STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

INQUIRY INTO PEEL HEALTH CAMPUS PAYMENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 30 OCTOBER 2012

SESSION FIVE

Members

Hon Giz Watson (Chair)
Hon Philip Gardiner (Deputy Chair)
Hon Liz Behjat
Hon Ken Travers
Hon Ljiljanna Ravlich

Hearing commenced at 3.24 pm

WILLIAMS, DR ALED
Director, Clinical Services, Peel Health Campus, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the hearing this afternoon. Before we commence, I am required to ask you to take either an oath or an affirmation. If you wish to take the oath, there is a copy of the Bible on the table in front of you.

[Witness took the affirmation.]

The CHAIR: Thank you very much. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Dr Williams: Yes, I have.

The CHAIR: The proceedings this afternoon are being recorded by Hansard, and the transcript of your evidence will be provided to you. To assist the committee and Hansard, if there is a document that you quote from, could you please give us the title of that document. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during the hearing this afternoon, you should request that the evidence be taken in closed session. If the committee grants your request, any media and public in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. This prohibition does not, however, prevent you from discussing your public evidence generally once the hearing is concluded.

Dr Williams, I just want to be sure that you have understood the terms of reference for this particular inquiry. Were you provided with a copy of the terms of reference?

Dr Williams: No.

The CHAIR: If not, we will give you a copy right now so that we can make sure that you are aware of them. I think you might have one in front of you now. Sorry about that. I just wanted to remind you of those limitations. Clearly this afternoon you have been summonsed to assist the committee with those particular terms of reference. At the outset I need to indicate that we note that to date you have not complied with the order to produce all documents in relation to this inquiry, and therefore in that respect it is likely that you are in contempt for not having provided that information. I wonder whether you can provide initially an explanation for why the full documentation has not been provided?

Dr Williams: Sorry; I am not aware that the entire documentation requested has not been supplied. I think we did try very hard, with quite a short time reference, to supply as much as possible. I am unaware what is missing.

The CHAIR: Okay—a fair amount; but perhaps we will see whether somebody else wants to take that up, so we will just have to note that at this point in time.

Ms ARCHER: Madam Chairman, would it assist the committee if I made an observation?

The CHAIR: No, I am sorry, Ms Archer. I apologise. We are not able to hear directly from you. But you are welcome to advise Dr Williams if you would like to do so.

Dr Williams: As I understand, the summons was sent to Mr Cameron Balyea at Clayton Utz on 25 October, and he has been in communication with the Clerk in order to negotiate facilitation of these documents. That is as I am aware.

[3.30 pm]

The CHAIR: For example, we are interested in, and we do not seem to have, all the board minutes. That was certainly one of the areas that we asked for documentation on. So I do not know whether there is further information that you have in that regard.

Dr Williams: We understand a letter has been sent to the committee to say that there are no such board minutes. I am unaware of any further documents that are needed to be produced. That is to the best of my knowledge.

The CHAIR: All right. We will see where we take that. I do also just need to indicate that as much as the communication has been with Clayton Utz, the summons was actually directed to Health Solutions WA, so in that sense the obligation rests with yourself to provide that documentation.

Hon KEN TRAVERS: And the other directors.

The CHAIR: Yes, and the other directors.

Hon LJILJANNA RAVLICH: Can we have a list of the directors?

The CHAIR: Yes.

I will start with some questions and we will see where we go from there. We are in receipt of the "Peel Health Campus Health Services Agreement" 1997. Has that agreement been subject to any variation since then?

Dr Williams: I would have to take that on notice. My main role is as director, clinical services. I do not have detailed knowledge of the contract. Dr Fong may have some more information.

The CHAIR: That is fine; we can ask that question of Dr Fong. In a hearing that this committee had with regard to the annual report of the Department of Health, we heard from a Dr Mark about a disproportionately large number of patients being admitted. For how long was that occurring?

