STANDING COMMITTEE ON PUBLIC ACCOUNTS

Review of Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information*

AUGUST 2012 – INTERIM REPORT

Report 29

Committee membership

Ms Caroline Le Couteur MLA	Chair
Mr John Hargreaves MLA	Deputy Chair from 5 August 2011
	Member from 20 November 2009 to 5 August 2011
Mr Brendan Smyth MLA	Member from 5 August 2011
	Deputy Chair to 5 August 2011
Ms Joy Burch MLA	Member to 19 November 2009

Secretariat

Secretary:	Dr Andréa Cullen
Senior Research Officer:	Dr Michael Sloane
Administration:	Ms Lydia Chung

Contact information

Telephone	02 6205 0142
Facsimile	02 6205 0432
Post	GPO Box 1020, CANBERRA ACT 2601
Email	committees@parliament.act.gov.au
Website	www.parliament.act.gov.au

Resolution of appointment

The ACT Legislative Assembly appointed the Standing Committee on Public Accounts on 9 December 2008 to:

(1) examine:

(a) the accounts of the receipts and expenditure of the Australian Capital Territory and its authorities; and

(b) all reports of the Auditor-General which have been presented to the Assembly;

(2) report to the Assembly any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Assembly should be directed;

(3) inquire into any question in connection with the public accounts which is referred to it by the Assembly and to report to the Assembly on that question; and

(4) examine matters relating to economic and business development, small business, tourism, market and regulatory reform, public sector management, taxation and revenue.[1]

[1] Legislative Assembly for the ACT, *Minutes of Proceedings*, No. 2, 9 December 2008, pp. 12–13.

TABLE OF CONTENTS

Committee membership i
Resolution of appointment ii

RECOMMENDATIONS V

1 INTRODUCTION AND CONDUCT OF INQUIRY 1
Terms of Reference 3
Conduct of the inquiry 3
Boundary of inquiry 4
Structure of the interim report 4
Acknowledgements 5

2 AUDIT BACKGROUND AND FINDINGS 7
Audit background and objective 7
Audit conclusions 7
Audit findings 10
Audit recommendations 16
Government response to recommendations 18
Guidelines for Responding to Reports by the Auditor-General 18
Response to audit findings and recommendations 19

3 COMMITTEE COMMENT 29
Immediate issues associated with the alteration and misreporting of performance information 31
Weaknesses in IT systems and processes 31
Emergency department context 40
Organisational behaviour matters 47
Reporting and handling of misconduct in the ACT Public Service 49
Performance measurement in health care 55
Wider context in which the health system operates 64

4 CONCLUSION 67

APPENDIX A: WITNESSES WHO APPEARED BEFORE THE COMMITTEE 69

APPENDIX B: AUDIT REPORT RECOMMENDATIONS 71

RECOMMENDATIONS

RECOMMENDATION 1

2.14 The Committee recommends that the Minister for Health give consideration to finalising the Government submission to the Standing Committee on Public Accounts in response to Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information* earlier than three months after the report being tabled.

RECOMMENDATION 2

2.39 The Committee recommends that the Minister for Health make representations at the appropriate forums to progress the concept of a regular national audit by the Commonwealth Auditor-General of health performance and data integrity as it relates to Commonwealth agreements through the recently amended legislative provisions of the Commonwealth *Auditor-General Act 1997*.

RECOMMENDATION 3

3.18 The Committee recommends that the Government of the day review the security of information which identifies individual patients at the Canberra Hospital and report on the outcomes of this review to the ACT Legislative Assembly on the first sitting day of 2013.

RECOMMENDATION 4

3.20 The Committee recommends that the Health Directorate in conjunction with Shared Services ICT ensure that appropriate training on every IT related hospital system, with a particular focus on the Emergency Department Information System (EDIS), is provided to all staff at the Canberra Hospital and Calvary Public Hospital.

RECOMMENDATION 5

3.24 The Committee recommends that robust data validation processes be established for the Canberra Hospital and that the Government of the day report to the ACT Legislative Assembly on the first sitting day of 2013 on their implementation.

RECOMMENDATION 6

3.32 The Committee recommends that, consistent with the recommendation of the Auditor-General, the rapid sign-on system be implemented as soon as practicable and that the Government of the day report to the ACT Legislative Assembly at the earliest opportunity on its implementation.

RECOMMENDATION 7

3.36 The Committee recommends that all ACT Government directorates and agencies should have effective practices and processes in place to review all reports of the Auditor-General, and to assess the relevance of the findings and recommendations to their agency, regardless of whether the agency was involved in a specific audit.

RECOMMENDATION 8

3.39 The Committee recommends that all ACT Government directorates and agencies should prioritise as a matter of urgency an assessment of the adequacy of controls over their respective IT systems and applications. This should include consideration of the controls that affect the reliability of all IT systems and applications (general controls) and controls that are specific to each application (application controls).

RECOMMENDATION 9

3.57 The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, how it will address and improve issues about achievements against throughput and triage targets as they relate to the Emergency Department at the Canberra Hospital.

RECOMMENDATION 10

3.63 The Committee recommends that clear guidelines be established concerning internal communication between the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.

RECOMMENDATION 11

3.64 The Committee recommends that clear guidelines be established concerning external communication regarding matters concerning the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.

RECOMMENDATION 12

3.68 The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, what action the Health Directorate has taken to assess whether a prevailing organisational culture at the Canberra Hospital contributed to the circumstances surrounding the alteration and misreporting of performance information.

RECOMMENDATION 13

3.81 The Committee recommends that, given the Health Directorate's failure to protect the privacy of the Executive who admitted to altering data—prior to any civil, criminal or administrative proceedings—the Health Directorate should: (i) issue a public apology to the individual concerned; and (ii) take appropriate steps to acknowledge the individual's contributions to the operation and administration of the Canberra Hospital.

RECOMMENDATION 14

3.86 The Committee recommends that the Commissioner for Public Administration, in consultation with ACT Government directorates and agencies, develop a whole-of-government policy for the management of private information relating to ACT Public Service employees and recipients of ACT Government services.

RECOMMENDATION 15

3.103 The Committee recommends that the Government of the day should inform the ACT Legislative Assembly, at the earliest possible opportunity, if the emergency access targets under the *National Partnership Agreement on Improving Public Hospital Services,* will not be reached by the Canberra Hospital for the 2012 calendar year.

RECOMMENDATION 16

3.124 The Committee recommends that the 8th ACT Legislative Assembly Standing Committee on Public Accounts should give due consideration to conducting an inquiry into the process of future delivery of health care services across the Canberra Hospital and Calvary Public Hospital.

1 INTRODUCTION AND CONDUCT OF INQUIRY

1.1 On 5 April 2012, the Australian Institute of Health and Welfare (AIHW) informed the Health Directorate of anomalies in data it had been provided from the Canberra Hospital Emergency Department. The Health Directorate undertook an initial investigation to determine whether the AIHW's concerns were warranted and determined that further investigation was required.[2]

1.2 On 21 April 2012, an executive at the hospital met with the Director-General and admitted to making improper changes to hospital records.[3]

1.3 On 27 April 2012 the Health Minister wrote to the Auditor-General to request that the Auditor-General undertake a performance audit of the Health Directorate's data collection, reporting and integrity systems.[4]

1.4 On 1 May 2012 the Deputy Chief Minister made a statement to the ACT Legislative Assembly (the Legislative Assembly) on the actions the Health Directorate was taking to address the data manipulation issue. The Deputy Chief Minister also informed the Assembly that he would take ministerial carriage of matters concerning the investigation. He stated that the Chief Minister had:

> …acknowledged that she knew the officer involved, in a professional capacity. However, Ms Gallagher has also acknowledged that the officer involved has a personal relationship with a relative of hers. It is for this reason that the Chief Minister has decided to step aside from the investigation to resolve any concerns or allegations of a potential conflict of interest.[5]

---

[2] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 4.

[3] *Ibid*., p. 4.

[4] *Ibid*.

[5] Mr Andrew Barr MLA, 'Canberra Hospital—emergency department data, Statement by Minister', Legislative Assembly for the ACT, *Debates*, 1 May 2012, p. 1639.

1.5 Following the statement by the Deputy Chief Minister, the Legislative Assembly also passed a motion which, in part, requested the Auditor-General to inquire into the data manipulation at Canberra Hospital:

> That this Assembly:
> (1) notes:
> (a) the Assembly's concern about alleged manipulation of Emergency Department data at The Canberra Hospital;
> (b) the need for the community to have confidence in the data that is being publically reported;
> (c) the work already underway to investigate the allegations and data collection systems;
> (d) that the Chief Minister has already written to the Auditor-General requesting that she undertake a performance audit of the Health Directorate's data collection, reporting and integrity systems; and
> (e) that the responsible Minister will make a further statement to the Assembly once those investigations are completed;
> (2) requests the Auditor-General to inquire into data discrepancies in Emergency Department waiting times at The Canberra Hospital; and
> (3) calls on the Assembly to offer its support to all of the staff at the Health Directorate who have been affected by this matter and who continue to provide our community with the highest standard of care possible through the provision of 24 hour access to emergency health care.[6]

1.6 The Health Directorate also engaged PricewaterhouseCoopers (PwC) on 1 May 2012 to 'provide forensic services to determine the integrity of ED *[emergency department]* records and processes, and other information assets with the ACT Health Directorate.'[7] The results of this review were presented to the Director-General of the Health Directorate on 29 June 2012 and included the following executive summary:

> We identified that an executive of The Canberra Hospital was responsible for a number of changes to Emergency Department (ED) data relating to wait times across triage categories 2, 3, 4 and 5.
>
> These changes have primarily occurred since January 2011. There were 7,506 changes in 2011 equating to 11.9% of all presentations and 2,733 changes to April 2012 equating to 11.4% of all presentations. An executive of the ED has admitted to making changes to the data.

---

[6] Legislative Assembly for the ACT, *Minutes of Proceedings*, No. 145, 1 May 2012, pp. 1863–1864.

[7] PricewaterhouseCoopers, *ACT Health Directorate Emergency Department Information System Data Integrity Summary Report*, 29 June 2012, p. 1.

> We note that there is a possible risk of other unidentified persons making changes to data some of which may date back to 2009.[8]

1.7 On 3 May 2012, the Auditor-General announced that she would conduct a performance audit in relation to Canberra Hospital Emergency Department performance data.[9]

1.8 Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information* (the Audit report) was presented to the Speaker of the Legislative Assembly on 3 July 2012. In accordance with the resolution of appointment of the Standing Committee on Public Accounts (the Committee), the Audit report was referred to the Committee for examination.[10]

Terms of reference

1.9 The Committee's terms of reference were to examine the Audit report and report to the Legislative Assembly.

Conduct of the inquiry

1.10 As noted above, under its resolution of appointment, the Committee examines all reports of the Auditor-General which have been presented to the Legislative Assembly. The Committee has established procedures for its examination of these reports.[11]

1.11 In accordance with these procedures, the Committee received a private briefing on the Audit report from the Auditor-General on 10 July 2012. After considering the Audit report, other information available in the public domain, and evidence from the 2012–13 Select Committee on Estimates public

---

[8] PricewaterhouseCoopers, *ACT Health Directorate Emergency Department Information System Data Integrity Summary Report*, 29 June 2012, p. 1—available at: http://health.act.gov.au/publications/reports/emergency-department-information-system-data-integrity-summary-report

[9] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 4.

[10] Legislative Assembly for the ACT, *Minutes of Proceedings*, No. 2, 9 December 2008, pp. 12–13.

[11] Available at: http://www.parliament.act.gov.au/committees/AGReports.asp

hearing of 5 July 2012, the Committee resolved on 10 July 2012 to inquire further into the Audit report and to table an interim report in August 2012.

1.12 The Committee held two public hearings on the Audit report findings. On 19 July 2012, the Committee heard from the Auditor-General and officials from the Auditor-General's Office. The Committee heard from the Minister for Health and officials from the Health Directorate on 20 July 2012.

1.13 Witnesses who appeared before the Committee are listed at **Appendix A** and transcripts of the public hearings can be accessed from the Committee's website.[12]

1.14 The Committee met on 2 August 2012 to discuss the Chair's draft interim report. The Committee met on 13 August 2012 to discuss the Committee's draft interim report which was adopted on 13 August 2012.

Boundary of inquiry

1.15 From the outset of the Inquiry, the Committee emphasised at each public hearing the boundary of its inquiry. Specifically in relation to the misreporting of data this was concerned with ensuring that questions and answers needed to be careful not to stray into matters that were: (i) currently under consideration by the police; and (ii) before, or due to come before, any disciplinary or misconduct proceeding.[13]

Structure of the interim report

1.16 The Committee's report is divided into four sections:

- Chapter 1—Introduction and conduct of inquiry
- Chapter 2—Audit background and findings
- Chapter 3—Committee comment
- Chapter 4—Conclusion

---

[12] http://www.hansard.act.gov.au/hansard/2009/comms/default.htm#public

[13] *Transcript of evidence*, 19 July 2012, p. 1; *Transcript of evidence*, 20 July 2012, p. 31.

Acknowledgements

1.17 The Committee thanks the Minister for Health and officials from the Health Directorate, and the Auditor-General and officials from the Auditor-General's office, who assisted the Committee during the course of its inquiry by appearing before it to give evidence and/or by providing additional information.

1.18 The Committee acknowledges the professional staff—doctors, nurses, allied health and other clinicians—who deliver health care services in ACT's public hospitals and the vast array of non-clinical staff (including significant numbers of volunteers) who support the professionals in the delivery of these services.

1.19 The Committee also acknowledges that health care services are delivered in ACT public hospitals—24 hours a day, 7 days a week, 365 days a year under significant pressure and increasing demand.

2 AUDIT BACKGROUND AND FINDINGS

2.1 This chapter presents an overview of the background to, and key findings of the Audit.

Audit background and objective

2.2 The objective of the Audit was to provide an independent opinion to the Legislative Assembly on:

- the circumstances associated with the alleged misreporting of Canberra Hospital Emergency Department performance information
- the effectiveness of the Health Directorate's systems and processes for reporting Emergency Department performance information, and
- the financial implications for the Territory associated with any potentially misreported Emergency Department performance information.[14]

Audit conclusions

2.3 The Audit report contained the following audit conclusions drawn against the Audit objectives:

> Hospital records at the Canberra Hospital have been deliberately manipulated to improve overall performance information and reporting of the Canberra Hospital's Emergency Department. The very poor controls over the relevant information 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, an executive at the Canberra Hospital has admitted to making improper changes to hospital records. While this is the case, Audit considers that it is probable that improper changes to records have been made by other persons.
>
> 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 records relating to Emergency Department presentations were manipulated during this period. The records that were manipulated mean

[14] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 4.

