LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Review of Auditor-General's Report No 6 of 2012: Emergency Department Performance Information)

Members:

MS C LE COUTEUR (The Chair)
MR J HARGREAVES (The Deputy Chair)
MR B SMYTH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 19 JULY 2012

Secretary to the committee:
Dr A Cullen (Ph: 6205 0142)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 9 August 2011

The committee met at 9.17 am.

COOPER, DR MAXINE, Auditor-General, ACT Auditor-General's Office
SHEVILLE, MR BERNIE, Director, Financial Audits, ACT Auditor-General's Office
STANTON, MR BRETT, Acting Director, Performance Audits and Corporate Services, ACT Auditor-General's Office

THE CHAIR: Good morning everybody and welcome to this first hearing of the Standing Committee on Public Accounts inquiry into Auditor-General's report No 6 of 2012, *Emergency department performance information*. In accordance with the committee's resolution of appointment, all reports of the Auditor-General stand referred to the public accounts committee after presentation. The public accounts committee has established procedures for its examination of referred Auditor-General reports. The committee considered Auditor-General's report No 6 of 2012 in accordance with these procedures and resolved to inquire further into the audit report. The committee's terms of reference are the information contained within the audit report.

Welcome, Auditor-General and officials from the ACT Auditor-General's office. I emphasise to members and witnesses that the misreporting of data has been referred to the police for investigation. Questioners and answerers need to be mindful of this process and be careful not to stray into areas that are currently under consideration by the police. In the event that misconduct proceedings are commenced, have commenced or may be commenced in relation to misreporting of data, the committee does not wish to prejudice any aspects of these proceedings. Questions and answers therefore need to be careful not to stray into matters that are before or due to come before any such disciplinary process.

I note that there are a number of members of the Assembly who are not members of the committee in attendance today. I welcome these members but I remind these members that, although the standing orders enable members who are not committee members to participate in the committee hearings and to question witnesses, there are conditions attached to this participation. In particular, whilst standing order 234 relating to the admission of other members permits members of the Assembly not being members of the committee to be present when a committee is examining witnesses, it also provides that any such member shall withdraw if requested by the chair or any member of the committee.

In relation to the right of other members to ask questions when a committee is examining witnesses, standing order 235 provides that members of the Assembly not being members of the committee are able to question witnesses by leave of the committee. I remind other members to ask questions through the chair and I emphasise that, if required, the committee will of course uphold the conditions pertaining to the participation of other members as specified in the standing orders.

I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the blue-coloured privilege statement before you on the table. Can I please confirm for the record that you understand the privileges implications in the statement?

Dr Cooper: Yes, I understand it.

Mr Stanton: Yes, I understand.

THE CHAIR: I also remind witnesses that proceedings are being recorded by Hansard for transcription purposes and are being webstreamed and broadcast live. The Assembly also has Committees on Demand, which allows the audiovisual record of proceedings to be publicly accessed via our website in the future.

Before we proceed to questions from the committee, would you, Auditor-General, like to make a short opening statement?

Dr Cooper: I would, please. Thank you, committee and other members of the Assembly who are here, for the opportunity to address you in regard to the emergency department performance information, report No 6. I wish to emphasise that, although this report, we hope, speaks for itself, I will very briefly outline our approach and provide a summary. Brett Stanton will then provide some more detail on the actual data manipulation issue. Mr Stanton is the project manager for this audit.

The objective of this audit is on the overhead here. Importantly, it is quite focused and contained. It is about circumstances associated with the alleged misreporting of Canberra Hospital emergency data performance information, it is about the effectiveness of the Health Directorate systems and processes and it is about financial implications for the territory associated with any potential misreporting.

The audit was completed within two months, which is a record for the auditor's office. Legal advice was provided to us by the Australian Government Solicitor, to ensure complete independence. Oakton consulting were the specialist technical IT services, and the Tasmanian Audit Office undertook what we call a hot review of our work. That simply means they checked our work to ensure that what we were saying was evidence based all the way.

ACT Health Directorate staff provided information, and some of their staff were interviewed under oath or affirmation. We also used PricewaterhouseCoopers, referred to throughout our discussion as PwC, based on the forensic audit they undertook for ACT Health. While the primary focus of the audit was on the Canberra Hospital, consideration was also given to the systems in place at the emergency department at the Calvary hospital.

Based on the audit, it was found:

> Hospital records at the Canberra Hospital have been deliberately manipulated to improve overall performance information and reporting of the Canberra Hospital's Emergency Department.
>
> …
>
> There is evidence to indicate that hospital records relating to Emergency Department performance were manipulated between 2009 and early 2012. It is likely that up to 11,700—

that is, six per cent—

> records relating to Emergency Department presentations were manipulated during this period. The records that were manipulated mean that publicly reported information relating to the timeliness of access to the Emergency Department and overall length of stay in the Emergency Department have been inaccurately reported over this period.
>
> …
>
> The very poor controls over the relevant information system—

the emergency department information solution, EDIS, system—

> means that it is not possible to use information in the system to identify with certainty the person or persons who have made the changes to the hospital records. Under affirmation—

under section 14A of the Auditor-General Act—

> an executive at the Canberra Hospital has admitted to making improper changes to hospital records. While this is the case, we—

I and my team—

> consider that it is probable that improper changes to records have been made by other persons.

We did so for the following reasons: the executive admitted to using two generic logins, "nurse" and "bedman", to make changes to the records. A small number of other changes were made using "doctor" and "clerk". There were also more changes made using "nurse" than those which the executive had admitted to making. The executive admitted to commencing making changes in late 2010. Changes were made prior to this, including in 2009, and the information which we did not report in our audit report but which we had was that the executive identified the times that the changes were made were almost always early morning and evening. PwC identified a sizeable proportion of changes were made between 9 am and 5 pm.

The audit identified:

> The executive's rationale for manipulating records was that they felt under significant pressure to improve the publicly reported performance information of the Emergency Department … there is a significant and ongoing focus on the timeliness performance of the two Canberra hospitals more broadly—

and importantly—

> and their emergency departments …

Although managerial pressure was placed on the executive to improve the performance of the emergency department, this was not manifested in direct or

indirect instructions or guidance to deliberately manipulate hospital records. Furthermore, the audit found no evidence that there was direct or indirect instruction given to the executive to change emergency department records by any person, including the Minister for Health/Chief Minister..

The audit identified:

> There is a considerable lack of attention on qualitative indicators, which may provide a more appropriate and rounded assessment of Emergency Department performance.
>
> …
>
> The very poor system access and user controls over the Canberra Hospital's Emergency Department management information system has wider implications beyond the inaccurate reporting of timeliness performance. There are risks to the privacy and confidentiality of patient information

A new version of the same management information system that is at the Canberra Hospital is also used at the Calvary Public Hospital. However, that has only been in place since the beginning of this year. There are more effective system access and user controls at the Calvary Public Hospital. The audit identified:

> There was also a lack of monitoring, review and assurance of the integrity and accuracy of the Health Directorate's publicly reported Emergency Department performance information.

Some commonwealth funding may be at risk, as it appears that the ACT is not meeting its timeliness performance targets. The audit identified:

> Under the recent National Partnership Agreement ($3.2 million over the four years to December 2015) is contingent upon the ACT meeting relevant timeliness targets. $0.8 million—

that is, $800,000—

> is contingent upon the ACT's timeliness performance in 2012. This funding may be at risk, as it appears that the ACT is not meeting its timeliness performance targets. However, it should be noted that this reward funding may be rolled over and provided in future years up to 2015.