Dr Williams: I think to start off with it is important to explain that we were coming off a fairly low base. We had had great difficulty in recruiting doctors to admit patients into the hospital, and that had led to our capacity to admit going down and down below what we would regard as normal benchmarks for a hospital such as Peel Health Campus. Normally we would sit between 15 and 20 per cent of admissions. That would be what you would expect for a community emergency department, and we had tracked down to—I do not have exact figures—around about 10 per cent in March of 2010. So that was when we took steps to be able to admit more patients by various processes, including introducing the clinical decision unit, and that did start to then increase the number of patients that were admitted to the campus. As we were able to recruit more doctors into the clinical decision unit, because the thing with the clinical decision unit was we had to have senior doctors to be able to admit and look after the patients, more doctors were recruited as we came through the process, particularly to difficult times of day like weekends and evening shifts, when a lot of patients do tend to get admitted. So admissions did start to track up. I think what Dr Mark may be referring to is the fact that probably around about October in 2010, admissions started to track up more abnormally than you would have expected. The clinical decision unit had been running at that time since May, so for five months or so. It did coincide with us having more doctors on board as well.

We were slow to pick that up. Our systems were slow to pick that up and bring it to our attention that that was the case. That was really when the admissions started to increase more than we would have expected.

The CHAIR: What happened then? Was there any action that followed from that disproportionate rate of admissions?

Dr Williams: It did take some time for us to become aware of it because of system issues—there was Christmas and all that kind of thing. We were talking about probably towards the end of January, beginning of February, by the time we did become aware that the spikes had really started

to—an abnormal increase in admissions. That is when we started to take a close look at the system. That is when we decided to do the audit. We ourselves decided to do the audit of all the admissions in the clinical decisions unit. We agreed terms of the audit with the health department. With in fact Dr Paul Marks' assistance, we drafted the terms of the audit. We applied the audit back to cover the months since the inception of the clinical decisions unit. That audit did find that whilst there were patients who had very sound clinical reasons to be admitted to hospital, they did not comply with the business rules for billing a patient. That is quite a tricky distinction to make, and I think it is a very important distinction to make. There are a group of patients who would benefit from admission to hospital but are not permissible to be billed to the hospital because they do not meet certain technical criteria. I do not know if you would like me to give an example of a patient.

The CHAIR: Sure.

Dr Williams: A classic patient would be an elderly person who fell over in the middle of the night, perhaps while going to the bathroom, and sustained an arm injury. An ambulance would bring them to the hospital at one o'clock in the morning. You would see them, put a sling on their arm, perhaps do an X-ray, give them the analgesic they required, but you would not want to send an elderly person like that home at two o'clock in the morning in a taxi. You would admit them to hospital, keep them there until the morning when perhaps they could be seen by a physiotherapist or a social worker and contact their relative who would then take them home. For example, that is a perfectly valid reason to admit a patient but not a billable admission.

Another example could be someone who had taken an overdose and who was acutely distressed or suicidal. Usually these things happen at weekends or late at night. You would not want to send them home. You would want to admit them to hospital, observe them for a while and get them to see a psych liaison nurse or a psychiatrist in the morning. Again, that is a very good reason to have somebody in hospital, but not a billable reason to have somebody in hospital. It is a difficult distinction. To be frank, it was a distinction that we were not very aware of at the time and we should have been aware of at the time. When we started the clinical decisions unit, it was really for reasons of trying to increase the quality of clinical care in the campus and reduce the number of patients that we were transferring out to other hospitals. Sorry, I have lost my train of thought. The bottom line is this: when we started it off, we were not aware of those technical criteria—the difference between what is a reasonable admission and what is a billable admission. It is quite confusing, and I think it is fair to say that, even now, knowledge of those technical criteria is not very widespread particularly amongst doctors in public hospitals. Doctors were admitting in the way that they were used to in the hospitals that they had worked.

The CHAIR: Were any concerns raised with you about these admissions; and, if so, when and by whom?

Dr Williams: Concerns as to?

