V E R I F I E D

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Review of Auditor-General's Audits on:

Biosecurity Incidents: Planning and Risk Management for Livestock Diseases; and

Managing Acute Patient Flows

Melbourne—28 April 2010

Members

Mr R. Dalla-Riva	Mr G. Rich-Phillips
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Mr W. Noonan	Dr W. Sykes
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Witnesses

Mr D. Pearson, Auditor-General,

Mr A. Greaves, Assistant Auditor-General, Performance Audit, and

Mr C. Sheard, Director, Performance Audit, Victorian Auditor-General's Office.

Acting Inspector J. Cole, Victoria Police.

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 audits: *BioSecurity Incidents: Planning and Risk Management for Livestock Diseases* and *Managing Acute Patient Flows*.

On behalf of the committee, I welcome Mr Des Pearson, the Auditor-General of Victoria; Mr Andrew Greaves, assistant Auditor-General, performance audit, Victorian Auditor-General's Office; and Mr Chris Sheard, acting director, performance audit, Victorian Auditor-General's Office. 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 Auditor-General, 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 if 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. In accordance with past practice, the transcripts and any PowerPoint presentations will then be placed on the committee's website.

I will now pass to the Auditor-General 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.

Mr PEARSON—Thank you, Mr Chair. The only opening comment I would like to make is just to clarify that we prepared these reports in November 2008 and at that point we sought to represent the context and in our findings as best we could and make the point that, as is usual, we have not done any further audit work since the tabling of the report, so I think it very much comes down to questions from the committee for further clarification and understanding. I will defer primarily to Mr Greaves on the *BioSecurity Incidents* report, and Mr Sheard on the *Managing Acute Patient Flows* report.

The CHAIR—Thanks very much. Which one do we wish to take first? The *Managing Acute Patient Flows* first? Richard, are you happy with that?

Mr DALLA-RIVA—Yes.

The CHAIR—I just want to say first of all, Auditor-General, that I very much appreciate the response that you provided us on 14 April. I should say that the committee thought this was a very helpful document that you provided, and a very comprehensive one, in terms of giving us some thoughts and directions for undertaking this follow-up audit. So I just want to put that on the record in terms of fair comment, because both these areas are quite complex in their undertaking. One is very much a management issue in terms of managing acute patient flows. The other one is more a strategic sort of arrangement, which of course raises a whole lot of issues in how you deal with that and what sorts of precautionary principles you might use in dealing with that. As I said before, we will start with *Managing Acute Patient Flows*. Richard, do you want to go to questions to start off with?

Mr DALLA-RIVA—Not at this stage, because I was ready to do the other one! But that's all right.

The CHAIR—Wade, do you wish to ask a question?

Mr NOONAN—From your document which you prepared for the committee, which will be useful later this afternoon, you go to recommendations 4.1, 4.2, 4.3, 4.4, 5.1, 5.2 and 6.1 as the most critical recommendations from the report. Just as an opening, I wonder whether you might explain why you considered those more significant and why you afforded them a higher priority.

Mr SHEARD—I just have to recall what all of those recommendations deal with.

Mr NOONAN—You might go to page 3 of the document that you provided the committee, which is the one I am looking at.

Mr SHEARD—Yes, I have got page 3. I am just going to quickly scan the actual recommendations to see what they are about.

Mr PEARSON—While Chris does that, I might just make an observation about my reading of this report. Fortunately, we have a good, reliable system, but when I look at our findings in overview, two points come out. One is that we drew attention to the focus on bed numbers and we made the point that, while that is a measure, there is a lot of scope to provide assurance that existing beds are being optimally used before investing in further beds—that sort of resource management push.

Mr NOONAN—Sure.

Mr PEARSON—And then the second one is that, when I read through the elements, broadly speaking I read that our audit found the elements of the system were there, but there are opportunities to finetune and leverage what was there. If I come back to the findings, in terms of planning for acute inpatient services we made the point that they had data and, as auditors, we would like to see assurance that that was more reliable. We also made the point that they had the base data, with the reservation that the reliability of their own data could be better assured. We also made the point that there is no benchmark data, so they had their data but it was in isolation. They are refinements. I do not know that we saw them as terminally critical type findings; it is an indication that there is a system there but it is in its early phase of development.

The CHAIR—I think benchmarks are quite important. We might come back to it a bit later, but did you want to—

Mr SHEARD—Yes. The quick answer really is that most of those recommendations we have listed as critical are the majority of recommendations in here, and they primarily relate to the actual flow part of the patient journey. We think the majority of those issues around the patient flow are critical. They are the important elements of the patient flow. The getting in, the patient stay and the getting out, which those recommendations broadly relate to, are all critical elements of that.

Mr NOONAN—There is much focus on the bed numbers and, from my reading of the report, it is the utilisation of those beds that becomes the critical issue. On page 14 of the report, under 2.2.2, you cite the United Kingdom as having a system that demonstrates how patient flow can be enhanced by, essentially, the processes that are placed in hospitals. There was not a lot of information about the United Kingdom as a model, but I could not help but notice that you went to it as an example. I wonder whether you might elaborate on that, because that seems to be the flavour of a lot of what you talk about.

Mr SHEARD—Yes, we can get you some more information later about that, if you like. It was more of an illustrative example of a health system—the UK health system—that has done a lot of work. When we did the background research for this audit, they had done a lot of work on patient flow and a lot of research into getting greater efficiency out of their existing beds as opposed to immediately going out and buying the physical beds, as Des was talking about before. So we used them as an example, looking at their extensive research, and there is a website with a lot of information for hospital practitioners who are interested in flow and systems and variation—all of those types of things. Primarily in here it is just illustrating that other jurisdictions, similar jurisdictions, have identified that you can make better use of existing beds before taking the next step and funding more physical beds and the staff that you need to run those beds.

The CHAIR—Just coming back on the benchmarking you talked about before, following what Des has just said, one of the things which interests me is we seem to have a very high utilisation of beds here in Victoria, it is well over 90 per cent. There is somebody in a bed for 355 days out of 365, which - New South Wales, there is only somebody in a bed for 304 days.

Mr SHEARD—That is a patient day, which is slightly different. It is not an actual day. There could be a couple of patient days in an actual day. I have got to remember what the definition of 'patient day' is, but

it could be a half-day. It is the use, so you could have a bed being used twice in the same day and, from memory, that could be two patient days.

The CHAIR—Even so, it is extraordinarily high compared to other jurisdictions. South Australia is the closest.

Mr SHEARD—Yes.

The CHAIR—There are a whole lot of recommendations, but what are the limits to this? There are some people saying that, in order for effective management of hospital beds, it should actually be lower than 90 per cent. I am not arguing. I am just taking in what people are saying and trying to get to a better system.