We made 10 recommendations to assist in issues that were identified during the audit. Recommendation 1 relates to improving publicly reported performance indicators. Recommendations 2 to 5 are very pragmatic about addressing shortcomings in the near future in the EDIS system. We also made a recommendation, No 6, about reviewing the ongoing appropriateness of even using the EDIS system. Recommendations 7 and 8 are about data validation. Recommendation 9 is in regard to the executive that has manipulated the data. Recommendation 10 is about all staff needing to act with integrity regarding management of data.

I will now hand over to Mr Stanton to give us some analyses of the data manipulation.

Mr Stanton: I would just like to briefly highlight a graph here on the screen, which is also on page 81 of the report; you may find it easier to refer to page 81 of the report. This graph represents—and I acknowledge that this was produced by PricewaterhouseCoopers—the total number of changes that have been made to EDIS records, whether that be changes made to the triage categories or changes made to the NEAT records. There are a few things that I would like to highlight. This graph represents the changes that have been made since January 2009.

What I would like to highlight is that there is what are called appropriate changes to EDIS records, and that is through a data validation process that occurs in the days after a patient's presentation to the emergency department. That is acknowledged and discussed in a little more detail in chapter 3 of the report. Administrative staff at the Canberra Hospital go through a process where they review previous days' presentations and look for opportunities to more accurately represent what the actual timeliness performance was on those days. Changes that have been made to EDIS records through that data validation process are highlighted there through staff 1, 2, 3, 4, 5 and 6. We have removed those staff members' names for the purposes of the report. Those changes have been made through that data validation process.

What the graph also represents is changes that have been made to the EDIS records in the days following presentation by the generic login accounts, primarily the bedman, clerk, doctor and nurse accounts. The nurse account there is represented by the pink line and you can see that a sizeable number of changes have been made using the nurse generic login. You can see that that really spiked through probably December 2010 through December 2011 and 2012, but you can also see that some changes were made using that account from about May 2009 through until about March 2010, although changes were made using that account throughout the whole period.

The other account that I would highlight there is the bedman account; that is represented by the purple line. There was a sizeable increase in that leading up to about September 2011. A small number of changes have been made using the clerk account, notably in July 2010, and the doctor account in September 2011. Thank you, and I will pass over to the Auditor-General.

Dr Cooper: That concludes our presentation, so in summary we are dealing with a situation where, because of the poor systems, there was the opportunity to manipulate data. We have an executive who had a motive to do that and we also have the means for that executive, having access to that system, to do it. So it is around the situation of opportunity, motive and means.

THE CHAIR: Thank you. First of all I would like to go to Mr Hargreaves for his statement.

MR HARGREAVES: This is not a correction; this is a statement to clarify something that I have already clarified in the estimates committee. Mr Smyth will remember this; Ms Bresnan also.

The data issue was identified to hospital management by the Australian Institute of Health and Welfare. My wife is a group head in that institute and responsible for that area which discovered the issue. I wish to place on the record that, firstly, I had no

knowledge at all of, one, the discovery and, two, what they did about it. I have had no discussions with my wife about how, why, what occurred. I also want to place on the record that I have never seen an Institute of Health and Welfare report; neither do I need to disturb my sleep such that I would need to read such a report, and, even though this issue received some media attention, we have not discussed it amongst ourselves; nor should we or would we. So I want the public record to know that.

THE CHAIR: Thank you, Mr Hargreaves. The first thing I would like to say is thank you, Dr Cooper and your team, for doing this report so quickly. Two months, as you said, is a record and we very much appreciate it.

My first question relates to the commonwealth. You said there was a possibility that this had impacted on some commonwealth funding. My question is: given the changes with the commonwealth Audit Act, I think in the last year, is there a possibility that this is something that would now be under the purview of the commonwealth Auditor-General; that this is what could happen?

Dr Cooper: I cannot speak for my colleague at the commonwealth level, but we certainly discuss issues at our ACAG, the Australian Council of Auditors-General. I was in Brisbane last week and this was one of the subjects that was discussed. Though I cannot speak for Mr McPhee, I can say that he, other auditors-general and I had a discussion around this issue and we are quite keen, where we can, to look at things in a cooperative manner. But I do not detect at this moment that there is a program in place for that to occur right now.

THE CHAIR: Thank you. You say that the performance against the ATS categories was not audited by the ACT Auditor-General's Office on an annual basis because these indicators are not included in the Health Directorate's statement of performance and they have not been since 2003-04. Do you think that is appropriate, given that clearly these are indicators of considerable public interest? Should there be more widespread auditing of things that clearly the public has an interest in?

Dr Cooper: In terms of background I will hand that to Bernie, and then I will give you the answer to that explicitly.

Mr Sheville: It is true that these indicators used to form part of the ACT Health statement of performance. We did look at those indicators back in 2003-04 and we were unable to form an opinion on the accuracy of the information in that system because there were no written records or supporting records to support the information on that. As a result of that we were unable to form an opinion at that time. So, even if you were to bring that accountability indicator back into the statement of performance, unless there were significant improvements to the controls over the records I suspect you would go down the same path of being unable to form an opinion on that particular information.

MR SMYTH: Just for the record, what is an ATS indicator?

Mr Stanton: Australasian triage scale categories of triage; that is categories 1 through to 5.

Dr Cooper: Let us give you the page reference.

Mr Stanton: That will be chapter 2.

THE CHAIR: It is in your glossary.

Dr Cooper: Yes, but it is in page 2 clearly.

MR SMYTH: The point was that with acronyms Hansard may not know them.

THE CHAIR: Yes, page 1 lists the abbreviations.

MR HARGREAVES: And, Mr Stanton, those categories that you talked about—this is just for Hansard really—are the categories that we charge. If you turn up and you are bleeding from the head you will fit into one of those categories in the ATS scale. Is that right?

Mr Stanton: That is right. Page 26 outlines the categories and the rationale behind the categories. Absolutely, category 1 is top priority; category 5 is less urgent.

Dr Cooper: And for the record category 1 requires immediate attention, performance indicator 100 per cent. Category 2 has a 10-minute time, 80 per cent is the indicator. Category 3, which is less intense of course than 1 or 2, is a 30-minute treatment waiting time with 75 per cent indicator. Category 4 is 60 minutes and 70 per cent. Category 5 is 120 minutes and 70 per cent.

MR HARGREAVES: I have a couple of questions and then, if we have time, some others. It is a bit unusual in the sense of an audit, is it not, to have the degree of checking that you have had with the use of the Australian Government Solicitor for a legal advice on the use of Oakton as the specialist IT people and then have your work checked over by Tas audit? How much of that is a bit extraordinary?

Dr Cooper: I would hope it is not extraordinary. Again maybe it is a style issue but internally I understand prior to my time there was an internal review that took place before an audit report was put out. Because of circumstances within my office and because of the nature of this, I wanted to make those external, so that is why we used the Tasmanian office; also too at a collegial basis the jurisdictions do share staff for doing such activities. So we will sometimes have some of our staff go to another jurisdiction to do a particular audit on their work.

In terms of using the Australian Government Solicitor, we decided to do that in consultation with the ACT solicitor because of any potential conflicts of them giving advice through to the government versus giving it through to us. So it has been quite open, quite transparent, in the way we have done that.

MR HARGREAVES: And you can be congratulated for that. You mentioned earlier on that there is a probability that others might have been involved in the process, and that probability is high, but also you said that it was almost impossible to identify anybody down the line because of poor systems control on the use of logins et cetera. You relied on the PricewaterhouseCoopers forensic examination. Are you satisfied

that the level of detail addressed by PwC was sufficient that you had actually got to the end of the road on that?