The CHAIR: The procedures and the issues that you have just raised about clinical requirements as opposed to other considerations?

Dr Williams: Concerns really started to be raised around the beginning of February 2012. They were raised by Sarah Ward who was running the four–hour rule project in the hospital at the time. She was the ideal person to be spotting concerns because she was intimately involved in the running of the emergency department and the flow of patients. When she did bring concerns out, we acted on the concerns pretty quickly and that is when the audit commenced. We looked at all the cases in retrospect.

The CHAIR: What was the nature of the concerns that were raised with you?

Dr Williams: The number of patients was increasing. There were concerns as to whether the patients, as I have discussed, were admitted for medical reasons or the technical criteria. There were

also some concerns raised around the process of admission. There had been a fair bit of confusion around the process of admission into hospital. Those were the main concerns that were raised.

Hon LJILJANNA RAVLICH: Can I just say, Mr Williams, that I find it incredible that as the director of Health Solutions you would not have been aware of the distinction between "reasonable" and "billable reason" in terms of admissions.

Dr Williams: At the time I was not a director of Health Solutions; that has been a recent thing. Even as a director of Health Solutions, my role really is advising on medical or medical issues—issues around the corporate side of things and the technical aspects of it. I was looking at the medical side of things and what was medically reasonable for the patients there.

Hon LJILJANNA RAVLICH: But you do not set that; that is set by WA Health, surely, in terms of framework for the admission of public patients into a public hospital. There is specific criteria by which patients are admitted into emergency and then, from emergency, into the hospital. At the end of the day, you cannot redefine that definition.

Dr Williams: I am sorry; can I have some clarification? Are you referring to the process of admission or the particular kinds of patients that can be admitted?

Hon LJILJANNA RAVLICH: Both.

Dr Williams: In reference to the particular kinds of patients that can be admitted, it is a difficult concept to explain. There are patients who are noncompliant with the technical criteria who are admitted to many hospitals every day, and continue to be done so. The technical criteria are quite old. I am not sure how they have been reviewed recently, but many doctors are not aware of all of the specifications in the technical criteria. Doctors will be admitting people to hospital based on what they feel is in the interests of the patient rather than what is written in a technical document.

Hon KEN TRAVERS: In a privately run hospital that provides public services, if it is not the director of medicine that advises people on that differentiation between an admission under the contract and an admission for medical grounds, who is it?

Dr Williams: At the time, my knowledge of the contract—I am not the person responsible for the contract, I am responsible —

Hon KEN TRAVERS: No; but you were the director of medicine, were you not, at that time?

Dr Williams: Director of medicine, yes.

Hon KEN TRAVERS: A contract manager is not going to be able to deal with the medical issues —

Dr Williams: Yes.

Hon KEN TRAVERS: — and do that interpretation. If it is not the director of medicine, who is the responsible officer in the hospital that would be training doctors on those issues?

Dr Williams: I understand what you are saying. I think that how it works with us now, and how, I think, it is beginning to happen at other hospitals as well, is that the authorisations of whether patients are billable or not are done after the admissions are done by an audit process so that we are not questioning the reasons that the doctors are putting patients into hospital. It is then, after the admission is done—the patient has received the treatment they require and then goes home—that somebody goes through the notes and sees whether that admission complied with the technical criteria.

Hon PHILIP GARDINER: I think I have here one of the documents you have given us. Madam Chair, can we quote from this?

The CHAIR: Yes.

[3.45 pm]

Hon PHILIP GARDINER: It is to Mr Fogarty from Paul Bailey dated 5 May.

> 2. To save the potential "expense" —

He is trying to justify to Mr Fogarty the payment of $200 but the interesting point is the reason why he is defending paying. It continues —

> of paying an extra $200/patient, you —

That is Mr Fogarty. It continues —

> are risking missing "revenue" in the order of $3000/patient. The main game here is to capture missed revenue. To me if that occasionally means paying $200/patient—it's worth it.