Mr PEARSON—If I could take a step back and put it in context: there is no denying that in Victoria it is a developed system, but you are at the level of optimising its use, and what the audit has found is that there is a lot of good work being done individually but, at the individual level, there is a lack of assurance that people know reliably how well they are going. They are working conscientiously, there is no denying that, and there is self-belief, but that is where benchmarking comes in. Then the second layer of the recommendations is at the systemic level and here we have an ongoing tension. There are the benefits of subsidiarity and letting the managers manage, but equally there are benefits in looking at the system and identifying the outliers, particularly good practice, and promoting that across others who have not yet thought of it, and poor practice, to target delivery areas that warrant a bit of support and attention to help them learn faster. I know that is very broadbrush, but that is the overlay I see of this report, again using that reference to the British experience, where they have had a large and complex system and, presumably by reason of economic necessity, they have looked very hard at better utilising what they have got. We were pointing to that as a source of inspiration to be applied here.

The CHAIR—I suppose, to put it around another way, what capacity is there in the Victorian hospital system for making improvements?

Mr PEARSON—That is a bit of a catch-22.

The CHAIR—Yes, I know.

Mr PEARSON—It is difficult to give an absolute answer to that until the existing system is reasonably well documented and assured. When you can independently assure that it is, for all practical purposes, as reliable as it is going to get, then you can decide what is the optimum level and what is the trigger for new beds et cetera. At the moment that framework is not as refined as you would like to see as an objective. We have to be careful. There is never going to be perfection.

The CHAIR—No, but it is pretty refined in terms of casemix and case management.

Mr PEARSON—Yes, elements of it are refined, but from what I read, this report is finding now that there is still a way to go. I do not mean that in a critical sense. Casemix is a core element, but you cannot rest on your laurels because that is going well. There are a range of areas—

The CHAIR—No, you have to be careful that you do not implement a system of casemix or systematic management of things which actually concentrates on some aspects rather than necessarily the best possible care. You can have throughput but you do not necessarily achieve quality in terms of results. Do you want to comment any more on the benchmarking?

Mr SHEARD—You raised the point about the 90 per cent occupancy, and you could probably get better clarification from DHS, because this is what they talk about all the time.

The CHAIR—Yes, probably we will.

Mr SHEARD—From memory, the patient days per bed is a different measure to the 90 per cent occupancy rate. On page 15 we talk about the occupancy rate. It can be higher if you have got, as we talk

about here, an eight-hour time limit from the emergency departments. You have a bit of scope to have more people in beds because you have got people waiting longer. If you reduce the time, then you are going to need probably a lower occupancy rate, but then you have got the old economic efficiency argument around having vacant beds sitting there.

The CHAIR—Yes. It also depends how acute they are and how—

Mr SHEARD—There are a whole lot of things they need to consider when they do these things.

The CHAIR—We are not talking about *Yes Minister*, where there was the famous case of the empty hospital. It worked very well! No patients.

Ms HUPPERT—You yourself raised in your remarks a few moments ago the issue of subsidiarity. To the extent that the health department says, 'Well, we provide guidance to the hospitals and we look at outcomes, but what happens in between is for the hospitals' management,' I think we were just looking for some comments on the nature of their response.

Mr PEARSON—I suppose I should declare a potential conflict. As a former resource manager and someone who has worked in accountability, I have definitely seen there being a gap in the middle. My induction as a public servant is that, yes, you establish the guidance and let the managers manage, but then there is an overlay of monitoring. For each convergence, you pat them on the back and further encourage. Where there are gaps, I see an obligation, because it has got an impact on taxpayers' dollars. There is an obligation to notice that at the earliest opportunity and, using a range of methods from advice through to interventions, seek to have it addressed.

Ms HUPPERT—So is this really a question of centralised data collection?

Mr PEARSON—Not necessarily. In today's world you can have dispersed networks—centralised and decentralised access. The important thing is the integrity of the data to start with, and then its active use. That is a challenge we are always going to face, because resources are always going to be limited, but from an accountability and a value-for-money point of view I will always be promoting active oversight and active management. There is a balance in there. You cannot get in the way of people doing the job but, equally, you should be watching it closely enough that you can see trends emerging and draw attention to them at the earliest opportunity, and if you have seen an adverse trend emerge, you have drawn attention to it and it is continuing to escalate, you then need to redouble your efforts to try to address it.

The other thing is—and I throw a challenge back to the committee—I think we have taken and applied sound principles but it is possibly a question, as we go forward in the system, of needing to re-evaluate the application and, under subsidiarity with autonomous hospital boards, okay, they are fully accountable, but as we raised in our report on hospital and health services, we have termed blurred accountability, because you hold the hospital board absolutely accountable, or legally, but your funding models can be argued to be impeding their ability to manage. The purest example is where you give them adequate resources and leave them totally alone, but where you, for instance—

The CHAIR—Determine the adequacy of the resources.

Mr PEARSON—Yes. I have got to be careful what word I use here, but in a sense the nature of capital funding is limited, so there is what some people call drip-feeding. The extent to which your infrastructure is out of date and deficient is going to impact your operations. You need to come back and modify to what extent the board can be held accountable.

Another area that we drew attention to in that report was the number of days of cash hospitals had available—a lot of hospitals with less than a week's worth of cash flow available to them. Eventually that is going to impact their operations. If there is a problem in a hospital related to cash flow, who should be accountable? Is it the board or is it central health? As our system moves forward, they are the sorts of questions that I think we have to revisit and look at in an objective way.

The other dimension I think that needs to be taken into account is that, in talking to a number of board members, they see themselves in many respects as the equivalent of directors of a listed company, whereas maybe they should be seeing themselves as directors of subsidiary companies, proprietary companies, where, while it is still a separate legal entity, it is wholly owned and subject to more direction by the owner.

The CHAIR—Or, now, 'the owners'.

Mr PEARSON—Sorry?

Ms HUPPERT—Now 'the owners'.

The CHAIR—'The owners'.

Mr PEARSON—Sorry, I missed that. But at the moment I do not see us as having thought that through. We have brought in the principles and, at first pass, we have done well, but the system is evolving and I think we now need to revisit those second-level implications.

The CHAIR—Why I talked about the owner there: there are obviously big changes occurring in the hospital sector following the COAG meeting and some of that has to be played out in a federal and state legislative situation and then followed through in terms of what happens. I see you have still got a job.

Mr PEARSON—Yes.

The CHAIR—Though it is generally in respect of Victorian hospitals.

Mr PEARSON—I am sure so, and I draw the parallel with universities. I have lost touch with the funding. I think it may be down to 40 or 60 per cent funding, depending how you look at it.

The CHAIR—Depending which university as well.

Mr PEARSON—It used to be as high as 80 per cent from the Commonwealth.

The CHAIR—For the Catholic University it was over 90 per cent.

Mr PEARSON—That is from the Commonwealth, yet they are created under state legislation. I think those sorts of challenges are going to be around for a long time and that is why it is probably worth the system beginning to look more objectively at disaggregating and thinking through the principles.

The CHAIR—On this issue of subsidiarity, we have got some information from the department to say that it generally monitors outcomes, not the implementation of strategies developed to improve emergency department patient flows. It said it is responsible for the overall system but not for the individual health services.

Mr PEARSON—I think the question for the committee is: who is? If you look at it from a taxpayer's point of view, they want somebody responsible and accountable for the use of their dollars, so it is probably for the committee to determine is there a gap and, if there is a gap, how is it to be filled.