Mr Stanton: Yes, in a nutshell. We understood the methodology that PwC employed, and we understand that PwC was working on behalf of the Health Directorate. For our own benefit, Oakton was also providing us with advice on the system itself. So in relation to the user access and the capability of the system to help us or assist in any way to identify other people, we were satisfied that we were getting two separate pieces of advice from different professional services.

MR HARGREAVES: I understand—I am not quite sure whether it was PwC or the audit report—that at one point somebody identified that there was an issue with the numbers spike and had actually referred it to a senior officer. That would indicate to me either a particularly honest employee or a system in place for reporting of such issues. Can you speak about both of those and why it was that it was not fixed?

Mr Stanton: Our understanding is that in February 2012 one of the system administrators at the hospital, through what I previously described as the validation process, identified what they perceived as anomalies in the data at that time. So that was in about February 2012. They did raise that through the channels at the Health Directorate. The response and the investigation in that process were beyond the scope of this audit and we did not look at whether it was an appropriate response or process that was employed after that.

Dr Cooper: However, we do know that the executive who has owned up to manipulating the data was actually somebody involved in that analysis. So that person had access to seeing what was coming through for at least a week before they admitted to manipulating the data.

MR HARGREAVES: I have other questions. I will just finalise this one and then come back again in the round, unless you have something else?

Mr Stanton: It was not a specific process whereby the administrator found out in February 2012. It was happenstance, if you like.

MR HARGREAVES: So what we had was a particularly honest employee in the system doing the right thing at that point?

Mr Stanton: They were employed to do a particular task and through that task they found what they saw was an anomaly and they raised it through the chain.

MR HARGREAVES: You also indicated somewhere that in other jurisdictions there have been issues around manipulation of the data and systems breakdowns. Not wishing to decry the seriousness of this, is this fairly consistent with the experiences in interstate jurisdictions?

Mr Stanton: Yes. Chapter 2 of the report highlights a 2008 report Deloitte undertook on behalf of New South Wales Health. A number of systems were employed in the hospitals. EDIS was the most common system and there was a raft of issues found in relation to the system access and user controls. We talked about that in chapter 2 of

the report. The Victorian Auditor-General also undertook an audit basically on this issue, performance information in emergency departments, and has come to similar conclusions about the assurance that you can obtain from the systems to produce accurate performance information.

MR HARGREAVES: Do they have common logons in those other jurisdictions?

Mr Stanton: Yes, I believe so.

Dr Cooper: I would like to add to that answer. For me, given the wide use of EDIS, given that this is something that has occurred in a few jurisdictions, and given the federal funding that is involved, it would seem that addressing these issues in a cooperative way around all hospitals would be highly productive. Having clear governance frameworks that are agreed upon, clear targets—that is certainly an indicator in that direction. Is it 190 in New Zealand and—

Mr Stanton: That is publicity material from the vendor which identifies the number of hospitals in which it is used. Can I add to the answer to that question, Mr Hargreaves? Paragraph 2.55 states that in New South Wales the Deloitte report found the existence of a number of generic logon and password combinations. So that would be similar to the ACT's experience.

MR SMYTH: Perhaps we could get to the mechanics of the audit and the way it was conducted. How many people did you interview and how was it determined that those individuals should be interviewed?

Dr Cooper: Interview, under oath, there were nine, and about how many not under oath?

Mr Stanton: In a normal audit you would speak to all sorts of people, so approximately 30 people were spoken to, to provide us with all sorts of information in relation to systems and practices.

Dr Cooper: What we did in terms of the executive who had taken accountability for manipulating the data was that we interviewed that person first and we then analysed the data. Then we went back and reinterviewed that person because we wanted to make sure that their knowledge of the exact data manipulation was not presented to them before we actually interviewed them. We were then able to correlate what we were being told with the evidence that we had in, if you like, the hard form.

Why did we interview certain people under oath or affirmation versus not others? We wanted those that were immediately or closely connected with the executive who had admitted to manipulating the data so that we could track and validate what was being said. We did it for security of evidence, because under oath it is a criminal penalty if you do not tell the truth. Also under oath under the Auditor-General Act you cannot withhold information because it might incriminate you. So it is quite powerful in terms of trying to distil exactly what is going on. We acknowledge that in taking the statements they rely upon their memory and the ability to do that can vary. However, for an issue such as this we felt that there was quite clear information on some aspects.

Also we wanted to allow those people affected or where there were inferences made about somebody to be given the opportunity to provide a statement quite firmly. We also felt that, given the current audit criteria, it was one way to have clarity and to prevent ambiguity because when we took the statement we actually then sent it back to them when it was typed up and documented. So there was no ambiguity between "I thought I said that" and "no, you didn't." It was quite clear having regard to the evidence we then had. So it was an important form of evidence given the type of audit we have undertaken.

MR SMYTH: So the nine who gave evidence under oath, were they people above the officer in the chain, below and at level? Who were they?

Dr Cooper: It was a mixture of that in terms of we were looking to see who might have influenced that executive and how.

MR SMYTH: The other approximately 20 that were interviewed, are they in the same position—they are above her, at level or worked for the officer?

Mr Stanton: These were a range of people across both Calvary and Canberra Hospital—administrators, clinicians, people that can help us form an opinion on the audit.

Dr Cooper: And that was much more around the system and the targets. So we quite clearly focused on the executive of concern for the under oath and the others more broadly about systems and targets because some of those would have absolutely nothing to do with that executive.

MR SMYTH: How did you determine which were to be interviewed under oath and which would not be interviewed under oath?

Dr Cooper: Primarily around the relationship with the executive.

MR SMYTH: Did everyone interviewed have access to the EDIS system?

Dr Cooper: No.

Mr Stanton: Not everyone.

MR SMYTH: Why would you interview some that did not have access?

Dr Cooper: Because it would be about—at the managerial level some of those do not have access. I think Dr Peggy Brown does not have access, yet she clearly through her leadership influences what happens. So we took that approach. We only ever interviewed under oath or not or under affirmation or not if we had a legitimate reason to. We did not just randomly select anyone. It was always quite clear with our criteria that we were trying to address.

MR HARGREAVES: You said that you looked at the relationship. What manner of relationship was that? Was it a managerial relationship, a supervisor, personal or what? What was the relationship?

Dr Cooper: It was a mixture of that. For instance, we knew that the Minister for Health-Chief Minister had said publicly that she was stepping aside from this. So we looked at whether—we quite openly asked the question to the executive who had come forward: what was that relationship and how it all functioned? So we picked it according to the information that we did have. Then, for instance, there were issues raised around management style. So, of course, we would interview the various managers that the executive had with some of those people coming from interstate because they are no longer here. We took that approach of trying to really understand what was going on.

MR SMYTH: I will go back to my line of questioning. Just following on something there, you said that you asked the officer at the centre of the controversy about her relationship with the Chief Minister. Was it both a professional as well as a private relationship or—

Dr Cooper: Yes, we did. That is why the statements are kept confidential because a lot more information than what we may have needed to come to the conclusion we have come to was also given.

MR SMYTH: But it was both a professional as well as a private relationship?

Dr Cooper: Yes, absolutely, Mr Smyth. We did that also with the Minister for Health-Chief Minister. We also did it with the member of the Minister for Health-Chief Minister's family and they were very explicit, very confronting questions to try to distil what was going on.

MR SMYTH: Was everyone interviewed directly asked if they had themselves altered data.

Dr Cooper: Yes, we also did that.

MR SMYTH: And all but the officer at the centre of the controversy denied that—

Dr Cooper: Yes.

MR SMYTH: I am sorry, inappropriately altering the data.