Clearly, the $200 is an incentive. Without that incentive, there could not really be—I suppose there could be—or it is unlikely to have, a rise in the admissions to such a dramatic extent. If it was just duty of care, it would remain the same, would it not?

Dr Williams: Not necessarily. I am sorry I have not seen that email and I cannot comment exactly what Paul Bailey and Jon Fogarty were speaking about.

The CHAIR: We will just find you a copy of that so you can actually see the context of that.

Dr Williams: I think, though, it was very clearly understood that the money that was paid to the doctors was a fee-for-service money for additional work that they were doing in admitting and looking after the patients and then subsequently discharging the patients that they were looking after. We would have expected the levels of admissions to rise because, firstly, we had slipped down to a fairly low base and we were in danger of not complying with our obligations under the contract to provide medical admissions services to people in the region. When we did manage to recruit doctors to admit people, the admission levels did rise. They continued to rise to the benchmark level that you would expect for a hospital like Peel Health Campus. I think that it is important to note that the fee-for-service model for the clinical decision unit was being phased out through this whole time as we were recruiting doctors on a salary basis. We knew that it was a short-term solution to attract the senior doctors that we required to admit the patients. Senior doctors, particularly emergency physicians and general physicians, were extremely hard to recruit at the time and there were many hospitals paying very, very high day rates to attract them. So, the fee-for-service model was a model to attract people to come down and work. As we managed to recruit people, we slowly phased it out and, in fact, early in the year—I think it was towards March 2011—when we got a registrar to help the doctor, therefore less work done in the admission of the patient, the fee for admitting the patient actually dropped down from $200 to $100. The level of admissions that we run at now is at benchmark and we have no fee-for-service arrangements. So, we have increased the level of admissions to what we would expect our hospital to be performing in order to fulfil its need to the people in the region and, under the contract, fulfil those needs. We have that level now still without any fee-for-service arrangements.

Hon PHILIP GARDINER: Can we just explore this?

Dr Williams: Of course.

Hon PHILIP GARDINER: The justification for the $200—you say "fee for service" —

Dr Williams: Yes.

Hon PHILIP GARDINER: In the documentation I have seen it is called a "patient fee".

Dr Williams: Or, I think sometimes it is referred to as an "additional clinical payment".

Hon PHILIP GARDINER: Let me call it a patient fee because that tends to kind of connect more readily to where the word "incentive" is used also through a number of documents. It is an incentive that you are saying must have been a temporary incentive to lift the percentage against the

benchmark of 15 to 20 per cent, where you were at 10 per cent, to get those additional admissions and that was where the $200 per patient came in. Is that the reason for it or not?

Dr Williams: The reasons for it were multiple. What we were trying to do was to increase the quality and level of services in the region and the way to do that was to get more senior doctors down. If you have more senior doctors down treating patients, you have more ability to admit those patients and that would then follow that if you had what you required in terms of senior cover to perform the needs required for the region, that the levels of admission would go up to what you would expect them to do. As I say, again, the doctors were very clear. This was money that they were paid for doing additional work in admitting and looking after these patients. I think it is important also to note that they were not paid any money for admitting patients to hospital under another doctor's care, for instance; the fee was only for patients that they admitted and they looked after themselves.

Hon PHILIP GARDINER: We will come back to that part a little later on. At this stage, the firm LocumForce, which I understand you also have involvement with —

Dr Williams: Correct.

Hon PHILIP GARDINER: — was that also involved in this arrangement?

Dr Williams: No; there was no arrangement between the fee for service and LocumForce at all.

Hon PHILIP GARDINER: When these doctors were hired by the hospital, by Health Solutions, was the $200 as part of their revenue included in the contract or in any discussions you had with those doctors?

Dr Williams: No.

Hon PHILIP GARDINER: When did they first become aware of it?

Dr Williams: Of?

Hon PHILIP GARDINER: Of receiving, or their ability to charge or receive, $200 per patient?