The CHAIR—Do you think that there is a need to further examine and articulate this—not just in this particular context in regard to this report, but overall?

Mr PEARSON—The generic answer is 'yes'. I think it does need it, because we are dealing with large and complex systems, and where gaps occur it becomes very public and generates a lot of heat, and certainly the accountability approach would be to try and prevent that.

The CHAIR—Do you have a suggestion how this work might be carried forward? I guess this committee could do it, but I am not sure that we are well resourced enough to do that. There are a range of views, clearly.

Mr PEARSON—Yes.

The CHAIR—We have come across that in a previous report, in which we partly agreed with the Auditor-General and partly agreed with the then Department of Human Services, in respect to the management of nursing homes.

Mr PEARSON—Yes. I think that is going to be a perennial problem. As the Auditor, I have to come to the point that the ideal outcome would be a firm framework, and I do not think we are at the 'satisfactory' level yet. I say that in the context that it is an evolving and developing system, but we cannot ignore it.

The CHAIR—How can we develop such a framework? What is the suggestion? A working party between the leading agencies—which presumably would be Department of Premier and Cabinet, and Treasury and Finance, as well as any other line agency, and yourselves—or is it something for the SSA to look at?

Mr PEARSON—I suppose from my and my colleagues' point of view, any one of those options. You mention one option is the central agencies and the line agencies and ourselves. I would take the audit independence view that I think auditors should be available for consultation but it is an executive responsibility, so one area is certainly the central agencies in consultation, and that is legitimate because it is a broad framework that is used in a number of portfolio areas in Victoria.

The CHAIR—I was not wishing to put the Auditor-General in an executive position.

Mr PEARSON—No.

The CHAIR—You clearly have experience and views on these matters.

Mr PEARSON—Yes.

The CHAIR—But it is a matter of trying to clarify things which may need clarification, rather than come up with a framework and then the next audit says, 'This is not the right framework.'

Mr PEARSON—This is why I say the audit should be available for consultation, but at the end of the day I would hope and take the view that there is not one framework, it is just that whatever framework is adopted is robust and rigorous. We would not take exception to it.

The CHAIR—Yes.

Mr PEARSON—But it is not for us to say which one should be used. Yes, the options you have talked about. I think there are at least three. It is certainly the sort of thing that the PAEC could have an inquiry into and do a seminal report on. You could recommend central agencies or you could recommend an authority like the SSA. There is a range. It could also be looking at the portfolio departments that have got the best current framework and promote that.

On the financial statement side of things I think the Department of Justice stands out as one of the better agencies, and there is not a legislative requirement, but in practice their CFO or corporate area coordinates across the broader portfolio. I think they should be acknowledged and given credit for the initiative they have taken.

The CHAIR—We have. This committee has in its reports suggested on occasion that the Department of Justice and a couple of other departments, in terms of annual reports, have been good models—deliberately so, in order to try and provide best practice guides insofar as we understand from looking at the annual reports. Most annual reports, of course, get a clean bill of health from the Auditor-General's Office.

Mr PEARSON—The financial statements.

The CHAIR—The financial statements do. But then in terms of looking beyond that, it is often

difficult for us to make strong comparisons without necessarily doing detailed departmental research, which this committee just does not do. It just is not set up to do so. We have not got several hundred staff, even though that might be a good idea.

Mr SCOTT—I note in your material provided to the committee and relating to recommendation 4.1 you suggest that we might want to inquire about taking up initiatives that are designed to manage acute inpatient services and substitutes to inpatient care, such as short-stay observation; medical assessment planning units; medi-hotels; Hospital in the Home; day surgery; 23-hour procedure units; and diverting patients from inpatient care, such as the HARP program, which I am familiar with from a prior life on a community health centre board, which is the bread and butter of that sort of organisation. What sorts of issues do you think we should take up with the department or concern ourselves with regarding those sort of demand management and demand reduction programs that exist outside of the acute setting?

Mr SHEARD—I think the key thing is just following up what they have done. I know that some of those things in the early dot points have been evaluated some time ago. The HARP one might have been done several years ago. I think where this was coming from was that evaluation is not a strong point of either the Department of Health or hospitals. How they evaluate these programs is that they do them and they get some results, but they do not check in detail what the results mean, and probably out of this the critical one is the Redesigning Hospital Care Program.

That is a new program that they have developed that really has a focus on patient flow and greater efficiency within hospital systems. So if you were going to ask some questions, I would probably be focusing more on that and what they have been doing and whether there are results coming out of that, and just talk generally about the other dot points. That is their sort of latest initiative; it was at the time when we did this audit. They had just set up a little team for Redesigning Hospital Care and were looking at similar things to this audit. So you could focus on that and see where they are up to because, as Des said earlier, we have not done anything since then. We do not know what the status of that is.

Mr PEARSON—Maybe it is the resource manager in me, more than the auditor, but if you do follow those ones up, it could be in terms of specifics. If they have done something, what are the milestones? What are the time lines? What is their estimate of the intended benefits? Then sometime in the future you have got a basis to assess how well the initiative has worked. Because you do not achieve the intended benefits, that should not per se be a negative, but it should be a key ingredient to a learning and refinement. We are working with large, complex systems, and they are not one of many, so it is important we stay actively engaged and keep thinking because, whatever your intentions at one point in time, it is probably better for you to consciously say, 'I've learnt a bit since then and I want to consciously recalibrate.'

The CHAIR—Chris, what is your understanding of the evaluation framework within the Department of Health in this regard, which is what the Auditor-General is obviously touching on, and its capacity?

Mr SHEARD—I understand they have an evaluation unit and they are probably better at evaluating in the health systems. I know they do evaluate things. One of our consistent findings over many audits in the hospital systems has been the hospitals' lack of evaluation. They get funded and they implement a lot of these programs, but a consistent finding over at least three audits is that they do not have strong evaluation. They cannot assure themselves that these programs are actually working. DOH could possibly instil some of that stronger evaluation practice in the health services.

The CHAIR—So that comes back to your initial comments.

Mr PEARSON—Yes. We have got to recognise in the public sector more generally—and health is probably one of the more pressing areas—resources are limited, so the natural tendency is probably always going to be to meet the obvious immediate need, but we need to balance, weigh, temper that with, in a sense, not running down the capital too much. You do need to pick the right things to evaluate and to learn from. It is a balance. And I am into speculation here, but Chris said health central has an evaluation unit but not so much in the hospitals, and it should be an issue in terms of that evaluation unit. It clearly will never have enough resources to do all the evaluations it would like to do, so one test would be: are they doing the highest priority ones or the ones with the biggest return? The other one might be: if there is a void in the hospitals, is there a

category of their evaluations that are like templates or frameworks that could be readily applied by the hospitals to leverage that? It is thinking organisationally.

The CHAIR—So the central evaluation unit providing guidance and templates, or providing a reasonable framework?

Mr PEARSON—Yes.

The CHAIR—These things all cost money of course, as we know, and often in an organisation, when you do a restructure, the first thing to go is the evaluation unit.

Mr PEARSON—It is a sad indictment on budgeting in the public sector.

The CHAIR—We have all headed an evaluation unit in the public sector—'Oops, I lost my job.'