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.

Data manipulation

The executive has admitted to manipulating hospital records initially in 2010 and on a much larger scale throughout 2011 into early 2012. The executive's admission of manipulating records does not account for all of the changes that were made to hospital records, where timeliness information was improved. The executive did not admit to making changes to records in 2009. Furthermore, changes to hospital records made throughout 2010 and early 2012 are not all accounted for by the executive's admission.

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. In this respect, Audit notes that there is a significant and ongoing focus on the timeliness performance of the two Canberra hospitals more broadly, and their emergency departments more specifically. Audit also notes that the recent National Partnership Agreement between the states and territories and the Commonwealth has placed an additional focus on hospital waiting times, targeting $3.4 billion in investment over the eight years to 2016-17 on hospital improvement. Of this Commonwealth funding, a comparatively small proportion ($200 million nationally and $3.2 million for the ACT) is directly dependent on improvements to Emergency Department timeliness performance. There is a considerable lack of attention on qualitative indicators, which may provide a more appropriate and rounded assessment of Emergency Department performance.

Managerial pressure was placed on the executive to improve the performance of the Emergency Department. This managerial pressure reflects the significant and ongoing focus on the timeliness performance of the Canberra Hospital and the requirements of the National Partnership Agreement. An organisational change management agenda was also underway at the Canberra Hospital since the restructure of the Health Directorate in early 2011. The organisational change process underway at the Canberra Hospital sought to achieve improved performance and accountability for performance.

Organisational change can be challenging and confronting for staff. In relation to the organisational change that was underway at the Canberra Hospital throughout 2011, one stakeholder commented to Audit:

The hospital is very resistant to outsiders coming in, very resistant. In a way, it's a very protected community and it has developed from a small regional hospital, you know, the Woden Valley Hospital, to the major tertiary referral centre for the region. And one of the challenges...is whether the change has happened as it's needed to for staff to move into that much more professional high-pressure dynamic organisation.

Although managerial pressure was placed on the executive to improve the performance of the Emergency Department, this was not manifested in direct or indirect instruction or guidance to deliberately manipulate hospital records. Furthermore, there was no direct or indirect instruction by any other person, including the Minister for Health.

Very poor systems and practices

The very poor systems and practices in place in the Canberra Hospital and the Health Directorate for preparing and publicly reporting performance information created the opportunity for persons to manipulate the hospital records. The Emergency Department's management information system, which is used to prepare the performance information, has very poor system access and user controls. There is a lack of governance and administrative accountability for this system, which means that there is no identifiable system owner with responsibility for ensuring the integrity of the system and the appropriateness of its access and user controls.

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. The very poor systems and practices also mean that there is a risk that the Health Directorate does not meet the requirements of Principle 4.1 of the *Health Records (Privacy and Access) Act 1997* relating to the safekeeping of personal health information.

Audit notes that the same management information system, albeit a newer version, is used at the Calvary Public Hospital. There are more effective system access and user controls over the newer system at the Calvary Public Hospital. Nevertheless, some features of the newer system and its implementation at the Calvary Public Hospital may also give rise to risks relating to the privacy and confidentiality of patient information and the potential manipulation of hospital records to improve timeliness performance reporting. There is also a risk, albeit to a lesser extent, that Calvary Public Hospital does not meet the requirements of Principle 4.1 of the *Health Records (Privacy and Access) Act 1997* relating to the safekeeping of personal health information.

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. Various data validation processes are in place within the Health Directorate, but these processes have not been designed to provide assurance over the integrity and accuracy of publicly reported Emergency Department performance information.

Audit notes that the current monitoring, review and assurance processes over the publicly reported Emergency Department performance information are not consistent with the apparent importance of the performance information, as demonstrated by the significant Health Directorate management and stakeholder interest.

Commonwealth funding
A comparatively small amount of Commonwealth funding 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 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.[15]

Audit findings

2.4 The Audit report provides a summary of key findings to support its conclusions. The conclusions are grouped according to three audit themes: (i) emergency department performance information (ii) systems and processes for reporting performance information; and (iii) data manipulation at the Canberra Hospital—which are reproduced below:

Emergency Department performance information

- Between 2008-09 and 2010-11, demand for ACT Emergency Department services has increased by more than the growth in the ACT population and more than the average national growth in demand for Emergency Department services.
- In all jurisdictions, there is a strong public focus on the performance of the health system. In the ACT the performance of the two public hospitals is particularly important and this receives significant and ongoing attention from the media, Legislative Assembly and the community in general.
- Since 2000-01, based on the Health Directorate's publicly reported performance information, there has been variable performance against waiting time indicators, and it is apparent that there has been an overall decline in performance over the last ten years. On the basis of the apparent

[15] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, pp. 4–7.

manipulation of hospital records discussed in detail in Chapter 4, it appears that the Health Directorate's performance has been over-estimated during this period.

- The level of over-estimation cannot be established with certainty due to the lack of a clear audit trail identifying what were legitimate and what were fabricated entries in patients' records. Nevertheless, Audit estimates that in the latest twelve months for which records have been examined (April 2011 to April 2012), the Canberra Hospital's ATS Category 3 results (i.e. achievements against the target) were overstated by at least 19 percent, and ATS Category 4 results were overstated by at least 10 percent.
- Emergency Department waiting times are reported with reference to the Australasian Triage Scale (ATS). The Australasian College for Emergency Medicine conducted a review of the ATS, which identified that the ATS should only be used to describe urgency and that separate measures are needed to assess quality of care.
- Emergency Department length of stay is primarily reported against the recently introduced four hour National Emergency Access Target (NEAT), which has been introduced as part of the National Partnership Agreement on *Improving Public Hospital Services* agreed to by the Commonwealth and all states and territories in 2011. An Expert Panel review of the introduction of the NEAT identified that there are risks associated with the introduction of quantitative targets such as the NEAT. The Expert Panel recommended that the targets themselves may pose a risk to safety and quality of patient care, in the absence of a balanced suite of indicators which measure different dimensions of quality.
- The ACT's hospitals' performance against timeliness indicators is regularly reported externally through a number of different mechanisms. There is a lack of qualitative indicators against which the Health Directorate regularly reports.
- Internal reporting on performance occurs on a high-frequency basis and is focused on quantitative measures. There is an opportunity to develop a more extensive and effective suite of indicators for public reporting, including qualitative indicators, against which Emergency Department performance should be reported.
- Emergency Department personnel spoken to by Audit advised that Emergency Department personnel are 'primarily interested in saving lives and providing high quality care, regardless of the existence of the targets'. Emergency Department personnel advised that the performance indicators are not targets that can be achieved by the Emergency Department itself, as

they are dependent on many variables that they have no control over, such as staffing, access block and demand for emergency services.

- The introduction of a four hour rule in the United Kingdom, similar to the NEAT, was accompanied by widespread gaming and fraudulent manipulation of hospital data.
- A 2009 Victorian Auditor-General's Office review of performance measurement in Victorian public hospitals identified that there was a significant risk of incorrect reporting associated with Emergency Department timeliness performance. Inconsistently interpreted reporting rules and data capture methods, as well as poor security over information systems, meant that 'it was not possible to assure that reported performance against the majority of access indicators fairly represented actual performance'.
- A 2008 Deloitte Touche Tohmatsu internal audit of emergency department performance reporting in New South Wales concluded that triage benchmark reports are limited in value as an accurate record of emergency department activity and performance due to inconsistencies in the way data is captured and recorded. The audit also found that the majority of hospitals used the same information system that is currently in use at the Canberra hospitals and that access controls within the system were ineffective and provided poor audit trail capabilities.
- The ACT Health Minister advised Audit that she has raised the issue of the risk of inaccurate measurement and reporting of performance indicators under the National Partnership Agreement at the National Ministerial Standing Council on Health.[16]

Systems and processes for reporting performance information

- An Emergency Department management information system primarily captures workflows and the allocation of patients for treatment according to ATS categories. The system also facilitates the recording of clinical and administrative data relevant to a patient's treatment.
- The Canberra Hospital and the Calvary Public Hospital both use the iSOFT Emergency Department Information Solution (EDIS) system. EDIS had been in place at the Canberra Hospital for approximately 15 years, while EDIS was only introduced at the Calvary Public Hospital in January 2012.

---

[16] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, pp. 7–9.

iSOFT's EDIS has been implemented in over 190 emergency departments across Australia, New Zealand, Canada and the United Kingdom.

- At the Canberra Hospital there is very poor EDIS system governance documentation, with no documentation for describing the system, its business owner, applicable policy, record-keeping obligations, training requirements and roles and responsibilities. While there was a lack of similar documents at the Calvary Public Hospital, Audit identified a range of governance documents reflecting the recent development and implementation phases of the new EDIS.
- At the Canberra Hospital, there is no identifiable EDIS system administrator with responsibility for managing internal administrative issues such as user management and activity monitoring. The lack of an identifiable system administrator has lead to a number of policy breaches, administration gaps and poor system practices. Discussions with Health Directorate and Shared Services ICT staff indicated that each party thought the other was responsible for key system administration activities.
- There are no formal training arrangements in place at the Canberra Hospital with respect to the use of EDIS. At the Calvary Public Hospital, planned and structured training has necessarily been provided with respect to EDIS and its use, given that it is a newly implemented system. At the time of audit fieldwork, however, there were a number of Calvary Public Hospital potential users who are yet to receive training.
- System security controls over EDIS are very poor at the Canberra Hospital. The very poor system security associated with EDIS at the Canberra Hospital means that a number of Health Directorate and ACT Government policies have not been complied with. There is no evidence that EDIS and its data had been classified or that there is a documented system security plan, as required by the *Shared Service ICT Security Policy*.
- User access controls over EDIS are very poor at the Canberra Hospital. The proliferation of EDIS access throughout the hospital, the widespread use of generic user logons and the very poor password controls over the generic logons has severely compromised the integrity of the data in the system. The very poor user access controls associated with EDIS at the Canberra Hospital means that a number of Health Directorate and ACT Government policies have not been complied with.
- Computer terminals carrying the EDIS application are widely available throughout the Canberra Hospital, yet all EDIS applications use the same workstation identification. The use of a common workstation identification, combined with the use of generic accounts means that any audit log of EDIS

access and EDIS use is ineffective. These practices mean that any improper changes made to EDIS records are impossible to trace to an individual user.

- User access controls over EDIS are more effective at the Calvary Public Hospital, but there remains some room for improvement. Key shortcomings relate to the proliferation of EDIS access throughout the hospital, the use of generic user logons and the very poor password controls over the generic logons.
- Due to poor user access controls and system security for EDIS, there is a risk at both hospitals that they do not meet the requirements of Principle 4.1 of the *Health Records (Privacy and Access) Act 1997* relating to the safekeeping of personal health information.
- The use of, and practices supporting, EDIS within the hospitals was variable and has developed over time with respect to reporting key 'clock starting' and 'clock stopping' moments. The different practices mean that data accuracy over time cannot be fully relied upon and publicly reported timeliness performance information should be treated with caution.
- The data validation process at the Canberra Hospital allows administrative staff to review Emergency Department presentations where timeliness targets have been breached for the day before the review occurs. The only purpose of the data validation process is to identify opportunities to improve publicly reported timeliness figures. Records where timeliness targets have been met are not reviewed as part of this data validation process.
- The Health Directorate has limited review and assurance processes over its publicly reported Emergency Department timeliness information. Despite the apparent importance and pre-eminence of Emergency Department timeliness performance information to the ACT Government, the ACT community and other stakeholders there is a lack of rigor in the monitoring, review and assurance processes over this information.
- Performance against ATS categories is not audited by the ACT Auditor-General's Office on an annual basis as these indicators are not included in the Health Directorate's Statement of Performance. These indicators were last included in the Health Directorate's Statement of Performance in 2003-04, where the ACT Auditor-General's Office identified an Emphasis of

Matter in its audit report based on the finding that the results were unable to be independently verified due to incomplete records.[17]

Data manipulation at the Canberra Hospital

- Approximately 11,700 EDIS patient records were changed between 2009 and 2012 so that Emergency Department waiting times and patients' overall length of stay in the department appeared to be shorter than they actually were.
- The very poor EDIS user access and system controls and the very poor audit log function means that it is not possible to identify, based on EDIS records, the person or persons who may have deliberately changed the EDIS hospital records.
- A Health Directorate executive has admitted to changing EDIS records to Audit in an interview on affirmation, pursuant to section 14A of the *Auditor-General Act 1996*. While an executive has admitted to changing EDIS records, it is probable that EDIS records have also been manipulated by other persons with access to the system. The executive's admission to Audit does not appear to account for all of the changes to EDIS records that have been made to improve timeliness performance.
- The executive has stated that they were not instructed or influenced to change EDIS records. Health Directorate personnel in the executive's line of reporting up to and including the Director-General, the Minister for Health as well as a family member of the Minister for Health who has a close personal relationship with the executive, have advised Audit, under oath or affirmation, that they have not provided any direct or indirect instruction or influence to change hospital records.
- Audit considers that the actions of the executive who has admitted to manipulating hospital records is seriously inappropriate and improper conduct. The executive may have breached the ACTPS Code of Ethics and section 9 of the *Public Sector Management Act 1994*, as well the terms of their executive employment contract.[18]

---

[17] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, pp. 9–11.

[18] *Ibid*., p. 11.