Dr Cooper: Yes, and with the officer that we interviewed about the manipulation of data, we spent a considerable time trying to clarify exactly what had happened. That is why we did it twice.

MR SMYTH: Were those that you interviewed asked if they knew of others who had altered data?

Dr Cooper: Yes, we absolutely did that. We had a series of questions where we were trying to find out what was going on. Particularly, we felt that was a powerful mechanism given the very poor system that is in place that would not allow that.

MR SMYTH: And those inquiries garnered no other names?

Dr Cooper: That is correct, and we were most emphatic to emphasise that this could result, if it is found out that we were not being told the truth, in criminal action. So we were quite forceful in terms of saying that we will keep it confidential but on the other hand we really do want to know what is going on.

MR SMYTH: What is involved in altering a record? I mean, 11,700 records is a large number of records. Can you run the committee through the process and what you feel is a fair estimate of how long each record alteration would take?

Mr Stanton: Absolutely. I believe it is a matter of seconds. It was demonstrated to me in the course of the audit by some personnel at the hospital as to what it does involve. My understanding is that it is very easy to pull up a list of what you could call exceptions from the day before—the number of presentations that exceeded the timeliness targets—and then basically click on each one of those records, change the data, save it, and move on to the next one.

MR HARGREAVES: How long would it take to do that sort of a transaction?

Mr Stanton: Ten to 15 to 20 seconds for a transaction, so that sort of order of time.

Dr Cooper: And I will emphasise that in the information we got from the executive who did this, from their perspective they clearly only did it enough to meet the target. So they did not go in and do a whole bulk lot just because that is what was happening. They clearly looked around at whether the targets were being met or not and how they could adjust that.

MR SMYTH: So it was being adjusted on a daily basis so that the previous day had met the target for that category?

Mr Stanton: It was—

Dr Cooper: On a regular basis. I would not say a daily basis, but on a regular basis. It was definitely around meeting that performance target. Once that was achieved, my understanding from the information we have is that that was that. It was not a matter of making it look exceptionally good or anything. It was absolutely around that target.

MR SMYTH: I will just finish with two last questions: were the people that you interviewed asked if they had ever raised concerns about the data system, the validity of the data, and how the data was being processed?

Dr Cooper: We did.

Mr Stanton: We asked general questions around their understanding of the production of data through EDIS and we talked around those issues.

Dr Cooper: And we asked had it ever been raised at the executive level, like with the director-general. We even asked the minister whether or not it had ever been raised with her. So we certainly did that. We also, as is documented—

MR SMYTH: Sorry, and what were the answers to those inquiries?

Dr Cooper: The answer from the minister was no. Those issues had not been put through to her.

MR SMYTH: And the other 30-odd people, had any of them ever raised a concern about this?

Dr Cooper: One or two I recall in a more obtuse way, not as in: "Well, look, this is really significant. I'll go and raise it." Because we need to remember that this system has been there 15 years. They all knew how to use it, and everybody assumed because it just kept on working that you would come in and use it, and it was working okay for them generally. So I think we are dealing with a long-term issue of acceptance of something rather than critiquing it, and where we need to look is at the governance arrangements of when the data is processed and who is keeping an eye over that.

MR SMYTH: In the chart on page 81 you have deleted the names of the six staff, as is appropriate, and you have interviewed 20 or 30 people. Is it possible for the committee to have in confidence a list of the six staff in the chart and the 30-odd people—

Dr Cooper: No, Mr Smyth.

MR HARGREAVES: We do not want it.

THE CHAIR: Mr Smyth, I do not think that is appropriate.

Dr Cooper: I think—

MR SMYTH: Sorry, it is a reasonable question, and the committee can take evidence in camera that need never be published. I am not suggesting that it be published. I want a full picture, because it is still very unclear. We are talking at quite a high level at this stage. And I want some clarity on who was interviewed.

MR HARGREAVES: With respect, I think two-thirds of the committee do not want it.

THE CHAIR: Yes, I—

MR SMYTH: Well, two-thirds of the committee can be of that opinion, but I think Dr Cooper has an answer anyway.

Dr Cooper: I think what we have tried to do in this report is to be tough, fair and caring, and in terms of caring we of course put it out there for the broader Canberra community—"Here's an issue"—but we also care at the individual level. We think we should be focusing on the issue. If there is a particular reason why information is needed around a particular person, I am open to take that on board to see if that would help the committee rather than just giving names. They have trusted us. They have been very honest.

MR SMYTH: I am not asking you to reveal the names. The committee is allowed to

take evidence on a confidential basis.

Dr Cooper: I understand that.

MR SMYTH: And it was on that basis. There is a cloud over everybody there because we do not specifically know who was interviewed.

Dr Cooper: Yes, but let me explain, if I can. This gave us a great deal of thought in terms of what do you do in a situation like this. There are hundreds and hundreds of people who have access to this.

MR SMYTH: That is right.

Dr Cooper: We are dealing with people in a hospital situation who are giving their best, doing a whole lot of things. So do we give names up for everyone? The system is so very poor that it is hard to target. So we have taken, we hope, a caring, balanced approach to say that we know this one person has come forward. Let us look around that. But for all the others—and there might be some others still out there—if you tighten up the system and if you put into place the right HR practices, we hope it will address it.

THE CHAIR: Mr Hanson.

MR HANSON: Thank you very much, Madam Chair. I would like to commend you on the timeliness of this report with the complexity of what you had to achieve and the time in which you turned it around. Certainly all members of the committee, I imagine, but certainly the Assembly, appreciate that you have been able to do that.

Turning to the executive in question, the executive has provided a pretty comprehensive view of why they did this in terms of their statements on page 88. Did they provide other evidence in writing as well, or was it simply that letter?

Dr Cooper: Not in writing. What we did, Mr Hanson, is we interviewed the person first. We did that data analysis and we interviewed them again. I offered, because I thought it was in their interests and the broader community interest, if they wanted to make a statement to make it complete from their perspective. So that was an offer that they took up. Similarly, the person to whom they reported took that offer up.

MR HANSON: So essentially they were interviewed twice under oath and provided this statement?

Dr Cooper: That is correct.

MR HANSON: Okay.

Dr Cooper: That came in after.

MR HANSON: And this executive essentially is the person that has come clean, to coin a phrase. They have made some reasonably serious allegations in their letter. Obviously they are the one at the centre of this. Have you found this executive to be a

credible witness?

Dr Cooper: I think we would have problems in not analysing what they have said to a far greater degree. This person quite clearly has been exceptionally emotional. They have been under what they perceive as enormous pressure. I am not sure, given that environment. This is their perspective on it. In terms of credibility I would need to validate their information with a lot of others before I would rely just on that.

MR HANSON: Sure. I believe, from reading your report, that you have spoken to others, though—

Dr Cooper: Yes, we have.

MR HANSON: that have in some ways validated or agreed with the statements made by this executive. Some of the statements, for example, were that they felt feelings of fear, isolation and distress; they were told to fix the numbers: "Your staff are not able to do their jobs and show no leadership." There are some quite serious allegations made there.

Dr Cooper: Absolutely.

MR HANSON: So there are other staff that agreed with those sentiments?

Dr Cooper: There were other staff who expressed similar sentiments, and there were other staff who expressed the opposite and said Canberra Hospital needed to undergo these changes and the management were stepping in the right direction. But, yes, there were other staff who expressed similar views.

MR HANSON: So there seems to be a more widespread concern with the cultural issue that may have led to this in terms of the feelings of fear, of isolation and the pressure on staff to get results that are publicly reported. What further analysis did you do of those concerns? You have not gone into that side of it, have you?