Mr PEARSON—It is usually training, evaluation—all those investment activities.

The CHAIR—Yes.

Mr DALLA-RIVA—I might expand on that. On the pushing and pulling of patients, pushing patients into wards then pulling patients from the emergency department, I note that your report is November 2008 and you reference the Redesigning Hospital Care Program. That had actually been in place since July 2008. One of your recommendations, 4.2, is about the greater use of interim orders and pulling of patients from the emergency department, and that seems to be where the issue then fell into stopping elective surgery and then the backlog in the emergency department, and one of the words you used was 'culture', on page 4:

> To improve the 'pulling' culture within wards ...

'Culture' often means a management issue rather than financial or anything else. It is a longwinded question, but the point I am trying to get to is: in your audit did you reference back to the July 2008 document and then say that, based on what you are finding on the audit and on the documents that have been provided, the document perhaps is not going to be satisfactory to the outcomes that are necessary as part of our recommendation 4.2?

Mr PEARSON—I think Chris will have more detail, but the issue of that policy in July, it would have been during the course of the audit, so there would have been limited opportunity.

Mr SHEARD—It was actually at the very end of the conduct that it came out.

Mr DALLA-RIVA—Was it created as a result of your audit?

Mr PEARSON—We would like others to—

Mr DALLA-RIVA—You would like to claim it is?

Mr PEARSON—Yes.

Mr SHEARD—You will have to check that with Health; I am not sure about that. I think they have work ongoing. I think they have recognised the need to improve things. It might have been coincidence. I cannot recall, so perhaps check with them, but I know that it did come out—

Mr PEARSON—It came out in July.

Mr SHEARD—Yes, it might have actually finished. We would have provided the report by then.

Mr DALLA-RIVA—Were you interested in their response on page 6? They said 'accepted in principle', 'will consider'. I consider a lot of things in life, I guess, but—

Mr SHEARD—I think those recommendations were all accepted in principle, weren't they?

Mr DALLA-RIVA—But they say they consider this recommendation in the context of the Redesigning Hospital Care Program.

Mr SHEARD—Yes. So I guess what they are saying is that they have just released this policy at that time and, 'Yes, that is a valid point you've raised, and we'll consider that as we progress with the work sitting under that program.' Speaking for them, I am assuming that is where they are coming from.

Mr PEARSON—I see that as an area the committee could pursue: how did the policy line up with our audit findings, how they reconcile the differences, and then what are the specifics of the action and the time lines they set.

Mr SHEARD—And this is the program I mentioned before, the one to follow up, because that is the most recent one they have released, and it is related to this—

Mr DALLA-RIVA—Yes. How did you get to the word 'culture'? As I said, to me 'culture' indicates more of a—

Mr SHEARD—Yes. What we meant by that was the hospital/staff culture, so the pushing and pulling thing. In the emergency department they tend to have a culture of being constantly busy and trying to get people out of the emergency department into beds, where it is most appropriate. What we found is that in the wards the culture is quite different. They were more—I am trying to find the right word.

Mr DALLA-RIVA—Nurturing?

Mr PEARSON—Reserved.

Mr SHEARD—More reserved perhaps—less frantic about what they do. They would discharge a patient, they would get the bed ready, they would go through the normal things, and they were not actively looking at the emergency department and thinking, 'How many patients are in there that are appropriate for this ward?' or 'this bed? Let's go and get those patients. Let's take them out of the emergency department.' It was all the pushing: the emergency department trying to find the beds within the hospitals to get the patients out.

Mr DALLA-RIVA—But who was that? Was it the administration? Was it the doctors? Was it the nurses?

Mr SHEARD—The nursing staff primarily. The doctors will approve a discharge and the nurses will probably discharge them. They will get everything ready, make their bed ready for the next patient, and—without demeaning the work they do; they certainly are professional in what they do—they do not have that same urgent emphasis that the emergency department has. They are not actively trying to get people into beds as actively as the emergency department is trying to get them out of the emergency department. That lack of urgency is cultural, basically, across all the hospitals.

The CHAIR—What evidence did you have for that?

Mr SHEARD—Off the top of my head, I cannot recall. It was some time ago. We did a lot of staff interviews.

Mr PEARSON—We have got some dot points in the middle of page 39, where we sought to cover it. The second dot, in the middle of the page:

> • ward staff prioritised meeting the needs of patients already on their wards and did not feel ‘ownership’ of patients waiting in the emergency department

And the compounding issue is:

- wards were often not confident of their capacity to take new admissions until late morning when ward rounds were complete

So it is the natural uncertainties and the local environment we are drawing attention to. I see primarily that is a management responsibility to broker.

The CHAIR—To provide more flexibility in the pattern of the management.

Mr PEARSON—Yes.

Ms HUPPERT—Clearly, with the policy framework coming from the department about how that can be better managed, then that brings us back to the earlier issue of how that policy is implemented and evaluated.

Mr PEARSON—Yes. Again it comes down to management information, and there is hard information and there is soft information, which really needs to be worked.

The CHAIR—You make a range of comments on discharges and say this is something to focus on. Do you want to talk a bit more about its importance as an area for making improvements and its impact in terms of managing beds?

Mr SHEARD—Sure. We make a point in the report that probably the most critical part of the patients' journey is getting them out. If the beds are blocked, then there are blocks throughout the systems. People in the emergency department will not get a bed because the people have not been discharged. We found a lot of practices—and these are practices that have been known for quite some time, since the major reviews around 2000, I think it was, about discharge practices—and there are a couple of figures in the report. Most of the hospitals had policies around discharge to get them out early in the morning because that is when most elective surgery comes in—they are booked in early—and also the peak in emergency presentations is around 10, 11 o'clock in the morning, so if you can clear the beds by then you are going to get better flowthrough in patients getting beds. What we found there was that most of the hospitals had much later discharge, for a variety of reasons. I think the peaks were after midday—12 to two o'clock—in most of the hospitals. So you have already got all these patients coming in and waiting for beds, but they are not actually discharging patients. And weekend discharge as well: we make the point in the report that a lot of the conditions that patients have should not prevent them from being discharged on weekends, but the hospitals do not work 24/7. Hospitals work, in essence, nine to five, Monday to Friday.

Ms HUPPERT—That is maybe more an issue of the consultants coming around and reviewing them.

Mr SHEARD—Yes, that is part of it as well, and having people working on the weekends to actually discharge these patients.

Ms HUPPERT—The comment made about when ward rounds are I think is a valid point.

Mr SHEARD—Yes.

Mr PEARSON—Just like judges working in January.

Ms HUPPERT—That is right.

Mr PEARSON—You optimise the resources.

Ms HUPPERT—It is optimising resources, because from personal experience we all know that, once the ward round has been done and you have been given the okay, you can go, but if the ward rounds are at 10 o'clock in the morning, not at nine o'clock in the morning, that will impact when you can be discharged.

The CHAIR—What I am looking at is: is this an area we should be, in terms of priority, questioning

for the department, to see how they have been implementing some of the recommendations, particularly on your section on discharges?