Audit recommendations

2.5 The Auditor-General made **ten** recommendations, which are reproduced in full at **Appendix B**. In evidence, the Auditor-General explained the rationale underpinning the framing of these recommendations:

> 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.[19]

2.6 The following table provides a summary of the ten recommendations, grouped according to audit theme:

Audit theme	Recommendation coverage
Emergency Department performance information	R1—Review of performance indicators used in public reporting on the Canberra Hospital Emergency Department.
Systems and processes for reporting performance information	R2—Development of essential EDIS governance documentation.
	R3—Finalisation of the draft Business System Support Agreement between Shared Services ICT and the Health Directorate for EDIS.
	R4—Distribution of access to EDIS and use of generic user accounts.
	R5—Documentation of responsibilities for user access management and log monitoring for EDIS, and processes for monitoring of user access.
	R6—Link EDIS upgrade with current Health Directorate Identity and Access Management and Rapid Sign-On initiatives and consider replacement of EDIS.
	R7—Develop policy and administrative guidance for EDIS data validation activities.
	R8—Additional review and assurance controls over the preparation and reporting of Emergency Department timeliness performance information.
Data manipulation at the Canberra Hospital	R9—Director-General of the Health Directorate and the ACTPS Head of Service to note the findings of this report with respect to the executive who has admitted to manipulating hospital records.
	R10—The need for Health Directorate employees to act with integrity with respect to the maintenance of health records and associated data.

[19] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, p. 4.

Sufficient powers to conduct Audit

2.7 In evidence, the Committee was interested to know whether the provisions in the *Auditor-General Act 1996* provided the Auditor-General with sufficient scope to conduct the Audit.[20] The Auditor-General advised the Committee that:

> ...in relation to a question that sought my opinion on whether I and my Office had sufficient powers to conduct this audit. I would like to note that the *Auditor-General Act 1996* does not provide me with explicit powers to audit the activities of Calvary Health Care ACT Ltd, which operates the Calvary Public Hospital. My Office was able to audit the operations of Calvary Health Care ACT Ltd, by virtue of their agreement and cooperation. Should this agreement and cooperation not have been extended, I could not have come to an appropriate conclusion on the operations of Calvary Health Care ACT Ltd.[21]

2.8 As the Auditor-General has highlighted, the provisions in the *Auditor-General Act 1996* do not provide a mandate to audit outsourced activities and services to examine whether public funds have been:

> …applied for the purposes for which it was made and whether the money has been used economically, efficiently, and effectively.[22]

2.9 As a consequence, the Auditor-General's Office is limited in its ability to audit outsourced activities (sometimes known as 'following the dollar') and is reliant largely on the adequacy of access provisions in contracts between the relevant government agency and the funded body. In the absence of an express power under the Act, the Audit Office is constrained in its ability to provide assurance to the Legislative Assembly on the accountability and performance of these significant public expenses by non-government bodies.[23]

2.10 The Committee notes it made extensive comment in relation to the Auditor-General not having the power to audit entities receiving public money in its report inquiring into the *Auditor-General Act 1996*. To address this limitation, the Committee specifically recommended that:

---

[20] *Transcript of evidence*, 19 July 2012, pp. 24–25.

[21] ACT Auditor-General, Correspondence to the Standing Committee on Public Accounts providing supplementary information following on from the public hearing of 19 July 2012, 20 July 2012.

[22] ACT Standing Committee on Public Accounts, Inquiry into the ACT *Auditor-General Act 1996*, Submission No. 2, ACT Auditor-General's Office, January 2010, p. 4.

[23] *Ibid*.

> ...the ACT *Auditor-General Act 1996* be amended to provide the ACT Auditor-General with an express authority to audit outsourced activities of the Government. This should provide the Auditor-General with authority to: (i) access documents of a recipient of public money; and (ii) audit a recipient organisation itself or the service(s) it provides.[24]

Government response to recommendations

Guidelines for Responding to Reports by the Auditor-General

2.11 In accordance with the *Guidelines for Responding to Reports by the Auditor-General,* government submissions to Auditor-General's reports should be provided to the Public Accounts Committee within three months of the report being tabled.[25]

2.12 The Committee acknowledges that if the full three month timeframe is taken the Government submission in response to the Audit report will fall due after the caretaker period has commenced.

2.13 As a means of avoiding this circumstance, the Committee suggests that the Government give consideration to providing its submission to the Audit report earlier than three months after the report being tabled, i.e., prior to the caretaker period. This proposed timeframe would permit the Committee to receive the submission, authorise it for publication, and thereafter have it uploaded to its referred Auditor-General's homepage.[26]

RECOMMENDATION 1

2.14 **The Committee recommends that the Minister for Health give consideration to finalising the Government submission to the Standing Committee on Public Accounts in response to Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information* earlier than three months after the report being tabled.**

---

[24] ACT Standing Committee on Public Accounts. (2010) Report on Inquiry into the ACT *Auditor-General Act 1996*, February 2010, p. 111.

[25] ACT Government. (2009) *Guidelines for responding to reports by the Auditor-General*, November, p. 3.

[26] http://www.parliament.act.gov.au/committees/AGReports.asp

Response to audit findings and recommendations

2.15 In evidence to the 2012–13 Select Committee on Estimates[27] and the Committee, the Minister for Health indicated that the Government had accepted all of the recommendations. The Minister told the Committee:

> ...I want to assure the committee that the recommendations from the audit are being taken seriously and that the work and resources will be allocated to ensure that necessary improvements are made as soon as possible.[28]

2.16 In evidence, the Minister for Health detailed action being taken to respond to the audit findings and its recommendations. This included: the Government's initial response; work that has already commenced; and measures to be progressed and implemented in the near future. These are discussed below.

2.17 The Minister for Health emphasised that the changes made to the emergency department (ED) performance data in no way reflected on the professionalism of staff at the Canberra Hospital (TCH) ED and the quality of care patients presenting at the ED receive. The Minister commented

> The care provided within the emergency department has not been affected by any changes to the data, as these data changes were made after the care in the emergency department had been completed.[29]

2.18 The Minister expressed a view that the issues identified in the Audit report and the forensic audit report by PricewaterhouseCoopers were clearly concerned with data and data systems, specifically the Emergency Department Information System (EDIS), and were not about the quality of patient care. The Minister elaborated:

> The primary purpose of EDIS, which is the IT system used in the emergency department, is to support staff to deliver patient care in the emergency department, and it is the clinical care in the ED that must remain paramount.[30]

2.19 The Minister acknowledged the increasing pressure being placed on emergency departments across the country.[31] In the case of the ACT:

---

[27] Public hearing—Thursday 5 July 2012.

[28] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33.

[29] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1370.

[30] *Ibid*.

[31] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 34.

> ...presentations to the emergency department...are increasing at a rate that is both higher than the rate of emergency departments elsewhere in Australia and significantly higher than population growth. At the same time, there is intense attention from a range of quarters on and calls to improve ED timeliness which I believe have created additional pressure on hospital staff.[32]

2.20 Notwithstanding that the TCH is a high pressure environment, the Minister did not believe that these circumstances provided any justification for a staff member:

> ...to deliberately interfere with or change data.[33]

Consistency in definitions for the use of ED data at a national level

2.21 The Minister highlighted that, amongst other things, the matter raises the importance of consistency in definitions for the use of ED data at a national level. At the present time there is no consistency with variable interpretation concerning data definitions and reported data across jurisdictions. The Minister elaborated:

> At a national level it is essential that we have agreed definitions for the use of ED data, and this is not the case at the moment. We have to put a stop to the variable interpretation that currently exists around data definitions and reported data, ensuring that we obtain and report data that is comparable between states and territories. This goes for elective surgery data as well, and I have been saying this for some time.[34]
>
> ...I will push hard with my interstate colleagues for agreed national definitions for ED data. We need to know that we are comparing apples with apples, and at the moment we do not. I will also argue strongly for regular national data audits using a common methodology.[35]

2.22 The Committee notes that the report of the Expert Panel reviewing elective surgery and emergency access targets under the *National Partnership Agreement on improving public hospital services* emphasised the importance of clear and consistent measurement with respect to targets under the

---

[32] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[33] *Ibid*., p. 1370.

[34] *Ibid*., p. 1371.

[35] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, pp. 33–34.

Agreement.[36] A key aspect underpinning consistent measurement is clarity about definitions. The Expert Panel stated:

> Confidence in, and the effectiveness of, the targets will be limited if there are not clear and consistent approaches nationally to their measurement. This concern was raised during consultations in relation to current measurement and approaches for both emergency departments and elective surgery, and is critical to ensuring that targets apply equally to all participating hospitals. We have made recommendations on these issues for emergency departments...and concerning inconsistencies in the categorisation of elective surgery patients...[37]

2.23 In evidence, the Minister for Health highlighted the challenges in achieving agreement at a COAG level on national definitions for ED care and also in relation to elective surgery. The Minister emphasised:

> Every time health ministers get together to talk about data issues, because this is a particular area, there is a lack of agreement or willingness to agree on national definitions for emergency department care, that is, what stops the clock. There is also a reluctance to agree in relation to elective surgery performance as well.
>
> The reality is that there is no measure of like with like. There is none. I have been saying that for years. That is not something I am saying just because we have got this audit report. I do not believe there will be national agreement reached because it is more likely not in any other health system's interest, particularly those whose data is looking very good, to change the way that they are reporting their data. Without getting everyone to agree on what is like with like, no-one can say that each hospital is being measured the same way.
>
> For a small jurisdiction, with two hospitals under enormous pressure, that will always put the ACT on the back foot. It is simply the case.[38]

2.24 With regard to performance measurement, the Minister for Health was supportive of the Auditor-General's recommendation for developing broader measures of ED performance.[39] As to practical implementation, the Minister explained:

---

[36] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June.

[37] *Ibid*., p. xv; pp. 32–34.

[38] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, pp. 36–37.

[39] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

> Work will also commence immediately in relation to other performance indicators for the ED that measure clinical outcomes and patient satisfaction. I think this work needs to be led nationally, and there is an expert panel established under the national partnership agreement on improving public hospital services, the AIHW and the National Health Performance Authority to further explore development of a more rounded suite of outcome indicators for emergency department care.[40]

2.25 The development of broader measures of ED performance, of which timeliness is one of a number, would give rise to more robust and meaningful outcome indicators to capture the full extent of ED care.[41]

Information technology controls

2.26 The Minister acknowledged that the Audit had identified problems with the controls and management of the EDIS at TCH. The Minister added that the Health Directorate was working to implement the recommendations as they relate to the shortcomings identified with the EDIS.[42] The Minister elaborated:

> Resources will be dedicated to implementing the action plan, starting immediately. Some of the recommendations require changes to technical functionality of the existing system, and the Health Directorate will commence working with the software vendors on those.[43]

2.27 In terms of addressing issues in relation to IT systems and processes it is imperative that any corrective measures do not impact on the functioning of the ED in a counterproductive way. The Director-General emphasised:

> ...in terms of addressing these issues, we need to ensure that we do not completely disable a functioning emergency department. This is in the context of highly trained professionals undertaking their professional role.[44]

---

[40] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[41] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, pp. 33–34.

[42] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[43] *Ibid*.

[44] Dr Peggy Brown, *Transcript of evidence*, 20 July 2012, p. 39.

Data integrity and validation

2.28 In relation to strategies to strengthen data integrity, the Committee was told that plans were underway for the independent development of a data integrity strategy for implementation across the Health Directorate. The Minister stated:

> ...I will commission from independent experts a data integrity strategy to implement across the Health Directorate. Preparatory work is already underway on setting out the various data and information systems in use and their current governance and reporting mechanisms.[45]

2.29 The development of a data integrity strategy will be supplemented by the creation of a new position—a director of data integrity. With regard to this new position and its scope, the Committee was told:

> We will also establish a new position of director, data integrity, which will be appointed in the Health Directorate. It will sit outside of the hospital structures and report directly to the director-general.[46]

2.30 The Committee queried whether strategies to strengthen data integrity would extend to Calvary Public Hospital (CPH) and was told:

> I think, considering the issues, we will work collaboratively with Calvary over any information that we get to improve our data processes here that could be shared with them. But ultimately that is a matter for them.[47]

2.31 The Minister advised that work to be undertaken with regard to enhancing data integrity would be further strengthened if a regular national audit was conducted across all jurisdictions:

> A regular national audit across all jurisdictions could further strengthen this process, and I will discuss this further with my ministerial colleagues. A national audit process would ensure that all jurisdictions are audited regularly and under the same audit methodology.[48]

---

[45] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[46] *Ibid*. p. 1371.

[47] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 34.

[48] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

2.32 The Committee acknowledges recent amendments to the Commonwealth *Auditor-General Act 1997* which give the Commonwealth Auditor-General the authority to audit 'Commonwealth Partners' under provisions set out in that Act may be a suitable mechanism for a national audit across jurisdictions. Such an audit could also consider consistency in definitions for the use of ED data and associated reporting.

2.33 'Commonwealth Partners' are defined in the Commonwealth Act to include:

> ...state and territory bodies, and contractors, that receive money for a Commonwealth purpose and have agreed to use the money in achieving the Commonwealth purpose.[49]

2.34 Importantly under the legislation, audits of state and territory bodies may only be undertaken by the Commonwealth Auditor-General following a request from the Joint Committee on Public Accounts and Audit (JCPAA) or the responsible Minister. Furthermore, the Act also allows the Commonwealth Auditor-General to ask the JCPAA or the responsible minister to make a request.[50]

2.35 The Commonwealth Auditor-General has highlighted that this new provision has a number of benefits. These benefits extend to the Commonwealth itself and jurisdictions receiving funds to deliver specified outcomes in accordance with agreements involving the Commonwealth. This includes, amongst other things:

- Responding to what is considered a contemporary challenge in public administration—that of managing effectively across organisational borders and a national audit focus could assist in examining how risks and performance are managed across jurisdictions.
- When multiple jurisdictions are involved in an audit, there is the ability to: compare and contrast performance by state and territory bodies; and learn from the better performing jurisdictions for the benefit of all.[51]

---

[49] McPhee, I. (2012) Audits of Commonwealth Partners, Presentation to ACPAC Mid-Term meeting, 25 May 2012—available at: http://www.anao.gov.au/Publications/Speeches/2011-2012/Audits-of-Commonwealth-Partners; *Auditor-General Act 1997* (C'wth).

[50] *Ibid*.

[51] *Ibid*.

2.36 The Committee sought the Auditor-General's views as to the plausibility of using the legislative provisions as provided for in the amended Audit Act of the Commonwealth Auditor-General to conduct a regular national audit along the lines suggested by the Minister for Health. The Auditor-General commented:

> 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.[52]

2.37 The Committee believes that there is merit in exploring the suitability of legislative provisions as provided for in the recently amended Commonwealth Auditor-General Act to provide for conducting a regular national audit of health performance and data integrity as it relates to Commonwealth agreements. Such an audit should also consider consistency in definitions of ED data requirements and parameters and associated reporting.