Dr Cooper: No, Mr Hanson. We stuck to the criteria and we wanted to put this out, if you like, again in fairness to the people involved. But that would have meant the audit would have gone on for a considerably longer time.

MR HANSON: Okay. So of the number of people that you interviewed you would say that about 50 per cent of them expressed similar concerns that were expressed by the executive?

Dr Cooper: I think our sample size was too small to draw a numeric out of it. Again, I am nervous of numerics, but I can say there were clearly other people, yes, who expressed concerns. But one of the things I think you have to look at, too, within this context is that the executive that we are talking about was in a very powerful position, and all executives are expected to fix numbers, not by manipulating data but by actually getting out there and looking at systems, trying to change things. This person was relatively new in the role. There may be something to do with level of experience. So there is not a black and white answer, Mr Hanson. It is very complex.

MR HARGREAVES: On that 50 per cent mark, Auditor-General—and I think it is reasonable—is it inappropriate, as you say, that a certain percentage of people have this view or that view?

Dr Cooper: I think it is totally inappropriate, from our audit, because it was not a broad enough figure. One of the criteria was not there to judge that. If it were, we could have designed it to get a sample size to do that.

MR HANSON: Essentially there are a broader number of people that are expressing similar sentiments to the view that there is an appearance of isolation and a fear of pressure?

Dr Cooper: Absolutely. There are other people expressing that view.

MR HANSON: And you have not been able to quantify that number of people because you did not go down that route?

Dr Cooper: That is right. Clearly within this environment, we were trying to find out what the manager above this person was like. That person was brought forward. Clearly, as we have said, there were issues raised about that person. But there were no formal complaints lodged and there were some actions to try to deal with the situation. Realising the context, it is a hospital undergoing change.

MR HARGREAVES: Was there a contrary view to that particular position expressed to you? Were there expressions of support?

Dr Cooper: There was a strong expression of support for the directions that executive was taking the hospital.

MR HARGREAVES: A bit of a balance, was it?

Dr Cooper: Then you get into issues: is it style, is it what you are doing? We did not get into any of that.

MR HANSON: So it is an area that went outside the scope? You have identified it as an issue, but it is outside the scope?

Dr Cooper: It came up as an issue but we could not, as we said in here, draw a conclusion around it. Dr Brown indicated to us that they have in place, given the types of issues that occur in the emergency department, a whole system to try to support staff.

MR HANSON: In your audit you noted, at page 89:

> Some staff asserted that the executive's supervisor demonstrated inappropriate managerial behaviours.

What unacceptable managerial behaviours were you referring to there?

Dr Cooper: I feel that I cannot share that with you. The reason I cannot do that is that

the sample is incredibly small. They raised specific issues, and we would have had to extend the investigation to validate those issues. We are happy to say "inappropriate managerial behaviours" clearly were experienced by some people, but whether or not one person viewed it one way or another was beyond the scope of our audit.

MR HARGREAVES: Did paragraph 4.70 on page 89 provide a counterpoint to the comment made in 4.69?

Dr Cooper: I think it provides the context of both. As I said, inappropriate managerial behaviours by one person may be viewed as such by another person as well. They really needed to say that to get us motivated. We just did not get into that area at all.

MR HANSON: I guess the allegations have been made by a senior executive and others against a supervisor. What action has been taken to investigate the validity of the managerial behaviours and the cultural aspects around that? I do not see a recommendation in your report to further investigate that. Is the directorate taking further steps to investigate that?

Dr Cooper: I cannot answer for Dr Brown, but I would say that is a question clearly for Dr Brown. I emphasise that no formal complaints were made. However, issues were raised and it was not our role to look at whether they were valid or not. We just could not do it in the time.

THE CHAIR: Ms Bresnan.

MS BRESNAN: I have a quick supplementary to Mr Smyth's question. You pointed out the seriousness of giving evidence under oath and the implications of that. Can you outline quickly the criminal penalties which you referred to? What are the implications of giving false evidence?

Mr Stanton: I can read them out.

Dr Cooper: This was read out to them.

MS BRESNAN: This was read out?

Dr Cooper: This was read out to everyone we interviewed under oath.

Mr Stanton: It was:

> The person cannot rely on the common law privileges against self-incrimination and exposure to the imposition of a civil penalty to refuse to give the information, produce the document or answer the question.
>
> However, any information, document or thing obtained, directly or indirectly, because of the giving of the information, the production of the document or the answer to the question is not admissible in evidence against the person in a civil or criminal proceeding

That is part 3 of the Auditor-General Act or part 3.4 of the Criminal Code. It is an offence to fail to swear the oath or make the affirmation, fail to answer a question and

fail to continue the examination. Giving false or misleading information during the examination is a serious offence under part 3.4 of the Criminal Code.

MR HARGREAVES: Mr Stanton, is that exact wording contained in the audit report somewhere?

Mr Stanton: No.

MR HARGREAVES: Could you please provide us with a written copy of that?

Dr Cooper: Yes. We can provide you with the preamble that we gave each person we interviewed, if that would help.

THE CHAIR: Thank you. That would be useful.

MS BRESNAN: Criminal—would that include, say, a jail term?

Dr Cooper: It would depend upon the investigation associated with that, but that is what I understand is one of the possibilities.

Mr Stanton: Part 3.4 of the Criminal Code will outline that in more detail.

Dr Cooper: And we can send a copy of that too.

MS BRESNAN: Thank you. The first recommendation you have made is about having more qualitative indicators. There is quite a bit of information in your report about that; you have talked about it, Dr Cooper, in your opening statement, and you have too, Mr Stanton. In terms of the investigation, how important is it that this particular recommendation is actually implemented and that the indicator, in your view, is actually changed?

Dr Cooper: We think all of our recommendations are important. We are very pleased that the Health Directorate and Calvary have agreed to take action in that manner. In terms of qualitative indicators, we think they are particularly important, but I also think, very importantly, that they are important to the hospital staff and the broader Canberra community. There is such a weighting on the quantitative ones, yet it is the qualitative ones. Also, when we are looking at those indicators, it should be around including compliments as well as complaints, so that you actually look at the total picture. And there will be people far better than us that can indicate what the qualitative indicators should be. We have referenced some, but the suite of them will give a more balanced approach. That has clearly been articulated in audits in other jurisdictions on this subject.

MS BRESNAN: Following on from that, there have been other jurisdictions where there have been investigations. It is mentioned quite clearly in your report, particularly with that four-hour waiting time, that it was open to manipulation, particularly in the UK. Do you think that having this sort of measure creates an environment where additional pressure is placed? Given that experience in other jurisdictions, how did that play into your looking at that particular—

Dr Cooper: It certainly creates a biased situation for focusing attention. What we need is a broad, all-encompassing approach to the way we actually deal with patients and their care. As it said, some people became so focused on that that gaming did occur.

Mr Stanton: The expert panel that reported on the implementation of the national partnership agreement was quite helpful and useful for us in making some commentary around that.

MS BRESNAN: Does it become symptomatic in that it creates a situation whereby if you have those sorts of measures and they have been in place it leads to this situation potentially happening?

Dr Cooper: I think the risk is enhanced in that, absolutely. I cannot quickly pick it up but in the report the emergency department staff clearly said that although reporting on these is important, it is far less important than getting on and giving care to the patients. So they were absolutely emphatic that they are there to look after the patients. The focus on it is more at the managerial level, where you are reporting it through nationally. So at the operational level, it was not seen to be that important. At the managerial level, it had a high level of importance.

MS BRESNAN: Because this is something which is applied nationally, particularly now that we have payments attached to it, do you have concerns about that—the fact that this is something that is used across the country?