Dr Williams: I think there is an explanation from Paul Bailey in one of the things around setting up a clinical decision unit. I cannot remember, recall, the date, but I think it was in late April or early May just before the unit was set up. It was a letter directly from him to the doctors. I think, if I may make the point as well, all the doctors were already working there at the time. At the time that the clinical decision unit was started, I think of 14 doctors who took part in the fee-for-service arrangements, only four were recruited through LocumForce. By the end of the year, that had dropped to only one, who did very occasional shifts. It was very much part of my role as director of medical services to reduce the use of all agencies in the hospital and LocumForce was part of that. In fact, in the last four years we managed to reduce agency use by 85 per cent, in fact, across the campus.

Hon PHILIP GARDINER: So around this time, the LocumForce-complemented doctors working for Health Solutions at the Peel campus was how many of 14?

Dr Williams: Four of 14.

Hon PHILIP GARDINER: Four of 14.

Dr Williams: At the beginning of the CDU period. It decreased through the year and by the end of it, there was only one who—I do not recall exactly how many—covered occasional weekend shifts.

Hon PHILIP GARDINER: When I read out the first quote, "The main game here is to capture missed revenue"—and this was by Mr Bailey to Mr Fogarty—that does not gel with the reason why you believe the $200 patient fee was implemented.

Dr Williams: Correct, but that is not the reason I believe that the patient fee was implemented, no.

Hon PHILIP GARDINER: Do you have an executive committee that you operate at the campus?

Dr Williams: Yes, we do.

Hon PHILIP GARDINER: A management committee of the executives, which then, I presume through you, reports to the board?

Dr Williams: At the time—perhaps again if you will indulge me—I was only at the campus for two days a week at the time; I was very much part time at the time. So, the main link between the board and the campus was through the CEO of the campus at the time rather than me directly.

Hon PHILIP GARDINER: Were you part of an executive committee where also Mr Bailey was as well? Was he part of the executive committee at this time—this was about May–June 2010?

Dr Williams: I will have to take that on notice. I do not recall if he was actually on the executive committee. He was the director of the emergency department.

Hon PHILIP GARDINER: Okay. Was there anyone else there from the management point of view? There must have been, of course, from the executive committee.

Dr Williams: Yes.

Hon PHILIP GARDINER: Were you part of that? You do not —

Dr Williams: My attendance was intermittent.

Hon PHILIP GARDINER: Ad hoc.

Dr Williams: Yes.

Hon PHILIP GARDINER: Okay. So, really, there could have been two agendas going through the organisation in relation to why and how this $200 patient fee was charged, and yet, as director of the clinical services or medical services—I am sorry if I have got the title wrong—you were not aware. You had a different reason that you saw for that $200 fee than management might.

Dr Williams: It was very clear to me and to the doctors what the fee was for. I think that if you are introducing a new system into a hospital, there has to be, I guess, some financial justifications and some financial analysis that goes around it. But it was very clear to the doctors what the fee was for. That is how they carried out their duties.

Hon PHILIP GARDINER: Okay. I will let someone else go and then I will come back.

Hon LJILJANNA RAVLICH: Just on that?

The CHAIR: On this one, Hon Ljiljanna Ravlich.

Hon LJILJANNA RAVLICH: Mr Williams, did you tell Ashley Foley that the fee was for compensation for CDU doctors for the extra work involved in looking after the patients who were admitted?

Dr Williams: I do not recall specifically saying that but that does describe the fee-for-service arrangement.

Hon LJILJANNA RAVLICH: Do you remember saying that or not?

Dr Williams: I do not recall, but compensation for the extra work in admitting patients is what we were doing. We were paying them for the extra work.

Hon LJILJANNA RAVLICH: What extra work?

Dr Williams: Well, they would have to look after the patient —

Hon LJILJANNA RAVLICH: But they would look after them in the role as a doctor, surely.