2.38 The Committee is also of the view that an audit along these lines would provide a baseline from which further changes could be made and assessed.

RECOMMENDATION 2

2.39 **The Committee recommends that the Minister for Health make representations at the appropriate forums to progress the concept of a regular national audit by the Commonwealth Auditor-General of health performance and data integrity as it relates to Commonwealth agreements through the recently amended legislative provisions of the Commonwealth *Auditor-General Act 1997*.**

---

[52] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, pp. 27–28.

Review of governance

2.40 The Audit signals that corporate governance across the Health Directorate and ACT's two public hospitals should be assessed and where weaknesses are identified that appropriate strengthening measures be put in place. The Government advised that it would be extending an invitation to Professor Mick Reid to conduct a review of governance across the Health Directorate. The Minister further explained:

> Ensuring strong governance of the hospital system is another area that requires consideration. I will be extending an invitation to Professor Mick Reid to conduct a review of governance across the Health Directorate. Professor Reid has a wealth of experience of running health systems and he also headed up a review into ACT Health back in 2002. From the government's point of view, this review would assist the directorate in strengthening, where appropriate, its corporate governance across all facets of the organisation, including at the Canberra Hospital.[53]

Follow-up audit

2.41 The Minister said an invitation had been extended to the Auditor-General to conduct a follow-up audit in 12 months time to assess progress with regard to implementation of recommendations.[54] The Committee was told:

> I have also asked the Auditor-General whether she would be prepared to carry out a review in 12 months time, to check on implementation of the recommendations. This, of course, is a matter that is up to the Auditor-General.[55]

2.42 The follow up of performance audits to assess whether agencies have addressed recommendations and findings arising from specific audits is an important exercise to inform the Legislative Assembly on progress towards implementation of accepted recommendations.

---

[53] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[54] *Transcript of evidence*, 20 July 2012, p. 33; 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, pp. 1371–1372.

[55] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33.

2.43 The Committee emphasises that it is the action taken by applicable agencies to implement audit recommendations that is all important in helping achieve better efficiency and improving accountability of the Government, not the recommendations *per se*.

Impact on Commonwealth funding

2.44 Consideration of any impact of the misreporting of performance information data on Commonwealth funding is relevant to this inquiry. This is on the basis that under the *National Partnership Agreement on Improving Public Hospital Services* (the Agreement), to which the ACT is a signatory, reward funding is linked to specified access targets for improving public patient access, amongst other things, to ED care.[56]

2.45 The Committee was interested to know whether any Commonwealth funding had been impacted by the misreporting and the Minister for Health emphasised:

> ...that no commonwealth funding has been impacted by this. Reward funding relates to the 2012 calendar year and is not due to be provided until June 2013.[57]

Conclusion

2.46 In considering the Audit findings and the Government response, the Committee notes the Chief Minister's comments:

> As Chief Minister within this community, it is my job to ensure that where problems are identified, they are fixed. And we are doing just that. I would also say that the hospital is experiencing unprecedented demand at this time and whilst these processes are important, we also need to keep focused on and support the work that is being done there right now, every day, all day and ensure that it is able to be done in a supportive environment.[58]

---

[56] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June, p. xi.

[57] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 32.

[58] *Ibid*., p. 34.

3 COMMITTEE COMMENT

It is good that we examine the structure of the delivery of health services. It is right that we try and analyse and try to control the costs of health. It would be better if, at some time, we strove to talk to one another and to the people who justify and use the services we represent, because I suspect, we would in that process find that we shared many common values, and many purposes in common. I suspect too, that we could find already existing, a language that, shorn of its jargon and its clumsy technical terms, would enable exchange of meaning, and not hinder it.

There is no doubt that economics and management ideas and methods have much to offer, but they cannot provide anything like a complete account of health and health services. They deal at a procedural and technical level with an institution that is justified by deeply held values that reflect a western regard for the worth of individual life.

If we are to develop and use economic and management models for human welfare, their simplicity must respect human complexity and individual worth. If we fail to do better than that, our models will always fall short of our desires to achieve good, and as disciplines we always will be in conflict.

I suspect also that, unless we do this soon and with determination, we will lose the opportunity forever, and that history will have the right to judge us harshly for our failure.

Emeritus Professor Miles Little[59]

3.1 The Committee is strongly of the view that the circumstances surrounding the alteration and misreporting of emergency department performance information at TCH is more than just 'about data and data systems'.

3.2 From an organisational case analysis perspective the circumstances are also about:

- The appropriateness of the application of the New Public Management (NPM) regime to the delivery of health care.
- The values that underpin the delivery of health care.

---

[59] Little, M. (1999) 'Economic Rationalism, Managerialism, Hard Facts and Soft Reasons', *ACT Pathology Newsletter*, January, p. 6; Emeritus Professor Miles Little—University of Sydney—has had an extensive career as a surgeon, academic, author, ethicist and philosopher.

- Hospitals as institutions that never shut their doors—delivering health care 24 hours a day, 7 days a week, 365 days a year.
- The professional staff—doctors, nurses, allied health and other clinicians—who deliver health care services and the vast array of non-clinical staff (including significant numbers of volunteers) who support the professionals in the delivery of these services.
- Human dignity, respect and care for the recipients of health services, the professionals who deliver these services, and those who support its delivery.
- The universal access to health care that underpins the Australian health care system.
- EDs at the frontline of our hospital systems.
- The increasing demand being placed on our hospital systems, in particular EDs as the public face of our hospitals that bear the brunt of this increasing demand.
- The changing nature of the demand on EDs—increasing acuity and complexity of presentations and the handling of primary care and social issues that are symptomatic of contemporary western society.

3.3 Hospitals are rich in what they stand for in terms of humane values for the recipients of health services, the professionals who deliver these services and those who support its delivery. In any quest to address shortcomings that may arise in the performance of hospitals, we should be careful not to jeopardise what underpins the delivery of universal health care and the motivations for why so many choose to work and volunteer in such institutions.

3.4 In responding to the audit findings and recommendations, the Executive Director of the Health Care Consumers' Association (HCCA) commented:

> I have confidence in the process, and in the commitment of the Health Directorate to address the issues that are identified in the audits. While the directorate will learn from this experience and put in place processes to increase the security of their data, we are keen for them to improve their policies and practices for supporting those staff delivering services on the frontline, as well as the executives responsible for achieving the targets. Staffing matters and workforce management are issues of importance to consumers, as our needs can only be met when staff are well supported and trained in their workplace.[60]

---

[60] Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

3.5 The Committee has striven to consider the incident that gave rise to the Audit in the wider context of the delivery of health care. It has endeavoured to focus beyond the 'blame game' and to be forward looking in its examination of the findings and recommendations of the Audit report.

3.6 The Committee's comments are framed in this context—first considering the immediate issues associated with the alteration and misreporting of performance information, followed by the issue of performance measurement as it applies to health care, and the wider system/context in which health care is delivered.

Immediate issues associated with the alteration and misreporting of performance information

3.7 In relation to immediate issues associated with the alteration and misreporting of performance information, the Committee makes comment in relation to four issues: (i) weaknesses identified in information technology (IT) systems and processes; (ii) the ED context; (iii) organisational behaviour matters; and (iv) the reporting and handling of misconduct in the ACT Public Service (ACTPS).

Weaknesses in IT systems and processes

3.8 The Audit report identified a number of weaknesses with regard to IT system controls, security and processes as they relate to the emergency department information system (EDIS). These shortcomings have been reproduced, together with the Government's response, in chapter two of this report. They can be summarised as follows—in that, the Audit found:

- very poor EDIS governance documentation at TCH
- no identifiable EDIS administrator at TCH with responsibility for managing internal administrative issues such as user management and activity monitoring
- confusion as to who—Health Directorate and/or Shared Services ICT staff—is/are responsible for key EDIS administration activities
- no formal training arrangements in place at TCH with respect to the use of EDIS

- poor system security controls over EDIS at TCH
- poor user access controls over EDIS at TCH
- computer terminals carrying the EDIS application are widely available throughout TCH, yet all EDIS applications use a common workstation identification
- user access controls over EDIS are more effective at the CPH, but there remains some room for improvement
- poor user access controls and system security for EDIS mean there is a risk at both hospitals that they do not meet the requirements of Principle 4.1 of the *Health Records (Privacy and Access) Act 1997* relating to the safekeeping of personal health information, and
- based on EDIS records, the very poor EDIS user access and system controls, together with very poor audit log function, make it not possible to identify the person or persons who have altered the EDIS hospital records.

3.9 In response, the Minister for Health commented:

> The issues identified in the Auditor-General's report and by PricewaterhouseCoopers clearly indicate that this is about data and data systems, not about patient care. The primary purpose of EDIS, which is the IT system used in the emergency department, is to support staff to deliver patient care in the emergency department, and it is the clinical care in the ED that must remain paramount.[61]

3.10 In addressing the shortcomings identified with respect to IT systems and processes, the HCCA cautioned:

> There is an issue of balance. The Health Directorate needs to put in place solutions that will enhance the protection and integrity of data without having an adverse impact on clinical workflow and timeliness within the ED. The HCCA will be interested to see how the matter of data integrity will be managed across the Health Directorate.[62]

3.11 This sentiment was also expressed by the Director-General of the Health Directorate:

---

[61] Ms Katy Gallagher MLA, Select Committee on Estimates 2012–13, *Transcript of evidence*, 5 July 2012, p. 1370.

[62] Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

> As I have indicated to you, this is an issue that we are looking at in terms of the remediation of the system that we need to undertake. Primarily that will be around ensuring that access is limited to those who need to have access. Again in terms of addressing these issues, we need to ensure that we do not completely disable a functioning emergency department.[63]

3.12 The Minister for Health has given an undertaking that all shortcomings identified by the Auditor-General with respect to IT system controls will be rectified. If the Auditor-General agrees to conduct a follow-up audit, the adequacy of this action will be assessed in approximately 12 months.

3.13 The Committee also emphasises that any rectification measures should not in any way impede the proper functioning of an ED, be appropriately resourced, and should not place any unnecessary administrative burden on already stretched ED staff.

3.14 In evidence, the Committee discussed a number EDIS governance, functionality and security aspects with witnesses. The Committee makes comment in relation to five matters set out below.

Privacy weaknesses

3.15 The Audit highlighted that poor EDIS user access controls and system security meant there was a risk that TCH and CPH may not meet the requirements of Principle 4.1 of the *Health Records (Privacy and Access) Act 1997* relating to the safekeeping of personal health information.[64]

3.16 The Committee inquired of the Auditor-General as to the scope of this risk, that is, whether it was limited to the altered records or went beyond them. The Acting Director of Performance Audits and Corporate Services explained:

> 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.[65]

---

[63] Dr Peggy Brown, *Transcript of evidence*, 20 July 2012, p. 39.

[64] Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information.*

[65] *Transcript of evidence*, 19 July 2012, p. 28.

> …
> 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.[66]

3.17 The Committee was interested to know what action was being undertaken by the Health Directorate to ensure that breaches of patient privacy were not occurring. The Director-General stated:

> As I have indicated to you, this is an issue that we are looking at in terms of the remediation of the system that we need to undertake. Primarily that will be around ensuring that access is limited to those who need to have access. Again in terms of addressing these issues, we need to ensure that we do not completely disable a functioning emergency department. This is in the context of highly trained professionals undertaking their professional role. We have not had a single complaint, to the best of my knowledge—and we have actually asked and gone back through our complaints—of any breach of privacy arising out of EDIS access.[67]

RECOMMENDATION 3

3.18 **The Committee recommends that the Government of the day review the security of information which identifies individual patients at the Canberra Hospital and report on the outcomes of this review to the ACT Legislative Assembly on the first sitting day of 2013.**

Use of EDIS

3.19 It is important to emphasise that full functionality of IT systems will not be realised if user training is fragmented and/or non-existent. The Audit found that there were no formal training arrangements in place at TCH in relation to EDIS and its use. In the case of CPH, the Audit concluded:

> At the Calvary Public Hospital, planned and structured training has necessarily been provided with respect to EDIS and its use, given that it is a newly implemented system. At the time of audit fieldwork, however, there were a number of Calvary Public Hospital potential users who are yet to receive training.[68]

---

[66] Mr Brett Stanton, *Transcript of evidence*, 19 July 2012, p. 28.

[67] Dr Peggy Brown, *Transcript of evidence*, 20 July 2012, p. 39.

[68] Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information*, p. 9.

RECOMMENDATION 4

3.20 **The Committee recommends that the Health Directorate in conjunction with Shared Services ICT ensure that appropriate training on every IT related hospital system, with a particular focus on the Emergency Department Information System (EDIS), is provided to all staff at the Canberra Hospital and Calvary Public Hospital.**

3.21 Robust processes for validating data entered into IT systems are critical aspects underpinning proper use of these systems. Furthermore, data validation processes should not be exclusively focussed on instances where certain benchmarks are not met but also on instances where benchmarks are met.

3.22 The Audit found that:

> The data validation process at the Canberra Hospital allows administrative staff to review Emergency Department presentations where timeliness targets have been breached for the day before the review occurs. The only purpose of the data validation process is to identify opportunities to improve publicly reported timeliness figures. Records where timeliness targets have been met are not reviewed as part of this data validation process.[69]

3.23 The Committee also notes the findings of the PricewaterhouseCoopers' ED Information System Data Integrity Summary Report in relation to shortcomings concerning validation of final data:

> The EDIS validation process conducted by the EDIS administrators is limited to validating breach reports. Breach reports identify where the time a patient has been seen by a Doctor has not met the established benchmarks. EDIS administrators then validate whether there is a legitimate reason why the time seen by Doctor may be changed. This process does not validate other times seen by Doctor that are within the established benchmarks.[70]

RECOMMENDATION 5

3.24 **The Committee recommends that robust data validation processes be established for the Canberra Hospital and that the Government of the day report to the ACT Legislative Assembly on the first sitting day of 2013 on their implementation.**

---

[69] Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information,* p. 10.

[70] PwC. (2012) *ACT Health Directorate—Emergency Department Information System Data Integrity Summary Report*, pp. 4–5.