Dr Cooper: Absolutely. We have become in not just this area but a few other areas quite numeric obsessed. What we really need is to have the balance. And I know qualitative indicators are incredibly difficult. We are the audit office and they do pose problems when we are auditing them or even developing them for ourselves. But they are really important in keeping the balance.

MR HANSON: A supplementary—

THE CHAIR: Mr Hargreaves has a supplementary on this.

MR HARGREAVES: Auditor-General, I notice that on pages 11, 12 and 13 is the Health Directorate's response to your report and it says that the directorate have agreed to all of your recommendations. Picking up on what Ms Bresnan was talking about in terms of the data, they say that they would like to emphasise that they in no way reflect on the issues, in no way reflect on the quality of care and later on say that "the focus on ED timeliness does not take into account broader measures of patient outcome". Are you satisfied from the investigations that you did down there that the quality of patient care in the emergency department was not compromised by this particular manipulation of data?

Dr Cooper: No, we are not satisfied with that inasmuch as we did not audit it. In order for us to be satisfied—sorry to be pedantic—we would have had to have audited that particular issue, and we did not audit it. So that is a claim by ACT Health and they would likely have information to back that. We did not get any of that information, Mr Hargreaves.

MR HARGREAVES: On the converse of that same coin then, the data that was manipulated, from my reading of the stuff, was about patient throughput. The point that I think you were making to Ms Bresnan was around needing to have a broader suite of indicators which include the quality of care, so it would be equally inappropriate to suggest that this particular manipulation of data did indicate a lack of quality of care out of ED.

Dr Cooper: I do not think you could draw a conclusion on that issue. Given what you were talking about for the hospital staff, on page 37, 2.46, we do say that we note that the recent COAG Reform Council report titled *Healthcare 2010-2011: comparing performance across Australia* reported that the ACT had rates that were significantly higher than the national rates for four measures: being listened to carefully and shown respect by ED doctors, being listened to carefully by hospital doctors, and given enough time by hospital nurses. It is interesting that a qualitative outcome is being reported as people having satisfaction with what is going on in the ACT and we are getting high ratings there.

MR HARGREAVES: We can take by that 2.46 that people are quite satisfied that the quality of care that they are getting in the ED is fine and that what we are talking about in terms of the manipulation of the data is the manipulation of throughput data, possibly with regard to satisfaction on the national stage rather than on the community stage.

Dr Cooper: Again we did not audit that, but what we are advocating is an explicit arrangement whereby different performance criteria are measured and reported in a package.

THE CHAIR: Mr Hanson, your supplementary.

MR HANSON: My supplementary on this is that on page 35 audit notes:

> Staff generally supported an overall 'length of stay' target, as the concept of minimising a patient's stay in the Emergency Department was widely supported in medical literature and a 'length of stay' indicator could consequently serve as a useful quality indicator.

I take it therefore that you are saying that the evidence from the staff and the literature was that the less time you spent waiting the better it is for your quality of care in essence, and I suppose that would be intuitive as well, the longer you wait.

Dr Cooper: I think we would have to go back and distil that a bit. Clearly if you are in the ATS 1 timeliness is everything; but whether it is four hours, five hours or six hours there is debate around that.

Mr Stanton: If I could add to that, I think that is true, absolutely. What is in the report was what was conveyed to us. In relation to that, whilst they said that, the next sentence states that the four hours itself was potentially arbitrary: should it be 3½, should it be five? That sort of thing.

MR HANSON: I note that 11,000 of the doctored records actually came in unassociated with the four-hour rule. But it says also on page 23: "it is apparent that there has been an overall decline in performance over the last ten years"; that is in relation to ED. So you have found that over the last 10 years there has been a decline in emergency department performance. Could you expand on that?

Dr Cooper: Yes. Can we go to figure 2.1.

Mr Stanton: Just in relation to that, what we were keen to do—

Dr Cooper: Page 27; 2.1 gives more detailed information on that.

MR HARGREAVES: Before you start, Mr Stanton, on Mr Hanson's question, when he talks about ED performance and your statement here, when you start your answer, are you only talking about the throughput performance waiting times? You are not talking about quality of care, or are you talking about quality of care?

Mr Stanton: No, that is correct—the timeliness performance.

Dr Cooper: Throughput.

Mr Stanton: A conclusion that was drawn at the commencement of that chapter was primarily based on figure 2.1 on page 27 of the report. All that we were simply doing there was conveying a context for the report. We re-presented information from the Health Directorate's annual reports. That is the basis for that figure.

MR HANSON: With that figure 2.1, have you tried to exclude the doctored data from that or is that including the doctored data? So it may be worse, in fact?

Mr Stanton: Paragraph 2.10 says "based on the Health Directorate's publicly reported performance information".

MR HANSON: Which we know was fabricated, so in actual fact the decline in performance over the last decade is worse than has been reported and worse than appears in that graph.

Dr Cooper: In 2.13 we have given some figures that we think are reasonable—that it would be less than what has been reported in the years where we know that manipulation has occurred.

THE CHAIR: Ms Bresnan?

MS BRESNAN: I think Mr Stanton has already answered my question. I was going to make the point that you said, Mr Stanton, that there was that variable support across the emergency department for the waiting times. Staff said that four hours was an arbitrary time frame for which there was no scientific or medical evidence. Thank you, chair.

THE CHAIR: We have been talking about changing throughput numbers, but to make the whole numerical-type system work, would this also mean that the actual

numbers in the emergency department must also be changed or is it possible that they could simply change the throughput without any other alternations?

Mr Stanton: That is correct. They can change the throughput without changing the quantitative statistics on presentations.

THE CHAIR: This might be outside your scope, but there is no evidence to suggest that anything apart from throughput changed?

Mr Stanton: That was beyond the scope of the audit.

MR HARGREAVES: Did any of the evidence you received point to a need to check that out?

Mr Stanton: No.

MR HARGREAVES: It did not; so there was nothing to indicate there was anything else wrong that you needed to look at?

Mr Stanton: Inasmuch as we approached the audit with that scope, we did what we needed to do to come to a conclusion there.

MR HARGREAVES: With respect to the way in which it could happen, am I correct in assuming that the use of those generic logons, particularly "bedman" and "nurse", was in fact the real system glitch that needs addressing?

Dr Cooper: No. I think the issues are permeated in many ways through the system. So it is not just a simple fix.

Mr Stanton: We made a series of recommendations. Recommendations 2 to 5 are more short term and pragmatic—"this is what needs to be done now". Recommendation 6 is the broader issue about how to review what system is in place at the hospital.

MR HARGREAVES: You will forgive me; I think we have had this conversation before but it was in camera. One of your recommendations is that we consider whether or not EDIS is a system we ought to use at all.

Dr Cooper: That is right.

MR HARGREAVES: Given that it is in almost every jurisdiction in the country, there would be national implications, would there not, if we were to change? Did you reflect on that when you made that recommendation?

Dr Cooper: Very much so. That is why we took a pragmatic approach to fix EDIS where you can at the moment and look at the objectives of that system, but also, given its inherent qualities, it does need some wider thinking. On that issue the wider thinking may come through leadership from the ACT that could affect what is happening nationally. One of the important issues is on page 64, 3.98, where the Oakton consultancy group, who looked at the technological aspects for us, said:

> The systemic insecurity exhibited in EDIS is not one that can be rectified easily, overzealous an approach will impact the [Emergency Department] preventing them from servicing patients, however not addressing the issues discussed … leave the organisation at risk of significant reputational damage.

It is very hard. It is not a black and white situation to come to terms with. That is why we thought it needed both approaches.