Dr Williams: No, patients were referred to the CDU doctor who was on call, who then looked after the patient in terms of doing a senior doctor assessment of the patient, ordering the appropriate tests, giving the correct —

Hon LJILJANNA RAVLICH: Let me stop you there. If they were a senior doctor, they would be doing a senior doctor assessment, surely. What extra work?

Dr Williams: I guess this was part of the thing. They were often referred to the patient by a junior doctor to take over the care of that patient and give the input that a senior doctor would require, so part of the clinical advantage, why this was a good clinical system to have, was that patients received input from a senior doctor very early on in their treatment in hospital, which leads to better outcomes at the end of the day and safer practice.

Hon LJILJANNA RAVLICH: Do you know what? In all the information we have seen in relation to this case, there is no distinction between senior and junior doctors; there is no issue about compensation of doctors for extra work that they do—nowhere. Can you tell me why that is the case? If this was the system and this was how the system worked and it was a legitimate system, authorised perhaps even by the health department, why is this all not transparent?

Dr Williams: I am sorry; could you repeat the question? I am not quite sure where you are getting at. I do not quite understand the question, I am sorry.

Hon LJILJANNA RAVLICH: I am saying that in all the documentation we have before us, there is no reference to payments for doctors performing higher duties or for them being senior doctors or for compensation for extra work that they are doing. Can I put it to you that this is your own personal construct to justify a series of activities which are probably unlawful?

Dr Williams: I think that there are some documents which state that—when we try and find them—one of the outcomes of the clinical decision unit was to attract senior doctors to the campus in order to provide a higher level of patient care. There is a very distinct difference between a senior doctor and a junior doctor, often referred to as an RMO. I think some of the memoranda was specifically addressed to RMOs separately to give them an indication —

Hon LJILJANNA RAVLICH: Why did you not just pay them a higher wage? Why did you have to give them a backhanded payment of $200 per patient and then bill the health department for that by making the figures rubbery?

Dr Williams: The $200 fee to the doctors was never charged to the health department; it was a contract between the doctor and the hospital so it was not charged to the health department.

Hon LJILJANNA RAVLICH: Who ultimately paid it?

Hon KEN TRAVERS: The hospital got $3 000 or thereabouts. They got a DRG payment from the health department as a result of the admission, though, did they not?

Dr Williams: The hospital did get DRG payments if the patient was an appropriate admission to be billed. That is what the audit went through—to ensure that every patient who was billed to the health department was an appropriate patient to be billed.

Hon LJILJANNA RAVLICH: But many were not appropriate patients, were they?

Dr Williams: They were not appropriate for billing. I think they were appropriate to be admitted to the campus for their best medical care.

The CHAIR: I refer to Hon Liz Behjat because she has indicated she has a question.

Hon LIZ BEHJAT: Thanks, Chair. It has been put to us that the reason for the CDU is that you have got your emergency department and it is pretty full and has got lots of patients in it and there is a four-hour rule.

Dr Williams: Yes.

Hon LIZ BEHJAT: And there are people who might not necessarily require admission to hospital for a long term. You might be waiting for some troponin levels to come back —

Dr Williams: Correct.

Hon LIZ BEHJAT: — or determine whether that person needs to have an ultrasound, so then this clinical decisions unit was created to put those persons into there with the prospect that within 48 hours, they would be going home.

Dr Williams: Correct.

Hon LIZ BEHJAT: Is that right?

[4.00 pm]

Dr Williams: Yes.

Hon LIZ BEHJAT: Are you aware of patients having been admitted to CDU without ever having seen a doctor?