EDIS functionality

3.25 TCH and CPH both use the iSOFT EDIS. EDIS had been in place at TCH for approximately 15 years, while EDIS was only introduced at the CPH in January 2012. iSOFT's EDIS has been implemented in over 190 EDs across Australia, New Zealand, Canada and the United Kingdom.[71]

3.26 The Committee understands that any decision to move to a different system would have implications given the wide proliferation of the EDIS across Australia and internationally. The Committee was interested to know whether the Auditor-General had considered this in framing her recommendations and was told:

> 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.[72]

3.27 The Committee understands that an upgrade project for EDIS across both hospitals is underway.[73] As to the status on the project, the Committee was told that CPH had:

> …implemented the current version of EDIS—I forget the actual number—in January this year. The Canberra Hospital was scheduled to implement the upgraded version, the same version, shortly thereafter. However, when Calvary implemented theirs, there were some problems. That is not uncommon when you are implementing a new software system. The upgrade at Canberra Hospital has been deferred until all of those problems have been sorted out at Calvary.

---

[71] Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information.*

[72] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, pp. 22–23.

[73] *Transcript of evidence*, 19 July 2012, pp. 22–23.

> We have to be a little cautious about the issue of the generic log-ons. It is ideal to have individual log-ons but we have to ensure that EDIS is able to do what it was intended to do. It is a work-flow tool. It is a question of whether the capability of the system to allow for individual log-ons, log-offs et cetera will still exist and allow the actual intent to be manifest—for the work flow still to occur in a timely way, with individual log-ons. We will investigate that as part of the upgrade but it is not a simple decision to just say, "Implement individual log-ons," because we could potentially impact very adversely on the clinical care that is delivered and everything that we do coming out of this. We have to make sure that we are not impacting the clinical care. This issue has been about the data that reports about the care, but the care on the floor has to be allowed to continue in the same way it has been.

3.28 The Health Directorate advised that the working time line for implementation of the EDIS upgrade at TCH was scheduled for October 2012.[74]

Modern contactless logon systems

3.29 The Audit found poor user access controls and system security for EDIS at TCH. In evidence, the feasibility of installing contactless logon systems as a means of addressing the shortcomings identified with system security for EDIS was discussed with witnesses. The Director-General commented:

> The ideal would be when you can come in and swipe your swipe card in front of the computer and that will log you on and log you off. We are working on that technology. We have been working on it for a number of years. At the moment there are some issues about the interface between EDIS and that new system that is coming. But that is what we will be working towards ultimately.
>
> In the interim, we need to ensure that the work flow of the emergency department still is able to effectively continue. But we will be looking to ensure that we minimise the number of logins to EDIS and that we actually have some processes in place.[75]

3.30 The Committee understands that work is underway in the Health Directorate to progress an identity and access management system in conjunction with Shared Services ICT. Such a system comprises two functional components—identity and access management and rapid sign-on. In evidence, the Health Directorate's Chief Information Officer explained:

---

[74] Dr Peggy Brown, *Transcript of evidence*, 20 July 2012, pp. 22–23.

[75] Dr Peggy Brown, Select Committee on Estimates 2012–13, *Transcript of evidence*, 5 July 2012, p. 1390.

> ...with the identity and access management system, we have actually just launched the first phase of that this week. The first phase of it is to establish the checking of the correct identity of people when they actually are issued with both logon to PCs and equally any access to buildings and swipe card access to any facilities within the Health Directorate.
>
> Now that anyone who is presenting to the Health Directorate for any logon has to go through is 100-point check to actually obtain access to the systems. So we are issuing swipe cards as part of that process. The next phase of the identity and access management solution will be integrating the applications with the overall government login. There are some issues—need to work through and look at each of our systems to see their capacity to be able to do that.[76]

3.31 As to the expected timeframe for completion of this work, the Chief Information Officer indicated that the Directorate was hoping to have swipe card access operational for logons:

> ...over the next 12 months we will have the ability to have the swipe card access. Once again, it will be—we have to work through each of the applications and the capability to be able to integrate with the whole-of-government user logons.[77]

RECOMMENDATION 6

3.32 **The Committee recommends that, consistent with the recommendation of the Auditor-General, the rapid sign-on system be implemented as soon as practicable and that the Government of the day report to the ACT Legislative Assembly at the earliest opportunity on its implementation.**

Information technology governance across the ACTPS

3.33 Notwithstanding the Minister for Health's undertaking to resolve the shortcomings identified with respect to EDIS governance, the Committee is disappointed that similar issues with respect to IT controls, security and processes have been raised in successive reports of the Auditor-General's annual report on financial audits. This has been supplemented by the Auditor-General's recent report on whole-of-government IT security.

---

[76] Ms Judy Redmond, Select Committee on Estimates 2012–13, *Transcript of evidence*, 5 July 2012, p. 1390.

[77] *Ibid*., p. 1391.

3.34 The Committee notes that recurring issues identified by the Auditor-General, in these reports, amongst other things, have identified significant control weaknesses in relation to key applications including: ICT security, password controls, the restriction of access by users; monitoring of activities through the use of audit logs; and backup and restoration arrangements.

3.35 The Committee is strongly of the view that all government directorates and agencies should have practices and processes in place to review all reports of the Auditor-General, and to assess the relevance of the findings and recommendations to their agency, regardless of whether the agency was involved in a specific audit.

RECOMMENDATION 7

3.36 **The Committee recommends that all ACT Government directorates and agencies should have effective practices and processes in place to review all reports of the Auditor-General, and to assess the relevance of the findings and recommendations to their agency, regardless of whether the agency was involved in a specific audit.**

3.37 The Committee reiterates the comments and associated recommendations it has made regarding measures to improve IT governance and security as detailed in its report inquiring into Auditor-General's Report No. 5 of 2011: *2010–11 Financial Audits*.

3.38 Furthermore, in the context of ongoing findings that weaknesses are present in IT control environments as identified in various financial audit reports, and more recently, in audit reports on whole-of-government information and communication technology security management and services[78] and emergency department performance information[79], the Committee is strongly of the view that all government directorates and agencies should prioritise as a matter of urgency an assessment of the adequacy of controls over their respective IT systems and applications.

---

[78] Auditor-General's Report No. 2 of 2012: *Whole-of-Government Information and Communication Technology Security Management and Services.*

[79] Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information.*

RECOMMENDATION 8

3.39 **The Committee recommends that all ACT Government directorates and agencies should prioritise as a matter of urgency an assessment of the adequacy of controls over their respective IT systems and applications. This should include consideration of the controls that affect the reliability of all IT systems and applications (general controls) and controls that are specific to each application (application controls).**

Emergency department context

Emergency departments are the face of the public hospital system, and problems in emergency departments, such as overcrowding and ambulance queues are the most visible sign of strain on our public hospitals to patients and the general public.

In 2009–10, Australian public hospitals provided almost 7.4 million accident and emergency services, with an annual growth rate of 4.3 per cent per year over the past five years. In conjunction with the increase in demand for emergency services, there has been an increasing awareness of the extent and impact of emergency department overcrowding, including delays in patient care. As emergency departments fill up to their capacity and beyond, staff are stretched between more patients, it takes longer for patients to be seen, and ambulances begin queuing or are diverted as there is no room for new patients.

Expert Panel Reviewing Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services[80]

Hospitals are high-pressure environments, particularly emergency departments, due to the nature of the work and the fact that they service the community around the clock.

Minister for Health, Ms Katy Gallagher MLA[81]

The Emergency Department is a high pressure environment, for staff, hospital managers, and consumers. The department is a gateway to the acute care system and is subject to access block and overcrowding, described as being the most serious issues confronting emergency departments across Australia and the world.

Executive Director, Health Care Consumers' Association[82]

---

[80] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June, p. 21.

[81] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33.

3.40 The ED setting warrants consideration as part of the circumstances surrounding the alteration and misreporting of ED performance information. EDs across Australia and internationally are experiencing unprecedented growth in emergency presentations and admissions.

3.41 Notwithstanding an ED's primary objective is that of managing sudden unexpected illnesses, major injuries and life-threatening conditions, EDs increasingly have to deal with primary care and social problems coupled with increased complexity and acuity of unplanned presentations.[83]

3.42 As a means of attempting to address increasing demand by way of improving efficiency and capacity, NPM principles are readily applied to the delivery of health services none more so than the concept of performance measurement. The specific performance measurement tool at the centre of the alteration of data matter is that of the 4 hour NEAT target. The concept behind this target is detailed in chapter two of this report.

3.43 The rising demand on EDs coupled with the requirements of various performance measurement regimes contribute to a high pressured working environment. Such an environment impacts on ED staff, resulting in work-related stress and decreased job satisfaction. As a consequence many ED staff opt to decrease their clinical hours adding to workforce problems.[84]

3.44 In evidence, the Minister for Health whilst acknowledging that EDs across Australia are under pressure, said that presentations to the ED in the ACT are increasing at a rate higher than in other jurisdictions and that of population growth in the ACT:

> At the same time, there is significant attention on, and calls to improve, emergency department timeliness data, which increases pressure on hospital staff.[85]

---

[82] Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

[83] Chung, C.H. (2000) Emergency department misuse and administrative interventions, *Hong Kong Journal of Emergency Medicine*, 7, 4, October, pp. 220–229; Drummond, A.J. (2002) No room at the inn: overcrowding in Ontario's emergency departments, *Canadian Journal of Emergency Medicine*, **4**, 2, pp. 91–97.

[84] Forero, R. and Hillman, K. (2008) *Access Block and Overcrowding: A Literature Review*, Prepared for the Australasian College for Emergency Medicine (ACEM), Simpson Centre for Health Services Research, University of NSW.

[85] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33.

3.45 A literature review of Access Block and ED Overcrowding prepared for the Australasian College for Emergency Medicine (ACEM)[86] provides a summary of the current evidence on the subject from around the world. The Committee is of the view that some of the key points of evidence as highlighted in the Review are pertinent to its consideration of the Audit report and management of access to EDs *per se*. In particular, the Review:

- …reports on 27 factors that have been described and documented in the literature as associated with access block and overcrowding. These include health system, demographic and clinical factors. These factors are having a major impact on the primary health care system, patients, their families, health professionals and the whole community.
- There is clear evidence that the main cause of access block and ED overcrowding is a combination of major increases in emergency admissions and ED presentations with almost no increase in the capacity of hospitals to cope with the demand. Between 2002 and 2007 the rate of available beds in Australia was reduced from 1998–99 levels from 2.65 beds per 1,000 population to 2.4 in 2002, and has since remained steady between 2.5–2.6 per 1,000 population. In the same period, the number of ED presentations increased over 38 per cent, from 4.1 million to 6.7 million. When compared with 1998–99 rates, the number of available beds in 2006–07 is very similar (2.65 versus 2.60 beds per 1,000) but the number of ED presentations has almost doubled from 3.5 to 6.7 million.
- The most vulnerable individuals affected by access block and ED overcrowding are those who due to their medical conditions require unplanned admissions to hospital. The most common groups include: the elderly, particularly those with chronic and complex conditions; people arriving by ambulance; people visiting EDs after hours or on week-ends; children and parents of young children; mental health patients; drug and alcohol patients; nursing home patients; people without social support; patients with medical conditions exacerbated by seasonal changes; people with painful conditions; the undiagnosed critically ill; seriously-ill patients who leave without being seen by a doctor; and patients who are inappropriately discharged from hospital in order to increase bed availability.
- Access block and ED overcrowding impact on ED staff, resulting in work-related stress and decreased staff satisfaction. Many staff choose to decrease their clinical hours in emergency medicine, thus exacerbating workforce problems.

---

[86] Forero, R. and Hillman, K. (2008) *Access Block and Overcrowding: A Literature Review*, Prepared for the Australasian College for Emergency Medicine (ACEM), Simpson Centre for Health Services Research, University of NSW.

- There is an absence of consistent outcome measures and definitions, which make it difficult to combine study results and assess their generalisability and external validity.
- There is also a clear need for robust, longitudinal data collections and trend data on hospital indicators such as available bed rates, occupancy rates (hospital and ED), DNW rates, total access block hours, access block mortality data, etc. Annual reports from both State and Federal governments need to be consistent and comparable from year to year. For example, the 2006, 2007 and 2008 *State of Our Hospitals* reports, present a different baseline rate for the 1998-1999 year when compared with the 2005 report.

3.46 The Committee is of the view that it would be beneficial for all non-clinical Health Directorate Executives, as a means of appreciating the working environment of employees delivering acute care services in ACT public hospitals, to spend some time with hospital staff and patients, at least once a month, at a frontline area in the hospital system delivering health care. This should extend to business and out-of-hours times as well as weekends. This could be mandated, for example, through executive performance agreements.

The Canberra Hospital emergency department

3.47 In the case of the ACT, between 2008–09 and 2010–11, demand for ACT ED services has increased by more than 'the growth in the ACT population and more than the average national growth in demand for ED services'.[87]

3.48 The Minister for Health commented:

> The Auditor-General's report discusses the increasing pressure that emergency departments are placed under nationally. Her report also shows that presentations to the emergency department in the ACT are increasing at a rate that is both higher than the rate of emergency departments elsewhere in Australia and significantly higher than population growth. At the same time, there is intense attention from a range of quarters on and calls to improve ED timeliness which I believe have created additional pressure on hospital staff.[88]

---

[87] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33; Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information.*

[88] Ms Katy Gallagher MLA, Select Committee on Estimates 2012–13, *Transcript of evidence*, 5 July 2012, pp. 1370–1371.

3.49 Over the last five years, at a minimum, the increasing demand on ED services has been the subject of much discussion, oversight, scrutiny, and presentation of reports in the Legislative Assembly.[89]

3.50 It is clear that, whilst EDs across Australia are under pressure, presentations to EDs in the ACT are increasing at a rate higher than in other jurisdictions and also at a rate higher than population growth in the ACT.