MR HARGREAVES: Let us say that the government picked up your recommendation and decided to go with another system. Do you know whether or not there would be a financial penalty for getting out of one system and going to another? Did you go down that track?

Dr Cooper: We do not know that at all. The only thing is that the current EDIS system has been there for 15 years. The upgrade—but we did not go there.

Mr Stanton: There is an upgrade project that had been underway.

MR HARGREAVES: Am I right in assuming that we are locked into the system for a number of years to come?

Mr Stanton: No, I do not know that.

Dr Cooper: We do not know that at all, no. Again, with the limited time for the audit, we did not go into the solution side. We stopped at "here are the problems; this needs to be considered now".

MR HANSON: I have a supplementary on that.

MR HARGREAVES: Please bear with me. Are there any other off-the-shelf substitute programs?

Dr Cooper: I would not know, but one of the consultants that we were working with mentioned something to the effect that if you are in hospital in the system in the United States, where you walk in and the dollars start churning over, they have systems over there that he thought would be a bit tighter. But that is simply a conversation. We did not investigate it.

MR HARGREAVES: In the context of what you have told us here, that there were other jurisdictions which encountered manipulation around the data, and given the nexus between that data and the commonwealth's approach to funding the states and territories, do you know what the commonwealth's attitude was to those manipulations that went on interstate, given that you were told about the manipulations interstate anyway?

Dr Cooper: No, we are unaware of that. We are aware, as we said in this, that it has been an issue for the Minister for Health in terms of looking at those systems and it has been raised at ministerial level, I understand, at the national ministerial council.

MR HARGREAVES: In the context of the EDIS system and the manipulation, you said that it had happened in New South Wales and in Victoria. Which was the earliest one and when did that occur?

Dr Cooper: We will just get that—

Mr Stanton: The New South Wales report came out in 2008. The Victorian report came out in 2009.

MR HARGREAVES: So the assumption can be then that the New South Wales experience was in about 2007-08 and then there was the Victorian thing. So the commonwealth government is fully aware of the potential for manipulation of data in this context?

Dr Cooper: All I can say is that the information is there clearly in the public domain, and leave it at that, Mr Hargreaves.

MR HANSON: I have two supplementaries. If this information was in the domain that there were risks, did you see any evidence that the Health Directorate had acknowledged or responded to those risks?

Mr Stanton: We did not look at that specifically.

MR HANSON: You saw no evidence that they had?

Mr Stanton: We did not look for it, no.

MR HANSON: The second point is that you mentioned in your opening statement that Calvary operates the same system but seems to have better controls over that system. Is that something that could be done in the short term to essentially implement the better processes at Calvary to fix what you have described as the very poor systems at Canberra Hospital?

Dr Cooper: Our recommendations actually capture what Calvary is doing and reinforce it. So some of those could be taken on to improve it. But it will not fully address everything because of the inherent nature of EDIS.

THE CHAIR: Auditor-General, do you think that your act has been the appropriate act for this? I was very interested to learn about the criminal penalties. Have you found it to be a workable act in terms of what you have been trying to do?

Dr Cooper: I think it is exceptional in terms of protecting and caring for the people that are involved, as well as caring for the broader community. I think that without these powers I would not feel as confident as I do about what I am reporting through to the Assembly.

THE CHAIR: I assume from that that there is nothing additional that you feel would be required or relevant?

Dr Cooper: Not around this current investigation on this particular issue around

section 14 in terms of under oath or under affirmation. It seems to be very powerful.

THE CHAIR: You may not know this but would it be as powerful as a royal commission? The impression I get from you is that it would have to be at least as powerful?

Dr Cooper: I cannot answer that, Ms Le Couteur.

MR SMYTH: The ED is sort of an entry portal into the hospital and obviously the systems that they have will have impact into the greater hospital. Is there a need therefore to look at the overall systems and systems management across the hospital and the health department at large?

Dr Cooper: For everyone's reference, figure 2.3 on page 36 shows patient flow pathways through the hospital. You can see in that diagram that, if there was a bottleneck somewhere in a unit that the emergency department wanted to refer somebody to, it would impact on the emergency department numbers and reporting arrangements. So from my perspective we have only looked at the emergency department on a particular issue. You would certainly need to look at the overall flows through the system to optimise overall patient management in terms of a processing arrangement.

MR SMYTH: You have mentioned Calvary a number of times. So if the ED is the portal to the rest of the hospital we need to look at those systems' flows. Is the relationship between ACT Health, Calvary and the Canberra Hospital working to maximise the care that we can give to patients?

Dr Cooper: We did not look at that in detail. In fact we did not look at that. We looked at the system that was in place at Calvary. But the community would expect that the two hospitals deliver a service regardless of which hospital delivers it. Their results in terms of emergency department are amalgamated and I think that is appropriate because that gives a level of service to the broader community rather than having one hospital competing with the other; it should be a collective service.

MR SMYTH: The issue of data management, both inside the hospital and inside ACT Health, has been the subject of a number of inquiries. We have got the ED, food services, interstate payments—there are a number of issues there. From what you have seen in the ED, the all-up data management by ACT Health, does that need to be looked at both in the way that it is entered, the flows and then the validation and the checking?

Dr Cooper: That is something that I think would add value to the performance overall of ACT Health.

MR SMYTH: Given the various elements—you have got TCH, you have got Calvary, you have got the health department, you have got the hospital, you have got the minister and the head of the directorate itself—in terms of both internal communications, because there seem to be in your report concerns about some people airing one thing and other people saying something different, are communications between the various entities and within the entities, from what you saw in the ED,

appropriate or do we need to streamline or improve that communication flow?

Dr Cooper: I think it is something that could do with a look at. Again our audit did not explicitly address that, but we as humans always have the communication problem, and it also seems that because we are the ACT with two hospitals instead of 10, 20 or whatever other jurisdictions have, they become particularly focused upon for some comments. It would be good if through communication we could have some regular routine system from the hospitals that talks about what is going on in terms of qualitative, quantitative and what they are doing, so that the community becomes empowered rather than the issues becoming so elevated that they are a drama before everybody understands them.

MR HARGREAVES: Is that a unique thing for health, Auditor-General, or is it something unique to nobody and in fact the public service generally should constantly evaluate its communication mechanisms?

Dr Cooper: I think it is all of us, including my office—all of us. I think it is just who we are at this moment in time on communication. But in the ACT, given the nature of us on all the issues, communication tends to be more personal and pointed on issues than in other jurisdictions.

MR SMYTH: On communication, an important part of a communication system, particularly in a hospital, is complaints. You mentioned that you had some concerns about patient information security. Were you satisfied that the complaints process is being used to the advantage of the system so that we can improve both the individual's care and care overall, and is work required on the complaints process?

Dr Cooper: We did not look at the management of complaints as part of the audit. However, it would actually fit as an associated adjunct to the performance reporting because it is another important piece of information.

MR HARGREAVES: And the compliments system would be another part of the same system?

Dr Cooper: You could. You would have to look at how they intersect and how you would put it through. They may get as many compliments as complaints. We did not look at that.

MR SMYTH: That leads to the HR policies at the hospital and the training in policies at the hospital. Obviously varying staff members, depending on needs, have varying access to the EDIS. Were the staff trained properly to use EDIS?

Dr Cooper: No, and that is the subject of one of the recommendations. It was really through one staff member training another staff member, so that if the staff member that was training the other staff member did not have the competency around how it could effectively work, that was passed on.

MR SMYTH: With respect to the HR policies at the hospital, and particularly the officer who was responsible for the manipulation, are staff being managed well from what you saw in the ED? Do they get access to leave? Are they working appropriate

hours?