Mr SHEARD—I think so. If you look at what the Department of Health does, they have a really big focus on getting in, so they have got a lot of work around elective surgery and emergency departments and access indicators and how you get in and get in quickly, but there is less emphasis on the journey in the middle—how you actually get through the hospital—and there is, again, less emphasis on actually getting out. Perhaps there should be as great an emphasis on getting out as there is on getting in.

Mr PEARSON—If I could draw us back to the last three paras on page 59 of the report, there is an area that the committee might like to explore, because again it is this crossover area. The third-last para says:

> Each of the hospitals reviewed recognised this need, with discharge planning policies identifying 10–00 a.m. as the time by which hospitals should discharge inpatients.

Then if you jump to the last para, the first line is:

> Across the state only 16.8 per cent of patients were discharged before 10–00 a.m.

This, to me, brings back this issue, and I contend it can be done without impeding individual operations. It is a systemic issue and the system is entitled to—

The CHAIR—Even if the department monitors outcome. This is an outcome to monitor even if it is not monitoring strategy.

Mr PEARSON—Yes, and even if the outcome of the monitoring is to provide reasons to say, 'Ten a.m. is an unrealistic objective. Modify it.'

The CHAIR—It would have to ask the question, wouldn't it?

Mr PEARSON—Yes. But from the audit point of view we are drawing attention to the fact that there is policy saying one thing—and you would hope that, if you had a policy like that, maybe 50 per cent or more of the time it would be good, but less than 20 per cent certainly indicates it needs attention, and again from an audit perspective I would make the point that this is where work needs to be done. My fear is that at the moment there is probably a void between central oversight and individual hospital or health service operation. For the benefit of the taxpayer and society, that needs to be bridged. It is not for me to say what the answer is, but it certainly needs to be explored.

The CHAIR—My reading was that discharge was an area to follow up in particular. So you are obviously agreeing that this is something which offers—

Mr SHEARD—Yes, absolutely.

The CHAIR—We are looking at scope here. The Victorian system is, on the figures, highly utilised, so it is a matter of trying to improve that utilisation.

Mr PEARSON—But again, if I can just take us back to that, on my reading—and I might be a year out of date—of the Productivity Commission *Report on government services*, I would agree with you on a couple: to me, Victoria performed very well in utilisation. If you say shortness of length of stay is a positive, we were shortest. But again it goes to another report we did, which was adverse events, and in that one, if I recall correctly, Victoria was one of the highest on adverse events.

The CHAIR—That is because Victoria reports them.

Mr PEARSON—You can argue that, or you can argue that maybe we are pushing some people out too soon. All I am raising is that, when you get that sort of anomalous statistic, it bears investigation to work it out. Maybe that is legitimate: that other states are not reporting. But, equally, in that audit we were the only state that did not have a central record.

The CHAIR—Sure. To be fair, I do not have evidence in that regard, but I do know that we have brought in systems of reporting as a way of looking at adverse events, particularly deaths from operations and that sort of thing, in order to actually improve the evaluation and then the service delivery further on, which is entirely appropriate. It is good, sound practice.

Mr PEARSON—Yes. My reading of it is that all states have got the reporting, but Victoria was a notable exception in not having a central accumulation of the reporting.

Mr SHEARD—Yes, Victoria does the sentinel event reporting, which is the most significant adverse events, but they did not have that broader 'other'—the majority of the events recorded—centralised or analysed.

The CHAIR—All right. Other thoughts?

Mr NOONAN—Just on the discharge, you made the comment about the creation of a criteria led process. Was it the view that that would still require, potentially, the involvement of a senior medical professional within the health system or the hospital? That seems to be one of the problems: that junior staff within the health network are reluctant to discharge and there is a high degree of difficulty in having access to the appropriately qualified people to do that. So is it the view that you could create a criteria led discharge process but, essentially, you would still have to come back to the same people? Was that essentially what you found in your audit?

Mr SHEARD—My understanding of the intent of the criteria led discharge—and it would be particularly useful on weekend discharges where there are fewer staff around—is that they develop agreed criteria for discharging, and then I think senior nurses, for example, could discharge someone. They can assess the patient against these agreed criteria and, if the patient meets them, they are well enough to go. So then it is not reliant on the senior consultants or the registrars to discharge those patients. The nurse unit managers or the senior nurses could say, 'Yeah, you meet those criteria that we've agreed beforehand. You're good enough to go,' and discharge them when the senior medical staff are not there.

Mr NOONAN—Is that view based on what you saw as part of that audit process or suggested as part of the audit process?

Mr SHEARD—From memory, the criteria led discharges are not unique. It is not something that we are suggesting is uniquely done. They are done elsewhere; it happens. It is just that Victoria has not really got onto this and, again from memory, I think criteria led discharges may have been highlighted as an option way back in 2000 when they did the big reviews. So it is something that has been around. They are in use in some parts of the system to varying degrees, but it is not universally used across the system, where it could be.

Mr NOONAN—In relation to the audit and the method that was used, obviously the issue here was to look at the efficiency and the effectiveness of hospital processes, but you do touch on the funding for inpatients at 2.5 and you make a point under 2.5.2 about the case funding and how that encourages efficiency by providing incentives for hospitals and the like. Obviously it was not a focus, but you have touched on it. I wonder whether you might provide a few comments about the funding models that exist—and go to activity targets and casemix funding specifically; but the funding model that exists and its impact on the health systems in terms of managing efficiency and effective processes in order to move people through the health systems effectively.

Mr SHEARD—We have put it in the background section. We did not actually go and examine it in detail. We just wanted to note that there is a funding system and also that it is, in essence, an efficiency based funding system; it encourages hospitals to move patients through the system a lot quicker. It is a very complex system. My recollection and my basic description, as is outlined in here, is that each illness has a cost associated with it and it is based on number of days. In essence, if you can move patients through the system at the lower end of those days, the less cost the hospital will incur, but the payment is the same. The quicker you move them through, the more money the hospital makes, in essence. In that respect, it should encourage hospitals to be more efficient in the way they move patients through.

Mr NOONAN—So it is a weighting. I understand it is complex to look at the way it is funded. I notice you give two examples—a liver transplant and an eye procedure—and I am just trying to understand what weighting the funding models actually have on efficiency processes within the hospitals or health systems that you had a look at in relation to this audit.

Mr SHEARD—You are going to questions that I probably cannot answer. They are questions for DHS. They could probably speak to you for hours about WIES and casemix funding and how it works, but again this is really just a bit of a desktop research to highlight that there is funding, and this is the funding model, to put in some context for the reader how it works.

Mr NOONAN—There are other influences. That is essentially what you are saying?

Mr SHEARD—That is right, yes.

Mr NOONAN—Okay, because I did notice that you talked at 2.3.2 about variation, which you highlight as a significant cause of bottlenecks, and you talk about how there might be great variation between health services in terms of how essentially the same procedure might be handled.

Mr SHEARD—Yes.

Mr NOONAN—And again I notice the context of the funding model. When you talk about variations causing bottlenecks, I am trying to understand why those variations can be so significant.