3.51 One of the key problems with comparing ACT hospitals to other Australian hospital systems is that this may not compare 'like with like'. As the watershed report on understanding ACT public hospital costs pointed out:

> Not all public hospitals or systems are the same and factors such as socio-demographic composition, scope of clinical services, referral patterns, options for down-transfer of patients, accounting practices, subspecialisation and scale have a profound impact…[90]

3.52 TCH is an acute care teaching hospital and a tertiary trauma referral centre that provides a range of clinical services to the people of the ACT and South Eastern NSW. TCH thus has multiple hospital roles by comparison with principal referral hospitals in other jurisdictions. It is the:

> ...largest public hospital in the region, supporting a population of almost 540, 000, with strong links to community-based services that provide continuity of care for patients.[91]

---

[89] 2008—Minister for Health provides a summary with figures of record demand in the ACT hospital system, question time, 3 July 2008, http://www.hansard.act.gov.au/hansard/2008/pdfs/20080703.pdf, pp. 2706–2707; 2009—Opposition motion in relation to health performance indicators at 11 Feb 2009—context of Public Hospital Report Card 2008—An AMA analysis of Australia's public hospital system, http://www.hansard.act.gov.au/hansard/2009/pdfs/20090211.pdf, p. 687; 2010—Minister for Health makes some comments about emergency department demand, 16 November, Hansard, http://www.hansard.act.gov.au/hansard/2010/pdfs/20101116.pdf, p. 5484; 2010—Matter of Public Importance, Health System—Canberra Hospital, 25 February http://www.hansard.act.gov.au/hansard/2010/pdfs/20100225.pdf; Health Minister's forwards as contained in the ACT Public Health Services Quarterly Performance Reports highlight increasing demand—available at: http://health.act.gov.au/publications/reports/act-public-health-services-quarterly-performance-report; 2011—Opposition motion on health performance reports, Hansard 30 March: http://www.hansard.act.gov.au/hansard/2011/pdfs/20110330.pdf, p. 1074.

[90] National Centre for Social and Economic Modelling (NATSEM) *Report on ACT public hospital costs*, prepared under commission from the ACT Health and Community Care Board by the University of Canberra, May 2001.

[91] The Canberra Hospital homepage—http://health.act.gov.au/health-services/canberra-hospital/canberra-hospital—accessed 30 July 2012.

3.53 TCH provides an extensive range of clinical services to the ACT and capital region. This includes: a Women and Children's hospital, cardiothoracic surgery, the Capital Region Cancer Service, an aged care and rehabilitation service, haematology and immunology services, the Shock Trauma Service, renal services, a major psychiatric unit, a geriatric medicine unit, intensive care, comprehensive outpatient services, and other surgical, critical care and medical services across a range of specialities. These multiple hospital roles, together with the catchment area of the ACT and the capital region, all have a profound impact on demand for TCH's services.[92]

3.54 Some of the specific factors that are unique to TCH and thus have potential to impact on ED presentations and admissions include:

- TCH's multiple hospital roles by comparison with principal referral hospitals in other jurisdictions
- TCH is a principal university teaching hospital of the Australian National University Medical School
- TCH is also part of the University of Canberra's School of Nursing
- TCH's role as a major trauma referral centre for the ACT and a substantial area of southern NSW (and the associated aeromedical retrieval service)
- TCH has virtually no opportunities to go on by-pass (as compared with other jurisdictions)
- limited discharge options (step-down facilities and other acute hospitals) when compared to other jurisdictions, and
- impact of cross-border patients.[93]

---

[92] The Canberra Hospital homepage—http://health.act.gov.au/health-services/canberra-hospital/canberra-hospital—accessed 30 July 2012.

[93] National Centre for Social and Economic Modelling (NATSEM) *Report on ACT public hospital costs*, prepared under commission from the ACT Health and Community Care Board by the University of Canberra, May 2001; The Canberra Hospital homepage—http://health.act.gov.au/health-services/canberra-hospital/canberra-hospital—accessed 30 July 2012.

3.55 A further consideration is that TCH is not just a local hospital; it is the hospital of the national capital. The flow-on effect of this status is that the TCH has to be prepared when any dignitaries and other VIPs are visiting Canberra, as the nation's capital. The Committee was interested to know whether this feature put pressure on TCH. The Auditor-General responded:

> 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.[94]

3.56 As noted previously, between 2008–09 and 2010–11, demand for ACT ED services has increased by more than 'the growth in the ACT population and more than the average national growth in demand for ED services'. [95] This increasing demand coupled with the factors unique to TCH, as outlined above, have significant potential to impact on the ED environment and expectations with regard to its performance.

RECOMMENDATION 9

3.57 **The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, how it will address and improve issues about achievements against throughput and triage targets as they relate to the Emergency Department at the Canberra Hospital.**

---

[94] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, p. 27.

[95] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, p. 33; Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information.*

Organisational behaviour matters

3.58 It is important to note that any performance related information system involves human behaviour and takes place within an organisational structure. The interaction between human behaviour and organisational structure is referred to as organisational behaviour. Organisational behaviour involves three levels of analysis—individual, group and organisation system—with each level contributing to behaviour in an organisation.[96]

3.59 The Audit and subsequent public hearing evidence highlighted a number of organisational behaviour matters. The Committee is of the view that two matters as they relate to the organisation systems-level warrant further comment. These relate to organisational communication and organisational culture.

Organisational communication

3.60 Organisational communication serves four main functions within an organisation—control, motivation, emotional expression and information.[97] Furthermore, organisational communication involves external and internal interactions that take place via upward, downward and lateral communication flows.

3.61 The Committee notes that the functioning of the Territory's public health system comprises a number of communication interactions and flows within and between various entities—TCH, CPH, Health Directorate, the Chief Executive of CPH, the Minister for Health, and the Director-General of the Health Directorate. The Committee also notes that the Audit report observed that different perspectives were held by people on some matters. The Committee was interested to know if the Auditor-General had a view about whether communication within and between the various health system

---

[96] Robbins, P., Millett, B. and Waters-Marsh, T. (2004) *Organisational Behaviour* (4th edn.), Prentice Hall, Frenchs Forest.

[97] *Ibid*.

entities, on the basis of the Audit, was appropriate or whether communication needed to be streamlined or improved.[98] The Auditor-General commented:

> 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.[99]

3.62 The Committee acknowledges that continuous improvement with regard to communication is a matter that all public sector organisations should be constantly monitoring and evaluating.

RECOMMENDATION 10

3.63 **The Committee recommends that clear guidelines be established concerning internal communication between the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.**

RECOMMENDATION 11

3.64 **The Committee recommends that clear guidelines be established concerning external communication regarding matters concerning the ACT Health Directorate, the Canberra Hospital and Calvary Public Hospital.**

Organisational culture

3.65 The discussion as contained in the Audit report relating to the rationale put forward by the Executive for altering performance information raises questions with respect to organisational culture that warrant further consideration.

---

[98] *Transcript of evidence*, 19 July 2012, pp. 25–26.

[99] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, p. 26.

3.66 Organisational culture refers to a system of shared meaning held by employees of an organisation that distinguishes the organisation from other organisations. The system of shared meaning is made up of characteristics that an organisation values. In aggregate these become the dominant culture within an organisation. It is important to note that large organisations can have a dominant culture and sets of subcultures.[100]

3.67 The Committee is concerned about an organisational culture that appeared to leave the Executive concerned with no other option than to feel they had to alter data to meet performance targets. The Committee believes that the Health Directorate should take all necessary steps to assess whether a prevailing organisational culture at the Canberra Hospital contributed to the circumstances surrounding the alteration and misreporting of performance information.

RECOMMENDATION 12

3.68 **The Committee recommends that the Government of the day detail to the ACT Legislative Assembly, at the earliest possible opportunity, what action the Health Directorate has taken to assess whether a prevailing organisational culture at the Canberra Hospital contributed to the circumstances surrounding the alteration and misreporting of performance information.**

Reporting and handling of misconduct in the ACT Public Service

3.69 The Audit report sets out a number of considerations, with associated commentary, regarding potential implications for the Executive who admitted changing hospital records.[101] This section in the Audit report concludes with a specific section entitled 'Breach of Employment Conditions' and a concluding comment, before leading into two recommendations, that:

---

[100] Robbins, P., Millett, B. and Waters-Marsh, T. (2004) *Organisational Behaviour* (4th edn.), Prentice Hall, Frenchs Forest.

[101] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, pp. 83–91.

> Audit considers that the actions of the executive who has admitted to manipulating hospital records is seriously inappropriate and improper conduct. Consideration should be given by the Director-General of the Health Directorate, in consultation with the ACTPS Head of Service, as to whether this amounts to gross misconduct for the purposes of the terms of their contract.[102]

3.70 Notwithstanding that the Executive concerned admitted to altering records, any formal disciplinary process had neither commenced nor been permitted to take its course at the time the Audit report was released.

3.71 The Committee notes the Commissioner for Public Administration's comments as reproduced in the Audit report, which emphasised, amongst other things, that any misconduct proceedings commenced in accordance with the applicable provisions of the *Public Sector Management 1994* or the terms of the Executive's employment contract, that:

> The decision-maker would...need to ensure that the usual matters of procedural fairness had been observed. In other words, that an appropriate investigation had been undertaken and that it is clear as a result that there has been gross misconduct, that the relevant outcomes of the investigation were given to the executive concerned and that the executive was given an opportunity to comment and that any comments made were considered. All of the circumstances need to be taken into account by the decision-maker.[103]

3.72 The Committee does not believe that consideration of whether the Executive's actions constituted misconduct for the purposes of their employment framework was directly relevant to the Audit objectives. Discussion and commentary to this effect has the potential to pre-empt the findings of any criminal, civil, or administrative case that could take place against the Canberra Hospital Executive.

3.73 The Committee notes the Health Directorate's response to the recommendation concerning the Executive (as contained within the Audit report):

---

[102] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, p. 91.

[103] Commissioner for Public Administration as cited in ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 85.

> The Health Directorate notes the recommendation regarding the Executive who has admitted to manipulating the EDIS records. As a matter of natural justice, any employee who is accused of misconduct must be given an opportunity to comment on the allegations before any disciplinary action is taken. The Health Directorate will put the Auditor-General's findings to the Executive as part of a misconduct investigation, and once the outcome of the misconduct investigation has been considered, a determination will be made on what disciplinary action will be taken in relation to the Executive's employment.[104]

3.74 Shortly after presentation of the Audit report, the Executive's name was disclosed to the media. The Committee inquired about whether the release constituted a breach of privacy and the Director-General stated:

> I had legal advice prior to that event in relation to the issue of whether the individual's name could or should be disclosed. I have indicated to the estimates committee that that legal advice was that it was preferable during the investigation period for the name not to be disclosed. The law is actually quite grey in relation to some of these matters. But the advice given to me was that it was from a legal point of view highly desirable not to disclose the name during the course of those two investigations, the Auditor-General's and PwC. Our own preference was to try and also not disclose it during the conduct of the disciplinary matter that followed. However, my clear legal advice was that there is no breach of any law. It was, as I have previously indicated, however, not intended to disclose it at that point in time. It was an error for which I take full responsibility. But it was not a breach of any law.[105]

3.75 The Committee is of the view that the disclosure of the Executive's name anytime, but especially in the highly charged political climate leading up to an election, was a breach of the person's rights and their expectation of natural justice in any proceedings. It also failed to have any regard to the welfare of the person concerned.

3.76 Subsequent to the appearance of the Minister for Health before the Committee on 20 July 2012, the *Canberra Times* reported that the Executive had submitted their resignation earlier that week and the Directorate had accepted it after taking legal advice.[106] The Director-General told the *Canberra Times*:

---

[104] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 13.

[105] Dr Peggy Brown, *Transcript of evidence*, 20 July 2012, pp. 39–40.

[106] Jean, P. (2012) 'Data doctor quits hospital', *Canberra Times*, 21 July 2012, p. 1.

> That [disciplinary] process was in chain *[sic]*, the individual involved has exercised their right to submit a resignation prior to that process actually being completed...[107]

3.77 The Committee emphasises that public sector disciplinary regimes such as misconduct action are focused on protecting the public, maintaining proper standards of conduct by employees, and protecting the reputation of the public service.[108] Importantly, they are also subject to a number of administrative law requirements.[109] Some of the guiding administrative law principles for public sector misconduct regimes[110] include:

- A decision maker who determines whether or not there has been misconduct must be independent and unbiased.
- Employment decisions such as misconduct action require that employees be afforded natural justice in decision making. An employee can seek judicial review under the general law or under the applicable administrative decisions review statute.[111]
- Procedural fairness—employees are entitled to have a reasonable opportunity to make their case prior to any decision being made that they have engaged in misconduct or that disciplinary action should be taken.
- Any disciplinary action which may be imposed, after misconduct has been determined, should only be in respect of the conduct found to have been in breach.
- Factors relevant to the assessment of disciplinary action should include all matters relevant to upholding required standards of conduct in the public sector, and may include a range of factors (aside from the actual misconduct) specific to the individual employee and the circumstances of the case.

---

[107] Jean, P. (2012) 'Data doctor quits hospital', *Canberra Times*, 21 July 2012, p. 1.

[108] APSC. (2007) (2nd edn.) *Handling misconduct—A human resources practitioner's guide to the reporting and handling of suspected and determined breaches of the APS Code of Conduct*, Canberra; Australian Government Solicitor (2006) Legal Briefing No. 80—Miscondcut in the Australian Public Service, October.

[109] *Ibid*.

[110] *Ibid*.

[111] ACT—*Administrative Decisions (Judicial Review) Act 1989*.

3.78 The Committee emphasises that whilst the Executive concerned has admitted to altering EDIS records, the Auditor-General also acknowledged that it was probable that EDIS records had also been altered by other persons with access to the system. In evidence, the Auditor-General advised that:

> 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.[112]

3.79 The Committee is saddened that the Executive at the centre of this matter will be remembered by this incident and not by her previous positive contributions to health care in the ACT. Notwithstanding that the Executive concerned admitted to altering records, the evidence suggests that EDIS records in all probability have also been altered by other persons. The Committee also emphasises that the Executive came forward on their own initiative to accept responsibility for altering records.

3.80 Notwithstanding that the Director-General of the Health Directorate accepted responsibility for disclosure of the Executive's name, the Committee is of the view that the Health Directorate failed to protect the privacy of the Executive who admitted to altering data, prior to any civil, criminal or administrative proceedings. The Committee believes that the Health Directorate should issue a public apology to the individual concerned and should take appropriate

---

[112] Dr Maxine Cooper, *Transcript of evidence*, 19 July 2012, pp. 2–3.

steps to acknowledge the individual's contributions to the operation and administration of the Canberra Hospital.

