is a very thick document, a very detailed document, that gets issued every year that provides a very large amount of detail about what is expected with health service delivery in a board policy, delivery and performance sense, and that is ratified in a formal way through the statement of priorities between the minister and the health service.

The Health Services Act—administrative act—is relatively elderly in terms of an act, so we are looking at that and asking, 'Is that up for a bit of a review?' and, as part of that, of course we will review the government's model. I am not suggesting that we think that there will be a fundamental shift in our idea of what is the right approach to governance, but within that we will look at the relative powers and balance of powers in the relationship. The act gives both myself and the minister final power on a number of things. We would generally regard it as a signal failure—

The CHAIR—To have to use it.

Ms THORN—if I ever exercised my powers of direction. I would regard that as a failure of the relationship, that the kind of rich daily detail had fallen apart, if I ever had to issue a formal direction to a health service. I and my predecessors have always treated that as a reserve power in extreme circumstances. But, as I said, if we do review the act—and just because it is ageing, we will in the next couple of years give it a very thorough review—we will look at it as a governance instrument and look at how we ought to arrange the governance pieces.

In respect of what the Auditor-General says, I do not think it is correct to say that we are hands-off. We do have a strong and collaborative relationship with the health services, and it is that collaborative approach that is—and they themselves would agree with this—very signally part of why they are very eager to cooperate,

and see the value in the relationship and how we manage the relationship. So I think if you asked them directly, they would not describe us as being hands-off at all. They might, indeed, say something quite different.

Mr DALLA-RIVA—'Please get out of our hair'!

Ms THORN—So when we talk to people about it, we may use language that leads people to say we never look at anything, but a health service will tell you that we are looking at things all the time.

The CHAIR—Okay. I think that is very valuable. I do not know, but it might be useful if you actually describe to us in a short paper the relationship.

Ms THORN—Okay.

The CHAIR—This has come up again and again and I think we are going to have to deal with it on a generic basis in this report rather than just in the particular. We had the Auditor-General this morning agreeing that this needs to be looked at in a special way because there is a real problem there. He also went on to say, for example, on evaluation that there is not enough evaluation capacity in health services; evaluation has been done 'up here' and there is not a lot of interaction or sufficient strength 'down here' to determine lessons learnt, and flow on down there, and flow back into your evaluation. What you have got is a reasonably strong evaluation service, as I understand. So there is a gap. Once again, he is describing this as one of those gaps.

Mr WALLACE—I think one of the reasons that this issue is coming up time and time again: when I have talked to the Auditor-General's staff, they understand the model that we run, which is a devolved governance model. You cannot control everybody's detailed inputs if you are holding them accountable for their outcomes.

The CHAIR—He wants you to be responsible for it.

Mr WALLACE—Yes, that is right. The other extreme is a command control where there is just one line of management and I do not think the Auditor-General thinks we should be at that extreme either. We do not think it is at the completely autonomous end of the spectrum, so it is: where are you? Somewhere in the middle between those two things. Where are you on every single topic? Should we double-check that all of the medical equipment has actually been replaced by the manufacturer's use-by date? Should we check every little project they do, and that they have done an evaluation, and that the evaluation is thoroughly done? Should we check all of the details? Where do we start and where do we stop? We believe that we have got a reasonable balance there. If the Auditor-General has specific issues, if he wants to raise a specific topic where he thinks we have not got the balance right, that is easy to deal with, because you are dealing with specifics. But if it is a general topic—'We do not think that you're exercising enough accountability in a general sense'—it is very hard to deal with, because there is a spectrum of issues and it is hard to know how to start to deal with it.

The CHAIR—Wouldn't he come back and say, 'This is a risk management issue,' and throw it right back at you in terms of, 'What are your risk management processes in terms of a performance sort of an evaluation?'

Mr WALLACE—Absolutely. So for something like quality and safety we have got quite a series of checks that we put in place to ensure that people come up to—

Ms HUPPERT—But it is not risk management just in the quality and safety area.

Mr WALLACE—That is right.

The CHAIR—Yes.

Ms HUPPERT—But I am assuming that you have protocols so that, for example, the materiality of what a health service is doing may impact on how regularly you review it. I am assuming that is what you

have got and that there are protocols and guidelines and procedures. I am assuming that they are enormous, but in the flavour of the response that we got, that did not come through. Maybe a paper that is setting out in summary some of those could be done so that we can perhaps hit it on the head in this review.

Mr DALLA-RIVA—Get Dr Brooks to write it. It will be very brief.

Ms HUPPERT—It is an issue, because that is not the flavour that came through in your response to the questions that were asked.

Mr WALLACE—I suppose one of the reasons for that is that six out of the 10 recommendations were made to health services.

Ms HUPPERT—Yes.

Mr WALLACE—So if the Auditor-General recommends that we do X,Y and Z, then when we write back to you we either say we will or we will not, and when the Auditor-General recommends that health services do X,Y and Z, then perhaps our response to you was a bit, 'Yeah. He's not taking full carriage of it, because the recommendations didn't come to us in our devolved system.'

Ms HUPPERT—Maybe then one way of dealing with it is that, 'This is being implemented by the health services and we will be reviewing this in our normal course of business.'

Mr WALLACE—Yes, that is right.

Ms HUPPERT—And maybe that is what is missing from the response.

Mr WALLACE—Yes, we will take that on—

Ms THORN—It was more what I was trying to say—

Ms HUPPERT—It was more that flavour that—

The CHAIR—Yes. We have got your information here, giving us an update on the range of things which have been done here, so we appreciate that.

Ms THORN—We will write a not long but a more full some explanation on the day-to-day relationships—

The CHAIR—You can see what we are getting at, can't you?

Ms THORN—Yes.

Mr SCOTT—I have to say—and this is, again, from an earlier life—I was the treasurer of a community health centre and obviously there is a change in governance now but—

The CHAIR—They are a company.

Mr SCOTT—Yes. I do not think the view of the Auditor-General would have been shared by a board of a community health centre.

Ms THORN—It depends on who you ask and where they sit. Absolutely: you ask any health service and they would have a very different response about the extent to which they have an interaction with the department.

Mr WALLACE—And the requirements and the governance oversight and the evaluation oversight.

Ms THORN—Probably the biggest complaint that government ever gets is of its accountability

requirements, the level of reporting it expects of people. The 'go back to them over what they report', the regime we have in place for those health services that are deemed to be on the edge of bad performance, they would never say that we were hands-off.

Mr WALLACE—No. There was never a complaint that we made—

The CHAIR—Particularly if they are in deficit, I am sure.

Ms THORN—No, it is not just deficit.

Ms HUPPERT—You can see if you have got the outliers when you look at reports for—

The CHAIR—All right. There are real issues here and, of course, probably the Auditor-General is into a bit of risk management as well; indeed, we probably are, in terms of making sure that there is proper accountability and reporting and that there are systems there that make sure things do not go wrong. I do not have any more questions. I think we have covered the main issues. Thank you very much for this document. That concludes consideration of *Managing Acute Patient Flows*. Thank you, Ms Thorn, Mr Wallace, Ms Diver for your attendance today. It has been an interesting session. For any questions taken on notice—and there are some—the committee will follow-up with you in writing at a later date, but I am sure you will start work on it now, and the committee requests that written responses be provided within 30 days. Thank you very much.

Ms THORN—Thank you.

Witnesses withdrew.

Committee adjourned.