Mr SHEARD—There could be multiple reasons. One of those reasons could just be the hospital practices. They all have the same incentive, in essence, to get the patients through because of the way the funding model is set up, but some hospitals' practices may be such that they are quite inefficient. The same patient will go through a lot slower in one hospital maybe because their discharge is really late and they are at the later end of the day. For the reasons we have outlined in here, that could be the case. Other hospitals could be far better at doing these things. Reducing the artificial variation is what we talk about. There is natural variation, which is that each patient is different—gender, that type of thing—and then artificial variation, which is the variation that the hospitals themselves create through their poor processes and bottlenecks and making people wait longer for access to imaging, and things like that that just slow the whole process.

Mr PEARSON—That is another area where the interplay between the centre's oversight—the helicopter view—and the individual hospital is important. The individual hospital might, understandably, not be aware of the variation, but that is where it is important for the centre to notice the significant variation and ask the question.

Mr NOONAN—And ultimately seek to improve the efficiency in the future.

Mr PEARSON—Yes.

Mr NOONAN—All processes around delivery.

Mr PEARSON—I have not got a basis to speculate, but there could be one hospital or health service that has got a notable variation, you ask the question, and it might be explained or it could be a prompt for them to change their practice.

Mr NOONAN—Is there an overarching question we should be putting to the department about some of the issues that we have just spoken about in relation to funding and variation that might be useful in actually understanding this?

Mr SHEARD—The variation aspect is certainly something that could be addressed through questions around the Redesigning Hospital Care project. Variation is a known issue; it has been known for a long time. Again, this is something the NHS has done a lot of work on in removing the artificial variation from processes, so one would hope that through the Redesigning Hospital Care Program they are looking at

variation and ways to get hospitals to remove those types of things.

Mr NOONAN—And what are the significant categories of variation they should focus on? Have they identified those?

Mr SHEARD—Yes, and I think they are known. There are known points where process variation happens, and access to imaging and X-ray and pathology is a common one.

Mr NOONAN—You talk about 'schedule admissions', 'time ward rounds' and 'discharge processes' as three areas under 2.3.2 in the report.

Mr SHEARD—Yes. The variation happens throughout the whole system.

Mr NOONAN—But essentially they are the three items. The chair has just identified on page 18 seven dot points, as well, which have a focus on variations, which you have highlighted.

The CHAIR—Can we move on to epizootics, which I am sure the Auditor-General has some experience with from his previous resource management days.

Mr PEARSON—A long time ago.

The CHAIR—It is like me, with my Food and Agriculture Organisation days, representing Australia in sessions discussing biosecurity and the different kinds of diseases at that time. Richard, do you want to ask a few questions on that?

Mr DALLA-RIVA—I will. On page 32, you say in 4.2.7 in the second para:

> ... the various parts of DPI ... do not see themselves as an integrated whole with a common purpose ... barriers exist between different professional groups and across the different parts of the organisation.

What led you to that conclusion and what effect could a fragmented DPI have on the implementation of the biosecurity measures in Victoria?

Mr GREAVES—In terms of the evidence that led us to that conclusion, a lot of the evidence we gather is based on our conversations with the different areas within DPI itself, and also our discussions with stakeholders who interact with DPI, and so those concerns were expressed internally and externally. But also what leads you to that conclusion: if you look at the organisational structure of DPI, you will see that Biosecurity Victoria is separate from the other divisional unit, Farm Services Victoria. So there were some structural issues about the centre and the policy versus the actual delivery of services on the ground, and throughout the report we talk about the SLAs—the service level agreements—between Farm Services Victoria and the service delivery model versus the central Biosecurity Victoria kind of policy and planning framework. When you have one group doing the policy and planning and another group doing the service delivery on the ground, you want to make sure that the people on the ground understand exactly what your policy intent is, and are executing that policy intent.

So they were the issues that we identified in this particular section of the report, and then throughout the report you will see we refer to it on a number of occasions, even to the point, in the last chapter, where we talk about data entry and field services staff not necessarily correctly entering data into the support systems they use to manage biosecurity. If you look at the department's response to that recommendation, they have basically acknowledged that is an area of concern and they have indicated that they are addressing that. They have not been very specific in their response as to how they are addressing it, but they do say that they are addressing it, so it is something you could take up with the department as to what they have done since then to bring their service delivery area closer to their central policy and planning area in terms of coordination and understanding.

Mr DALLA-RIVA—The report is dated November 2008. On my understanding, there were some 70 job cuts from the Future Farming Strategy in the same year. Did that have any impact on—

Mr GREAVES—I cannot answer that in terms of the Future Farming Strategy. We did not examine job cuts in that area as a part of this review.

Mr DALLA-RIVA—But the issue is about the resources and I was just wondering about whether that—

Mr GREAVES—Yes, but the issue was not so much about the quantum of resources but the integration of the resources to the coordination and the consistency of understanding per se. There were some resource issues when we talked about their response to EADs and their ability to cope with the two cases we modelled here, the AI and the equine influenza, and their capacity and capability to respond, but you will see that their response in the report was to then further train other people in the department to be able to cope with that in the future.

The CHAIR—So this would be particularly important, presumably, in any simulation exercises.

Mr GREAVES—Yes.

The CHAIR—Which is something which you commented on.

Mr GREAVES—And then the other comment there, to lead on from that, was the evaluation of the simulation exercises. They did not necessarily have a strong evaluation framework, so it would be good, as a part of that, to be capturing what the field staff are doing and how they have interpreted it.

Ms HUPPERT—But really in recommendation 4.1 you talk about a closer working relationship between the different—

Mr GREAVES—That is right. So you have got Biosecurity Victoria and then you have got Farm Services and the regional staff, and it is trying to get, as we say, closer working relationships.

Ms HUPPERT—And your comment on the department's response there? I mean, the departments all talk about work that they have got in progress. Do you have any comments?

Mr GREAVES—It is difficult for us to comment on what has happened since because, as the Auditor-General said in his opening comments, once we table the report we do not then follow through. All we can do is, as you do, go on the public information they have provided in the minister for finance's response, and our interest in that response is not so much whether or not it is accurate—that is up to the department and you can obviously ask them—but whether or not we think that their response has addressed the recommendation.

The CHAIR—So whether it is sufficiently comprehensive and has been done in a timely way.

Mr DALLA-RIVA—Exactly.

Mr GREAVES—And the general response in the report did not really specifically address the recommendations.

Ms HUPPERT—No, it just said 'generally' there.

Mr GREAVES—Exactly. So we were then interested in the specific responses in the minister for finance's report. But, as I said, that is something you could take up with the department.

The CHAIR—'Actively engaged in a series of discussions'.

Mr GREAVES—Yes, whatever that may mean.

The CHAIR—Can I ask a general question. In the area of biosecurity we are talking about, obviously

value for money is an important concept, but in many ways the biosecurity is setting up almost a precautionary system, and then you come to the issue of how much do you invest in this and what is a reasonable investment in terms of strategy, and of course there is the further issue of how well the strategy is put together. There is some big money in this. I noticed the response to the equine influenza cost Victoria $110 million or $120 million, whereas if we actually had an outbreak in Victoria it would have cost two or three times that.

Mr GREAVES—Correct.