RECOMMENDATION 13

3.81 **The Committee recommends that, given the Health Directorate's failure to protect the privacy of the Executive who admitted to altering data—prior to any civil, criminal or administrative proceedings—the Health Directorate should: (i) issue a public apology to the individual concerned; and (ii) take appropriate steps to acknowledge the individual's contributions to the operation and administration of the Canberra Hospital.**

3.82 The Committee also notes that after the tabling of the Audit report there has been public commentary, for example in the public press, that could be regarded as impinging on the rights of private individuals. The Committee emphasises that the privacy of private individuals should be respected.

3.83 The Committee believes that the Audit report and events post its tabling highlight important issues with respect to privacy and the rights of private individuals. This extends to employees and the recipients of public services. The Committee is of the view that it is incumbent on all Directors-General to ensure that staff in their respective directorates and agencies are: (i) knowledgeable of applicable privacy policies; (ii) aware of their responsibilities; and (iii) held accountable in respect of compliance with applicable policies. Furthermore, the Committee believes that education and awareness programs should be accompanied by the development of a breach notification policy that details how breaches of privacy are to be managed, including how impacted individuals will be notified in the event of a breach, criteria for determining the impact of a breach, and assessment of harm to individuals impacted by a breach.[113]

3.84 The Committee notes that expectations by the public about what they expect from public services will continue to emphasise the importance of effective privacy management at a whole-of-government level. This is further emphasised by the increasing use of the online environment, as a preferred

---

[113] PwC. (2008) *Safeguarding Personally Identifiable Information in the Federal Government*.

medium, for a vast array of transactions involving communication of private information. This ranges from prospective employees lodging employment applications and the safekeeping of personnel records of ACTPS employees, to Canberra Connect logging personal details of private citizens and the private information stored within the MyWay card registration activation process. Furthermore, in the case of the ACTPS, the transition to a single unified organisation, would be supported and strengthened by a whole-of-government approach to the management of privacy for ACTPS employees and recipients of government services.

3.85 The Committee considers that there is merit in the development of a whole-of-government privacy management policy that, amongst other things, details privacy obligations of ACTPS employees concerning information related to employees and recipients of public services and how breaches of privacy are to be managed.

RECOMMENDATION 14

3.86 **The Committee recommends that the Commissioner for Public Administration, in consultation with ACT Government directorates and agencies, develop a whole-of-government policy for the management of private information relating to ACT Public Service employees and recipients of ACT Government services.**

3.87 The Committee is also of the view that it is incumbent on all Members of the Legislative Assembly, as parliamentarians, to respect the privacy and rights of private individuals when giving effect to parliament's important oversight and scrutiny function/role.

Performance measurement in health care

3.88 The circumstances surrounding the alteration and misreporting of data raise important issues in relation to performance measurement in the public sector and importantly in its application to the delivery of health care services.

3.89 Prior to considering specific issues as it relates to the data alteration incident, in particular the four hour NEAT introduced as part of the *National Partnership Agreement on Improving Public Hospital Services* as agreed to by the Commonwealth and all states and territories in 2011, it is useful to consider some of the literature as it relates to performance measurement in the public sector. A précis is discussed below.

A précis of the literature on performance measurement in the public sector

3.90 A distinguishing feature of performance measurement in the public sector is that it adopts a 'one size fits all' approach assuming that its many facets can be readily applied across all areas of public sector service delivery. However, there are important differences between areas of the public sector. Spigelman (2001) cautions about the extent to which important decisions are made concerning public service delivery only on the basis of what can be measured.[114]

3.91 The literature also notes concern where qualitative activities are measured using quantitative methods, that there are difficulties in knowing what the data really means, for example a higher level of service or inefficiency. Concern has been expressed that managerial values, in these circumstances can erode the significance of professional values impacting not only on institutional trust but also on professional trust.[115]

3.92 Performance measurement is based primarily on quantitative measurement and cannot adequately measure qualitative decision making processes. Reducing decision making in professional areas such as health care to 'standards and indicators', such as timeliness, has consequences for trust, not

---

[114] Spigelman, J. 2001, 'Quality in the Age of Measurement: The Limitations of Performance Indicators', *The Sydney Leadership Alumni Society*, 28 November, pp. 1–8. Retrieved 6 August 2008 from http://www.lawlink.nsw.gov.au/lawlink/supreme_court/

[115] Spigelman, J. (2002) The maintenance of institutional values, *Evatt Foundation*, 26 May, pp. 1–10. Retrieved 6 August 2008 from http://evatt.labor.net.au/publications/papers/31.html

only in the relevant public sector institution but also for the respective profession.[116]

3.93 In summary, whilst the literature presents a range of perspectives with respect to performance measurement, it cautions about the limitations of performance measurement in making assessments about professional decision making involving qualitative judgments.[117] Generally, the literature conveys concern not against performance measurement *per se* but in the case of professionally delivered services, it cautions that measurement should not be 'determinative in decision making processes where qualitative judgements are essential'.[118]

3.94 A useful piece of research which highlights the counterproductive effects of performance measurement as it relates to management by targets involved the examination of public attitudes to recent National Health System (NHS) reforms in the United Kingdom (UK). The research focused on the impact of quasi-market and management-by-targets policies on public satisfaction and public trust.[119]

3.95 The research found that the current reforms highlight the rational actor approach and whilst operating entirely in a rational actor framework may improve service provision it fails to address the non-rational foundations of public trust and may damage public support. The end result is counterproductive reform. According to the research principal:

---

[116] Spigelman, J. (2002) The maintenance of institutional values, *Evatt Foundation*, 26 May, pp. 1–10. Retrieved 6 August 2008 from http://evatt.labor.net.au/publications/papers/31.html , p. 8; Bevan, G. and Hood, C. (2006) 'Have targets improved performance in the English NHS?', *BMJ*, 332, pp. 419–422; Power, M. (1997) *The Audit Society: Rituals of Verification*, Oxford University Press, Oxford.

[117] Spigelman, J. (2002) The maintenance of institutional values, *Evatt Foundation*, 26 May, pp. 1–10. Retrieved 6 August 2008 from http://evatt.labor.net.au/publications/papers/31.html, p. 8; Bevan, G. and Hood, C. (2006) 'Have targets improved performance in the English NHS?', *BMJ*, 332, pp. 419–422.

[118] Spigelman, J. (2002) The maintenance of institutional values, *Evatt Foundation*, 26 May, pp. 1–10, retrieved 6 August 2008 from http://evatt.labor.net.au/publications/papers/31.html, p. 7; Calnan, M. and Rowe, R. (2007) Trust and Health Care, *Sociology Compass*, **1**, 1, pp. 283–308; Power, M. (1997) *The Audit Society: Rituals of Verification*, Oxford University Press, Oxford.

[119] Taylor-Gooby, P. (2008a*) Institutional Trust and Health Care Reform: Full Research Report*, Economic and Social Research Council (ESRC) End of Award Report, RES–000–22–1867, Swindon; Taylor-Gooby, P. (2008b) *Institutional Trust and Health Care Reform: Non-Technical Summary* (Research Summary), Economic and Social Research Council (ESRC) End of Award Report, RES–000–22–1867, Swindon.

> The importance of this finding is that many health reform programmes tend to understand relationships in terms of the rational deliberative choices on individuals within a market or faced by strong incentives to meet strict targets. However, a strong tradition in the health care system understands trust as strongly influenced by caring relationships, respect for the interests of others and humane values. The risk with reform focused in this way is that the reforms will damage the normative aspect of trust and reduce public confidence in the health service.[120]

3.96 Further, the research found that the overall value orientation of the public regarding health care emphasised universality and fairness along with care and respect of staff for patients. This contrasted with the individualism that underpins an instrumental approach to agency. The research commented that:

> …this instrumentalist logic was viewed by three-quarters of respondents as encroaching upon the ability of staff to maintain the more human elements of health care provision— the iconography of the 'bean counter' vs. the 'matron'.[121]

Implementation of emergency department access targets in other jurisdictions

3.97 The specific performance measurement tool at the centre of the data alteration matter is that of the four-hour NEAT target.[122] The Committee notes that the introduction of similar access targets to that of the NEAT in EDs across Australia and internationally has been accompanied by reported instances of alteration of performance information as contained within the EDIS (or equivalent). The Committee understands there have been at least three reported instances of, or alleged, systematic alteration of ED performance information. For example, in the United Kingdom, the four-hour rule, which is linked to a matter central to the Audit report, was subject to "widespread

---

[120] Taylor-Gooby, P. (2008b) *Institutional Trust and Health Care Reform: Non-Technical Summary*, (Research Summary), Economic and Social Research Council (ESRC) End of Award Report, RES–000–22–1867, Swindon, p. 15.

[121] Taylor-Gooby, P. (2008a) *Institutional Trust and Health Care Reform: Full Research Report*, Economic and Social Research Council (ESRC) End of Award Report, RES–000–22–1867, Swindon, p. 18.

[122] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June; Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

gaming and fraudulent manipulation of hospital data".[123] In 2009, the Victorian Auditor-General's Office discovered alteration of data in one hospital sampled regarding emergency access indicators.[124] In 2008, the NSW Department of Health commissioned an independent review[125] following allegations that emergency triage data was being inappropriately manipulated by NSW Health staff in order to meet key performance benchmarks. Whilst the Deloitte review did not identify any instances of inappropriate data alteration for electronic patient records that were matched to supporting paper documentation, it commented that:

> Patient ED presentations are largely documented in accordance with the NSW Department of Health Emergency Department Data Definitions i.e. presentations are largely classified according to the triage scale. However, due to the limitations in record keeping we were unable to verify in all instances that the application of these definitions was reflected in the manual records. For those items which were matched to supporting documentation, we did not identify any instances of inappropriate data manipulation.[126]

3.98 In evidence, the Committee advanced that this appeared to suggest a systemic weakness, in that it was not unique to the Territory. In response the Director-General of the Health Directorate commented:

> Yes. I think the Auditor-General was making the point yesterday, when she appeared before the committee, that this has occurred in other jurisdictions and indeed in other countries.[127]

3.99 The Committee also notes that the report of the Expert Panel reviewing elective surgery and emergency access targets under the *National Partnership Agreement on improving public hospital services* acknowledged the potential risks and challenges in relation to using performance targets:

> The use of access targets is intended to increase access to services and therefore improve overall patient outcomes, but there are also well known potential risks

---

[123] ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 7; 38.

[124] Victorian Auditor-General. (2009) *Access to Public Hospitals: Measuring Performance*, April.

[125] Deloitte. (2008) *Triage Benchmarking Review*, 26 November. The Review was commissioned by NSW Health to independently report into the triage indicators used within NSW Emergency Departments. 498,000 electronic patient records covering presentations to 11 hospitals were considered and reported on as part of the Review..

[126] Deloitte. (2008) *Triage Benchmarking Review*, 26 November, p. 5.

[127] *Transcript of evidence*, 19 July 2012, p. 36.

> of imposing performance targets, and these risks were an ongoing topic of concern through our consultation process. Broadly speaking, they relate to gaming and target fixation, with both having possible consequences for the overall quality of patient health care.
>
> 'Gaming' involves the intentional manipulation of demand and/or data with the predominant intention of meeting targets rather than patient care needs. It is most often referred to in the elective surgery context with the possible manipulation of urgency categories and waiting lists to meet the targets, although it can also occur with emergency departments and other areas of the hospital system. As identified by stakeholders, there is clear potential for gaming to occur in order to meet the targets and achieve the associated incentive funding…[128]

Implementation of the NEAT at the Canberra Hospital

3.100 As noted in the PricewaterhouseCoopers' (PwC) ED Information System Data Integrity Summary Report, the Executive who had admitted to altering the data advised that:

> ...the reason for making the changes was to improve the wait time performance and discharge times of the ED at The Canberra Hospital.[129]

3.101 PwC further reported that the Executive had stated that:

> ...the only that [sic] thing that worked to achieve benchmark targets was to alter the data.[130]

3.102 In evidence, the Committee was interested to know what the Government's response would have been if the correct information in respect of performance against the emergency access targets had been reported.[131] In response, the Minister for Health commented:

> I think from my point of view, practically—and, in a way, it is a hypothetical situation—
>
> ...
>
> We do not have the finalised data as to what the corrected data would be—how much difference we are talking about in percentage terms that that would have

---

[128] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June , p. 15.

[129] PwC. (2012) *ACT Health Directorate—Emergency department Information System Data Integrity Summary Report*, p. 4.

[130] *Ibid*.

[131] *Transcript of evidence*, 20 July 2012, p. 34.

> been. But I would not think—there are some workflow process changes which are already underway and have been underway. There are extra resources going in. I think from a practical sense I am not sure we would have done anything differently, because the focus is on continuous improvement. The timeliness results were not reaching the benchmark anyway. We have a target that we were focused on and are focused on for the four-hour rule. But in terms of the changes that have been done in the ED, they were being done anyway because we were trying to reach the target, which has not changed.[132]

RECOMMENDATION 15

3.103 **The Committee recommends that the Government of the day should inform the ACT Legislative Assembly, at the earliest possible opportunity, if the emergency access targets under the *National Partnership Agreement on Improving Public Hospital Services,* will not be reached by the Canberra Hospital for the 2012 calendar year.**

Emphasis on qualitative aspects of care in emergency departments

3.104 The Audit raises several issues about the sole reliance on quantitative measures to assess ED performance. The specific performance measurement tool at the centre of the data alteration matter is that of the four-hour NEAT target. Interestingly, whilst quality of care received is considered to be a critical measure in performance, the emergency access target under the *National Partnership Agreement on improving public hospital services* is based on the length of time a person spends in the ED, that is, with few exceptions, patients are to be seen and dealt with in a four-hour period.[133]

3.105 ED waiting times are reported with reference to the Australasian Triage Scale (ATS). The Australasian College for Emergency Medicine conducted a review of the ATS, which identified that the ATS should only be used to describe urgency and that separate measures are needed to assess quality of care.[134]

---

[132] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, pp. 34–35.

[133] Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

[134] ACT Auditor General's Office, Report No. 6 of 2012: Emergency Department Performance Information, July 2012, p. 7.