Dr Cooper: We did not look at HR issues as part of the audit but clearly, with the officer who manipulated the data, that person did not take leave in the last while, while the major manipulation was going on. They were working extremely long hours. When they were asked to take leave and reduce their hours, they decided not to. We understand that the supervisor found it near impossible to actually say, "You must." So that did not occur. We have dealt with a systems issue. The HR would probably merit some consideration.

MR HARGREAVES: Can I ask you again about that. You are saying that the supervisor of the executive that had the issue identified that outstanding leave needed to be taken and actually tried to get the executive to take some leave, to refresh and do all those sorts of things. They actually did try on a number of occasions?

Dr Cooper: They actually tried to do that and to get that executive to reduce their hours of working.

MR HARGREAVES: So the executive was the person who said, "No, I'm fine"?

Dr Cooper: They just did not do it.

MR HARGREAVES: So it is not about managing pressure at all; it is about the person saying, "No, I don't want to take my leave"?

Dr Cooper: Management did not say, "You have to work the hours and not take your leave." A lot of people in that situation feel that they would like to give more, but management in this particular instance actually had conversations around working a shorter time: "You need it now; take it." And it was not taken.

MR SMYTH: The Canberra Hospital is not just our local hospital. In a way, it is the hospital in the nation's capital. Does that put pressure on the system or not?

Dr Cooper: It does, and we did not look into it in detail, but a piece of information we had was that, for instance, when there are major events in the ACT, that hospital has to actually undertake a plan in order to accommodate any emergency. That is a considerable amount of work. The hospital staff that we did interview, one in particular, outlined the amount of pressure that put on the hospital in addition to daily activities.

MS BRESNAN: You said earlier in response to a question about the commonwealth Auditor-General that it is an issue that has been raised in that forum, but I appreciate that you cannot report on what the commonwealth Auditor-General might then do in terms of their work. You talked about the need for cooperation at a national level because this is a system that is used widely and it is a measure that is used widely. We know there have been issues previously. Do you think perhaps that avenue of cooperation with the Auditor-General, meeting with the commonwealth Auditor-General, would be one way of looking at this issue at a national level?

Dr Cooper: I think it would be more productive in the first instance to try and address

it more at the heads of health agencies and ministerial level, to try and investigate what you can do and what they would be willing to do, and then look at making some changes and then doing an audit. I think that pattern would be more productive. You could do a cooperative audit. However, one of the things that auditors-general all have in common is competing priorities, whereas all health heads of agencies have one priority in terms of focus.

MR HANSON: I want to clarify that you said you did not investigate the internal processes of the Health Directorate when this first came to light and with respect to how they responded.

Dr Cooper: Until the point where we got our criteria. We did not look at whether that was appropriate, their method or—

MR HANSON: Sure. Can you clarify when this was first reported? When the executive essentially said, "I did it," when was that? What date was that and who did that executive report to, to say that?

Dr Cooper: It was Saturday, 21 April that the executive met with Dr Peggy Brown in Moore Street and admitted to making improper changes.

MR HANSON: And that is as a result of some of these internal audits? The problem has been flagged?

Dr Cooper: We did not look at why but that executive was involved at least in the prior week, to my knowledge, in part of—

MR HANSON: Of the internal staff and then it got to the point and they went to Dr Brown. You have not looked at the internal processes beyond that point?

Dr Cooper: We were much more focused upon trying to get to the essence of what—

MR HANSON: Of what had happened prior to that point?

Dr Cooper: Yes.

MR HANSON: In terms of the privacy of records, you raised that earlier. Beyond the scope of this there are some real concerns about privacy issues. Could you explain what those concerns are? Are these 11,700 records now open or does it go beyond that? What is the issue?

Mr Stanton: The Health Records (Privacy and Access) Act 1997 states the requirements that are placed on the Health Directorate. This is discussed in some detail in chapter 3 of the report. I cannot quite recall what page it is. Basically the conclusion that we came to was that with the large group of users of the systems, poor user access, systems controls, that sort of thing, that leads us to question whether there was adequate record protection and reasonable safeguards over the integrity of access to that information under that legislation.

MR HANSON: I assume that under the act there are certain responsibilities—

Dr Cooper: Absolutely.

MR HANSON: for people to safeguard medical information, and your view is that those safeguards have not been met. Does that constitute a breach of the act?

Mr Stanton: We have not come to a conclusion as to whether it is a breach of the legislation. We are flagging what the legislative requirement is in the act. You may have to get some legal advice on that. But we have called that into question.

MR HANSON: So that has been called into question.

Dr Cooper: That is right.

MR HANSON: Are you further investigating or what is happening now?

Dr Cooper: No. This is an audit that we feel we have delivered to the Assembly that will allow the Assembly to seek particular actions that they may wish, and also for the Health Directorate to take on board. As we do in our normal audit programs, we will be looking forward, because as you would appreciate, there are competing priorities. So we have to look at where we feel we can add significant value.

MR HANSON: There seem to be a whole bunch of other things that this audit has uncovered—potential breaches of the Privacy Act, managerial issues and cultural issues, HR issues, IT systems issues. You have uncovered these probes but the depth and breadth of the problems within the directorate seem to be quite extensive. So you will now incorporate that into your—

Dr Cooper: We will consider that in competing priorities for future audits. But we would also hope that in the system that prevails we put forward the audit, the Assembly has the information, the agency has the information. While audits are about accountability, they are also about continual improvement. So we would hope that the agency in particular would take on board a lot of this and then, when we look at it in the future, we can see where they have moved to.

MR HANSON: So between audit, the Assembly and the Health Directorate, there is a lot to do.

Dr Cooper: It depends upon whether or not the hospital, ACT Health, consider that they have got different things under control.

MR HARGREAVES: In the context of that privacy issue just raised, is it appropriate to make judgements either way until that is looked into? Is it appropriate to say, "We have a problem here" or "We don't have a problem there"? Would it be more prudent to wait until something has been looked at before making widespread comments?

Dr Cooper: Given the fact that the information is in a system whereby hundreds of people have access to it years and years after somebody may have been into the hospital, and yes when you go to the hospital you want quick access to any material that may help the doctor diagnose, this system was so open that we felt we had to

make a comment around that. As one doctor said to me: "If I want to know about when you last went to the hospital and what you went in for, Maxine Cooper, I can go back today and I can then tell you. It is not just about input-output. I can tell you some of the clinical things around that." So I think it is worth highlighting, to empower ACT Health to look at that issue.

MR HARGREAVES: And, given the throughput of clinical staff going through the ED, would it not be quite appropriate, indeed necessary, that the ED staff would be able to find out when Maxine Cooper went to the hospital last and why?

Dr Cooper: Absolutely, but it is the degree of access and how they do that. You could possibly achieve both, but they need to give it a little bit of attention. And it is a very vexed issue, that hospital, in terms of privacy for the person and access by the medical profession; I agree, Mr Hargreaves.

THE CHAIR: Thank you all very much. Our scheduled time basically came to a close a minute ago, so we have to conclude this public hearing. On a number of administrative matters, the committee has agreed that supplementary questions from members will only be accepted for three working days following this public hearing. Therefore I would ask members to provide any supplementary questions to the secretariat by the close of business Tuesday, 24 July 2012. Answers to questions taken on notice at this hearing and supplementary questions that will be forwarded by covering correspondence from the committee are due with the committee secretariat by Friday, 3 August 2012.

On behalf of the committee, I would like to thank you, Auditor-General, and your officials from the ACT audit office who appeared today. When the opportunity is available, a proof transcript will be forwarded to witnesses to provide an opportunity to check for accuracy and suggest any corrections.

The committee adjourned at 10.46 am.