The CHAIR—In doing the audit, did you get a sense of what is the right balance in terms of investment? You were suggesting a range of things and the department did come back and say, 'Yes, we need some more resources and we'll put a bid up,' but is this meant to be $20 million, $50 million, $300 million over five years?

Mr GREAVES—Chair, we did not go to that last point about what the quantum may be, but to answer your question about value for money—and it might not be evident in the report—Biosecurity Victoria championed the risk management approach in DPI, and that is certainly a flavour of this report, that the strongest element of the management of this within DPI would be its risk management approach—a very strong, formalised approach that is consistent with the Australia/New Zealand Standard 4360. It led a lot of the decisions they have made and a lot of the resourcing.

Under the risk management approach—the point you make—you have got some risks that have high likelihood but low impact, you have also got some risks that have a very high impact but a very low likelihood; therefore, you need to balance your risk management strategy. The more recent research in the Beale report and the later Biosecurity Strategy recognises that you cannot ever prevent things from happening altogether, so what you have to do is take a reasonable approach to either reducing the likelihood of the risk in the first place or responding quickly, depending on the nature of the incursion. So I think our report highlights that their approach there was very good, very strong, very rigorous. We highlight in the report that we saw areas for improvement in the integration of the risk management, which had been done well, back into their planning processes.

The CHAIR—Closing the evaluation gap until the lesson is learnt.

Mr GREAVES—Absolutely. And even the linkages between their corporate plans and their business plans for each group and the risk management exercise. A lot of organisations do risk management separate from planning, but in the ideal world you bring together your risk management as a part of your planning and, as you say, it then becomes a feedback into your evaluation processes and you start all over again in terms of planning. So that was the area that we recommended they focus on, particularly in that first part of the report, because the other part of their risk evaluation—and there was evidence within the department that they had been looking at issues of longer term risks or longer term impacts of things like climate change, change in demographics, the peri-urban farms that are springing up on the urban boundaries and—

The CHAIR—Or even coalmines in prime horse territory.

Mr GREAVES—Right. So as a part of their risk approach they were starting to identify and look at these issues, but their planning horizons, in a corporate sense or in a business sense, were not aligned with those longer term risks.

Mr NOONAN—Reading this, you could be a bit confused. You obviously make the point that DPI have got clear and relevant objectives and a coherent planning framework, and then in 3.2.4 on page 23 you do talk about the longer term planning focus.

Mr GREAVES—That is right.

Mr NOONAN—But you also talk about the unpredictability and difficulty associated with longer term planning. You talked about climate change and urban movement and some things that we already understand. The things that arise seem to be largely unpredictable. I have little understanding about

biosecurity issues, living in Williamstown. You do mention in this report that they are looking at this issue over a longer term—this is Biosecurity Strategy for Victoria. What are the sorts of things that we should be trying to understand more clearly as a committee when we talk to DPI about the longer term strategy and whether it accords with what might be happening on a national level in this area?

Mr GREAVES—You are right: we make a general point about complexity and the difficulty of long-term forecasting and we talk about some other models, or we talk about scenario based modelling.

Mr NOONAN—That is right.

Mr GREAVES—And there are other models in other industries—transport industries, for example—where they look at longer term scenario forecasting. Having accepted that there is a lot of inherent uncertainty and it is a difficult thing, it is also to some extent predictable for changing land use patterns and shifting in primary production. There might already be some patterns and trends emerging which will tell you that maybe the focus on ruminants or particular types of animals and particular vectors for diseases will be changing as climate change—if and/or as it becomes a reality—hits home. So they would be doing work around those scenarios and they would be thinking in their risk management plans, 'What does this mean?' in terms of the likelihood, in terms of the risk, of a disease coming into Australia, or occurring within Australia if it is endemic. So we are simply saying, 'Given that you're already doing work on this, understanding that it's not an exact science, when you're looking for your planning, think about your long-term plans. Think about the resources you may need 10, 20 years out and what you need to do now to prepare for that.'

Mr NOONAN—So in saying that they have a coherent framework for planning currently, are you suggesting that that is only on the basis of dealing with something that happens in the short term?

Mr GREAVES—It is the short term. When we say 'a coherent framework', we look at the top-down strategic planning: have you got yourself a strategic plan that is aligned with the government—GVT, for example? Do your strategic plans cascade down to a business plan? Is there a clear alignment there? Are the strategies well articulated? So we are talking about a framework for doing planning, and all those elements were there. The elements that were missing, as we said, were a tighter fit between the risk management and the planning and some consideration of the longer term planning horizons.

Mr NOONAN—Taking it to a national level, are you satisfied through your audit that Biosecurity Victoria is working well at a national level? Obviously, when these things come into the country they do not respect the borders that we have, but can you give us an indication. Can you also go to the issue of the longer term planning and how you see Victoria within the national biosecurity area.

Mr GREAVES—At the time of the audit, the evidence we had was that Victoria was working well nationally. Obviously it has some accountability and responsibility back to Animal Health Australia, and has some reporting requirements, and it was discharging those appropriately. It was being involved in national exercises. In fact, it was leading the National Livestock Identification System. So all those were evidence to us that they were working well and cooperatively nationally.

I cannot really comment on what has happened since. Obviously we made some recommendations around the AusBIOSEC, which has now been replaced with an intergovernmental agreement. My understanding is that that is a draft agreement, but I am sure the department will be able to update you on the status of that new agreement, and the higher national agreement, which I understand they are still negotiating. So I really cannot comment about what may or may not come out of that agreement in terms of the longer term. While we are aware that they have introduced a new biosecurity strategy, we have not really looked at that since the audit.

The CHAIR—No. We can get an update following the Beale review et cetera.

Mr GREAVES—Yes. A lot of their responses to this audit, from my reading, are encapsulated within the new Biosecurity Strategy for Victoria; therefore, it would be worthwhile the committee pursuing what that has got in it and what they are doing, and how what they are doing relates to the findings we have got in this audit.

The CHAIR—We can also ask how they read the response. There is also the Intergovernmental Agreement for Emergency Responses to Nationally Significant Biosecurity Incidents.

Mr GREAVES—Yes.

The CHAIR—Which is slightly different to risk management across the board, in the way you were talking before about it.

Mr GREAVES—It is. It is the subset. It is the immediate response.

The CHAIR—Yes.

Mr GREAVES—But, as I said, my understanding—and I am happy to be proved incorrect by the department—is that that is still a draft agreement at this stage.

The CHAIR—Right. So it is a subset. We probably need more.

Mr DALLA-RIVA—There are a number of recommendations that you have made, as outlined in the executive summary. Other reports that you have done go off and the department responds back specific to each recommendation. How do you reconcile the numerous detailed recommendations with the waffle that has come back from the department that really says nothing? Were you disappointed in the extent to which it was really more about spin and rhetoric than it was about actually dealing with the specific recommendations? There is nothing in the response—other than waffle—that you could actually hang your hat on to say, 'Yes, the department are going to deal with recommendation 3.2,' for example. I pluck that out of the air. Do you feel confident that there are going to be addresses made by the department, given the response?

The CHAIR—Just before you answer, I think that there are really two responses.