3.106 ED length of stay is primarily reported against the recently introduced four-hour NEAT, which has been introduced as part of the *National Partnership Agreement on Improving Public Hospital Services* agreed to by the Commonwealth and all states and territories in 2011.[135]

3.107 An Expert Panel reviewed the introduction of the NEAT and identified that there are risks associated with the introduction of quantitative targets such as the NEAT. The Panel recommended that the 'targets themselves may pose a risk to safety and quality of patient care, in the absence of a balanced suite of indicators which measure different dimensions of quality'.[136]

3.108 The Committee notes that the Auditor-General was of the view:

> Audit considers that there is an opportunity to develop a more extensive and effective suite of indicators for public reporting, including qualitative indicators, against which Emergency Department performance should be reported.[137]

3.109 The Auditor-General recommended that the Health Directorate should review its performance indicators for publicly reporting the performance of Canberra's hospitals' EDs to include and give a greater emphasis to qualitative indicators relating to clinical care and patient outcomes.[138]

3.110 The Audit report also acknowledged that the Health Directorate is 'currently researching other indicators that would better represent the quality and performance of Emergency Departments'[139]. The Committee notes that the HCCA has signalled its support for this and its commitment to working with the Directorate to provide input into developing these indicators.[140]

---

[135] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June.

[136] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June; ACT Auditor General's Office, Report No. 6 of 2012: Emergency Department Performance Information, July 2012, p. 8.

[137] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, p. 37.

[138] *Ibid*.

[139] *Ibid*., p. 14.

[140] Cox, D. (2012) 'Health reporting going awry', *Canberra Times*, 26 July 2012, p. 17.

3.111 With regard to performance measurement, the Minister for Health was supportive of the Auditor-General's recommendation for developing broader measures of ED performance.[141] As to practical implementation, the Minister explained:

> Work will also commence immediately in relation to other performance indicators for the ED that measure clinical outcomes and patient satisfaction. I think this work needs to be led nationally, and there is an expert panel established under the national partnership agreement on improving public hospital services, the AIHW and the National Health Performance Authority to further explore development of a more rounded suite of outcome indicators for emergency department care.[142]

3.112 The development of broader measures of ED performance, of which timeliness is one of a number, would give rise to more robust and meaningful outcome indicators that capture the full extent of ED care.[143]

3.113 With regard to the importance of qualitative measures, the Executive admitting to altering the data commented that:

> We should be very clear that all electronic information management information systems in Health are there to support eh *[the]* work of delivering patient care, not become the work.
>
> From a cultural perspective it would be good to see a more balanced approach to measuring the delivery of quality patient care in an environment that supports staff to do so and where we are collectively responsible for delivering that care. Where demonstrated quality outcomes such as re-presentation rates, hospital acquired infection rates and patient experience are at least as important, if not more so, than numerical measurements. Not only does this better demonstrate excellent care delivery, but experience in the literature from other jurisdictions demonstrates the more the focus is on purely a numerical figure as a measure of good patient outcomes the higher the likelihood of the figures being altered to reflect that.[144]

---

[141] Ms Katy Gallagher MLA, 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, p. 1371.

[142] *Ibid*.

[143] Ms Katy Gallagher MLA, *Transcript of evidence*, 20 July 2012, pp. 33–34.

[144] As cited in, ACT Auditor General's Office, Report No. 6 of 2012: *Emergency Department Performance Information*, July 2012, p. 88.

3.114 The Committee notes that subsequent to its public hearings the Chief Minister has secured unanimous agreement with her COAG colleagues that:

> ...that quality and not just quantity should be measured in health service provisions.[145]

3.115 As to proposed timing with regard to implementation of these measures, the Chief Minister was reported as stating:

> The Auditor-General's view was that quality measures were not being given equal weight. So we had a paper that went to COAG today saying that we should continue the performance measures that are in place.
>
> But they are being reviewed in 2013 and as part of that review there was agreement that qualitative indicators be looked at as a way of measuring performance too.[146]

Wider context in which the health system operates

> ...health systems are an investment in people. Healthier people can contribute to the economy and society more easily....but the structure of the health system, as well as spending, needs to be appropriate and take into account local conditions and constraints.
>
> Shah, 2009, p. 1[147]

3.116 The NSW Auditor-General (2008) commented that if new ways are not found to deliver health care out of hospitals and health services, NSW Health would have to open at least 300 new beds—equivalent to a new medium sized hospital—every year just to keep up with the predicted growth in demand.[148] Further, the British Medical Journal[149] declared that the rising levels of obesity, and its consequent demand on the health system, could bankrupt the NHS if left unchecked.

---

[145] Johnson, C. (2012) 'Chief Minister leads push to rethink service measures', *Canberra Times*, 26 July.

[146] *Ibid*.

[147] Shah, A. (2009) Health care around the world, *Global Issues*, August, pp. 1–21,viewed 9 June 2010, http://www.globalissues.org/article/774/health-care-around-the-world

[148] NSW Auditor-General. (2008) Delivering health care out of hospitals, *Performance Audit Report—September, viewed 10 November 2008, htpp://www.audit.nsw.gov.au/publications/reports/performance/2008/health_care/health_care_contents.htm*

[149] Lean, M., Gruer, L., Alberti, G. and Sattar, N. (2006) Obesity—can we turn the tide?, BMJ, **333**, 16 December, pp. 1261–1264.

3.117 As the aforementioned illustrates, the demand for health care is 'potentially boundless, but the collective systems that fund health care must impose limits'.[150]

3.118 The circumstances surrounding the alteration and misreporting of performance information must be viewed in the wider context of how the health system operates but not so as to reduce (or excuse) the appropriate responsibility for decisions which were made. This includes in a climate of increasing demand for health care with bounded constraints on its supply.

3.119 The Committee notes that the report of the Expert Panel reviewing elective surgery and emergency access targets under the National Partnership Agreement on improving public hospital services emphasised that whole system reform was needed to achieve access targets under the Agreement:

> Meeting the targets cannot be solely the responsibility of emergency or surgery departments. Whole-of-hospital engagement in achieving these targets will be essential, ensuring that all obstacles to effective patient flow are removed. In terms of emergency access, the Panel noted that in systems that had undergone these changes, the vast majority of the process change occurred at the 'back end' of the hospital rather than in the emergency department. Without whole-of-hospital involvement, it will not be possible to meet the targets. To this end, we have recommended that the title of the emergency access target be changed to broaden the focus from emergency departments to the necessary whole-of-hospital change process (Recommendation 4).[151]

3.120 The Committee is firmly of the view that the circumstances surrounding the alteration and misreporting of performance information must be considered as part of a wider inquiry. Due to the time constraints, the Committee has not been in a position to progress an inquiry of this scale and scope.

3.121 The Committee therefore suggests that the 8th Assembly Standing Committee on Public Accounts give due consideration to conducting an inquiry into the process of future delivery of health care services across the ACT's two public hospitals that is focused on drawing lessons to improve accountability and performance. This could include: (i) the health system as an open system;

---

[150] Wallace, P. (2004) The health of nations, *Economist*, 17 July, p. 3.

[151] Australian Government. (2011) *Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services*, Report to Council of Australian Governments, 30 June, p. xii; p. 29.

(ii) supply and demand issues; (iii) the drivers of organisational culture specific to the hospital system; (iv) performance measurement in the hospital system; (v) potential for politicisation, and perverse outcomes, of waiting times and waiting lists in the health system; (vi) the unique operating environment of hospital emergency departments; and (vii) the unique attributes of TCH as compared with other principal referral hospitals—for example, as the tertiary trauma referral centre for the ACT and region.

3.122 Accordingly, the Committee has resolved to table an interim report and to leave Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information* to stand referred to the 8th Assembly Public Accounts Committee.

3.123 Such an inquiry should be timed to take account of any follow-up audit that may be conducted by the Auditor-General to assess progress with regard to implementation of recommendations of the Audit report.[152]

RECOMMENDATION 16

3.124 **The Committee recommends that the 8th ACT Legislative Assembly Standing Committee on Public Accounts should give due consideration to conducting an inquiry into the process of future delivery of health care services across the Canberra Hospital and Calvary Public Hospital.**

[152] *Transcript of evidence*, 20 July 2012, p. 33; 2012–13 Select Committee on Estimates, *Transcript of evidence*, 5 July 2012, pp. 1371–1372.

4 CONCLUSION

4.1 The Committee is of the view that the delivery of ED services is complex and is also determined by the wider system in which it operates. Any strategies to improve the performance of ED services must take into account the drivers and features of the increasing demand being placed on EDs, the way in which other demands on the hospital system are dealt with, and the whole system within which a hospital operates.

4.2 The Committee acknowledges that maintaining an appropriate focus on delivery of ED services in the context of growing hospital demand is a challenge for all health services.

4.3 The Committee has striven to consider the incident that gave rise to the Audit in the wider context of the delivery of hospital services. It has endeavoured to focus beyond the 'blame game' and to be forward looking in its examination of the findings and recommendations of the Audit report.

4.4 The Committee's comments in this report have been framed in this context—first considering the immediate issues associated with the alteration and misreporting of performance information, followed by the issue of performance measurement as it applies to health care, and the wider system/context in which health care is delivered.

4.5 The Committee is firmly of the view that the circumstances surrounding the alteration and misreporting of performance information must be considered as part of a wider inquiry. Due to the time constraints, the Committee has not been in a position to progress an inquiry of this scale and scope.

4.6 Accordingly, the Committee resolved to table an interim report and has suggested that the 8th ACT Legislative Assembly Standing Committee on Public Accounts should give due consideration to conducting an inquiry into the process of future delivery of health care services across TCH and CPH.

4.7 The Committee has made **sixteen** recommendations in relation to its interim report inquiring into Auditor-General's Report No. 6 of 2012: *Emergency Department Performance Information*.

Caroline Le Couteur MLA

Chair

13 August 2012

APPENDIX A: Witnesses who appeared before the Committee

List of witnesses who appeared before the Committee at public hearings:

Public hearing of Thursday 19 July 2012

- Dr Maxine Cooper, ACT Auditor-General
- Mr Brett Stanton, A/g Director, Performance Audits and Corporate Services, ACT Auditor-General's Office
- Mr Bernie Sheville, Director, Financial Audits, ACT Auditor-General's Office

Public hearing of Friday 20 July 2012

- Ms Katy Gallagher MLA, Minister for Health
- Dr Peggy Brown, Director-General, Health Directorate
- Mr Ian Thompson, Deputy Director-General, Strategy and Corporate Services, Health Directorate
- Mr Lee Martin, Deputy Director-General, TCH and Health Services, Health Directorate

APPENDIX B: Audit report recommendations

Emergency Department performance information

Recommendation 1—The Health Directorate should review its performance indicators for publicly reporting the performance of Canberra's hospitals' emergency departments to include and give a greater emphasis to qualitative indicators relating to clinical care and patient outcomes.[153]

Systems and processes for reporting performance information

Recommendation 2—The Health Directorate and Calvary Public Hospital should develop essential EDIS governance documentation, including:

a) an overarching governance statement that describes:
   i. the purpose and use of the system;
   ii. its business owner, system administrator and all roles and responsibilities associated with the system and its support (including third party stakeholders such as Shared Services ICT);
   iii. the security classification of the system and its data;
   iv. applicable policy and administrative guidance;
   v. record-keeping obligations;
   vi. training requirements; and
   vii. what is monitored and audited to ensure compliance with policy and supporting system documentation.[154]

b) standard operating procedures for all roles and responsibilities associated with the system and its use[155];

c) training material that covers all dimensions of EDIS including user roles and responsibilities, processes described in standard operating procedures and specific policy that is applicable to the system[156]; and

d) a System Security Plan, which is informed by a risk assessment and risk management plan.[157]

---

[153] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, p. 37.

[154] *Ibid*., p. 48.

[155] *Ibid*., p. 50.

[156] *Ibid*., p. 51.

[157] *Ibid*., p. 55.

Recommendation 3—The Health Directorate should, in conjunction with Shared Services ICT, finalise the draft Business System Support Agreement between Shared Services ICT and the Health Directorate for EDIS.[158]

Recommendation 4—The Health Directorate and Calvary Public Hospital should:

a) review the current distribution of access to EDIS throughout the hospital and remove any users who do not have a specific and documented requirement for access to the system; and
b) develop policies, administrative procedures and system controls (if possible) that restrict the use of generic user accounts outside the Emergency Department work environment.[159]

Recommendation 5—The Health Directorate and Calvary Public Hospital should:

a) identify and document responsibilities for user access management and log monitoring for EDIS; and
b) develop a process to monitor user activity within EDIS and how to report and escalate unusual activity to the appropriate authorities.[160]

Recommendation 6—The Health Directorate should:

a) review the current EDIS upgrade project and link it with current Health Directorate Identity and Access Management and Rapid Sign-On initiatives that are currently underway, to allow staff to be individually accountable for their actions; and
b) review all available Emergency Department software to evaluate whether or not the current EDIS should be replaced with one that has strong confidentiality and integrity controls as well as appropriate process linkages.[161]

---

[158] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, p. 49.

[159] *Ibid*., p. 61.

[160] *Ibid*., p. 64.

[161] *Ibid*., p. 65.

Recommendation 7—The Health Directorate should develop policy and administrative guidance for EDIS data validation activities for the two Canberra hospitals. The policy and administrative guidance should identify and document:

a) agreed Emergency Department actions which constitute 'clock starting' and 'clock stopping' moments for the purpose of EDIS timeliness records; and
b) protocols for data validation activities in the day(s) following a patient's presentation to the Emergency Department.[162]

Recommendation 8—The Health Directorate should implement additional review and assurance controls over the preparation and reporting of Emergency Department timeliness performance information. These review and assurance controls should address both Canberra Hospital and Calvary Public Hospital performance information. The Health Directorate should consider whether the additional review and assurance controls should be applied to other performance information.[163]

Data manipulation at the Canberra Hospital

Recommendation 9—The Director-General of the Health Directorate and the ACTPS Head of Service note the findings of this report with respect to the executive who has admitted to manipulating hospital records, and consider whether this executive has engaged in misconduct in breach of section 9 of the *Public Sector Management Act 1994* and their executive contract.[164]

Recommendation 10—The Health Directorate reinforce to Health Directorate employees, especially executive staff, the need to act with integrity with respect to the maintenance of health records and associated data.[165]

---

[162] ACT Auditor General's Office, Report No. 6 of 2012*: Emergency Department Performance Information*, July 2012, p. 70.

[163] *Ibid*., p. 72.

[164] *Ibid*., p. 91.

[165] *Ibid*.