Mr DALLA-RIVA—I have asked the question, Chair.

The CHAIR—No, I am just clarifying.

Mr DALLA-RIVA—If the government want to put the spin line on, that is fine, but if you go through the other reports, there are specific recommendations. You cannot hold hand on heart and say that they have addressed their responses—

The CHAIR—I am just providing a clarification for the committee and I am doing it as the committee chair. There were actually two responses from the department and from the government. One is the one you are describing in the audit report itself. The second one is the response from the minister for finance. We probably need to look at both of those in the context of the question which has been asked by Mr Dalla-Riva.

Mr GREAVES—I think the general response to that question is that we have no control or influence directly over the response by any department to our reports. There is nothing in the act that mandates that they must respond line by line to each recommendation and, as we note clearly in our later reports, more recently the practice is that we highlight that it is totally in the agency's control, what they put in their response is totally up to them and we have very little influence over that.

Where we do not get a specific response, then the question is: what do we do about that? Well, it is not really for us as auditors. We have identified the issue and we have made the recommendations. It is over to government and the parliament to then follow through. In my introductory comments I referred to the general response, and then I made a comment that that is why we were also interested in the detailed responses we then got in the minister for finance's report, to understand better what they were proposing to do, and we look at that as a part of our ongoing planning process to determine whether or not we need to do future audits in this area.

Mr NOONAN—Plus it is an area we are looking at in our Audit Act inquiry.

The CHAIR—So, Richard, the letter from the Auditor-General—you included the sections from the—I did not bring a copy of the minister for finance's report with me.

Mr DALLA-RIVA—That is correct.

The CHAIR—But you had it fully in your letter anyway, which you will find is a far more direct and specific sort of commentary in response to the recommendations.

Mr DALLA-RIVA—Yes. I did read it.

The CHAIR—But you have also added to that a number of questions which we could follow up with the department, which, as I mentioned right at the beginning, the committee thought was really quite valuable.

Mr DALLA-RIVA—Page 49 of the report, 5.3.3, is about capacity and capability, which is one of your recommendations which has got no real response from DPI. The first line says:

> The major issue identified in the EI outbreak was that resources were considerably stretched.

I am interested in the words 'stretched resources'. Has this situation of stretched resources resulted from the government's closure of five depots and the cuts to around 70 jobs from the DPI in 2008 as part of its Future Farming Strategy?

Mr GREAVES—Chair, I cannot answer the specific question about the cuts, and I referred to that earlier. The audit did not look specifically at the Future Farming Strategy or the cuts. The context of that comment in relation to this was that EI was actually more of a national issue, and the normal strategy for the department, which we talk about in the report, is to, if needed, supplement resources from interstate, and there are some interstate agreements whereby we can share resources.

In this case, because it affected New South Wales and Queensland, those interstate resources were not available, and figure 5C runs through the issues that they had. The question for management is: what kind of contingent resource capability do you maintain for events of this nature, which you would expect would have a very low probability of occurring? The audit identifies that they in fact identified themselves that, because of the particular circumstances of this incident, their resources were stretched, so then they took some action to work out how they could get some contingent resources without actually growing their resource base, and they talk about how they are training 40 DPI staff in non-animal health to assist in these kinds of situations in the future.

Mr DALLA-RIVA—But obviously the cuts were an issue, because you must be aware of it during the audit process. That must have been brought up by somebody within the department—by staff or whatever.

Mr GREAVES—I am not going to speculate.

The CHAIR—It was not specifically addressed.

Mr DALLA-RIVA—No, but it must have been brought up. Somebody within the department must have said, 'Hey, we've had 70 people removed and five depots closed.' Given that you are talking about resources, given that you are talking about capacity and capability, given that you made a recommendation specific to those issues, at some point in the audit process it must have been an issue.

Mr PEARSON—I cannot give a categoric assurance, but it was not to the extent that it impacted on this. From my looking at this, there was a stretch of resources and, as we have outlined here, part of the mitigation is training 40 staff from another area to compensate. So it certainly did not come up as a major issue.

Ms HUPPERT—I guess this is part of the risk management strategy: how much in the way of resources do you have that is dedicated solely to a particular risk, or is it a matter of training staff so that they

can deal with a variety of risks when/if they do arise? I think what we are talking about, as the chair mentioned earlier, is that with equine influenza it is a low-level risk but with a high impact if the event occurs. How then do you best deal with that? So what you are saying is that the response to multitask staff rather than have dedicated staff for a very low probability risk is in fact a sensible way of addressing that type of risk.

Mr GREAVES—Yes. And—as the Auditor-General said—I cannot categorically say yes or no, but my recollection of the audit and the working papers is that that risk, that particular issue, was not raised in the context of this finding, and I think this finding is not strictly directly relevant to the issue of staff cuts. This is more about your contingent or reserve capacity and where you resource that from.

The CHAIR—In actual fact, Victoria sent resources to Queensland and New South Wales.

Ms HUPPERT—But again it is a question of managing risks in an appropriate—

The CHAIR—It is a fair question.

Ms HUPPERT—Yes.

Mr SCOTT—You mentioned earlier the Australia/New Zealand Standard for Risk Management 4360. I would be interested in some further information on that particular standard and the framework it provides.

Mr GREAVES—Sure. That risk management standard is a longstanding Australia/New Zealand standard. From my recollection, it has been in place from at least the nineties. In fact, it was kind of a world-leading standard. It sets out a framework for risk management which is now pretty much generally accepted and I think has been adopted worldwide. It sets out some principles around establishing the strategic context, identifying the risk, and assessing the likelihood and consequence, so it sets out a process for applying risk management to any process, or any business, or any organisation, or any incident. So we found in the audit that it was quite appropriate that BV had picked it up, had identified it and had applied it, because it is a well-recognised and very robust and longstanding framework for assessing and managing risk.

Mr SCOTT—Can I take it it deals with the sorts of issues we were just discussing about low-probability but high-impact risk, which would be at the heart of biosecurity, obviously?

Mr GREAVES—It does, because under the risk management standard you assess separately the likelihood of the risk event occurring and the impact of the risk and you combine those two assessments to give yourself a risk rating. We saw in some of their work that they were actually, in their modelling and their exercises, focusing on high likelihood but where they thought they had a low preparedness, and we said, 'Well, actually, what you should really focus on is high likelihood and high impact, which is high risk. So even if you think you're well prepared, make sure you're still testing the high-risk scenarios.'

Mr SCOTT—Because the materiality is much greater.

Mr GREAVES—Absolutely. The potential impact is much higher.

The CHAIR—I notice the art in the room is very apposite for today! They were using animals for security purposes some hundred-odd years ago.

I think we have been through quite a number of these, and I appreciate the responses and particularly the information you provided. That concludes the consideration of *BioSecurity Incidents: Planning and Risk Management for Livestock Diseases* and *Managing Acute Patient Flows*. I thank Mr Pearson, Mr Greaves and Mr Sheard for their attendance today. It has been a useful session. Where questions were taken on notice—I do not think there are any—the committee would have followed them up with you in writing at a later date. We thank you for your attendance today.

Witnesses withdrew.

Hearing suspended.