Dr Williams: I think that what you are referring to is that there was a lot of confusion about some of the paperwork process and some of the paperwork issues. Senior doctors can decide very quickly if a patient does need to come into hospital or not. The paperwork processes around that—when a doctor decides a patient needs to come into hospital, generally they would fill in a form, and they may leave it for a while. They may, you know, leave it on the clerk's desk, or the clerk may have left it and not entered it into the computer, and that sort of confusion around the time of admission. The recorded times when doctors are recorded as seeing patients on a computer, tends to be when the doctor goes back to the computer and enters the time—well, they click on the patient and click on "seeing now". So, sometimes there is confusion around the times and confusions around the process or the time lines going through. This was one of the issues that Sarah brought to my attention. We did institute some process checks fairly immediately after that, including the use of time stamp clocks so that everybody understood the governance around the process of admission better.

Hon LIZ BEHJAT: But everyone who goes to or went to the CDU had been seen by a doctor. They were getting towards the end of the four-hour time frame and then they were referred to the CDU. Now, I also understand that that is not a physical change of location in most cases; that was just people being re-categorised, basically, and they stayed in the ED and did not actually physically go off to something that was called the CDU—is that right?

Dr Williams: The CDU was a virtual ward, but it did exist on several —

Hon LIZ BEHJAT: A virtual ward?

Dr Williams: Well, it existed on several inpatient wards; there was not one physical space—the only place they could go. So, some would have been in the emergency department observation ward, which is a separate part of the emergency department. Some would have been on Barker Ward or Whelan Ward and some would have just moved to a quieter part of the emergency department.

Hon LIZ BEHJAT: And if somebody is in the CDU and the reason for them being there is that they are waiting for troponin levels to return or for an ultrasound to be done, why would that require a senior doctor to then take care of that person, if you are waiting for test results, and to then pay them $200 to wait for results?

Dr Williams: Well, with the troponin thing, it is not just a question of waiting for the results —

Hon LIZ BEHJAT: Well, that is just an example of what we have been given.

Dr Williams: Sure. Usually they were on a cardiac monitor as well, because troponin is trying to exclude a patient having had a heart attack. Generally, people who come in with chest pain—and assessment of people with chest pain is best done by a senior doctor—it could be the heart or any one of a number of serious issues. A senior opinion on a patient like that early is of benefit to the patient.

Hon LIZ BEHJAT: And you talked before about the timing sometimes was an issue. Are you aware that time-stamping was being altered by doctors on some of the records?

Dr Williams: I have no awareness of time stamps being altered, no.

Hon LJILJANNA RAVLICH: Everyone else knows. Everyone in the whole hospital knew.

Hon LIZ BEHJAT: I do not know that everyone else knows, but I am just saying it has been —

Hon LJILJANNA RAVLICH: Well, this has come up a number of times.

Hon KEN TRAVERS: The question is: you have never had the allegation put to you that the time stamps have been changed?

Dr Williams: The time stamps were put in place because of the confusion around the arrangements for filling in the forms. I have —

Hon KEN TRAVERS: You never had an allegation put to you that people had backdated the times on the forms?

Dr Williams: People have used the term "backdated" I think to imply that when people were writing forms physically and where the forms were going—there was a lot of confusion around the process. The time stamps were meant to give a clear line of the process of admission.

Hon LIZ BEHJAT: But did not the CDU payment only kick in if the patient was there for four hours and one minute and beyond?

Dr Williams: An admission is not a valid admission if they are in hospital for less than four hours.

Hon LIZ BEHJAT: And no-one has ever come to you to say that someone within the first 10 minutes of being in hospital was admitted to CDU?

Dr Williams: I do not recall, but that may have taken place.

Hon LIZ BEHJAT: And no-one has ever made the allegation that times were altered so that the four hours one minute rule kicked in?

Dr Williams: I think people did admit people early—senior doctors can make a decision to admit people very early on.

Hon LIZ BEHJAT: Would they have then been paid the $200?

Dr Williams: Well, it would have depended if the patient had a valid reason to be in hospital, whether they were a billable patient and whether the patient did in fact stay for long enough to be counted as an admission to hospital.

The CHAIR: Can I just pick up on a couple of those things? Just to pick up on—because I do not think there was a clear answer with regards to whether you are aware that any patients were admitted without actually having seen a doctor, or are you aware of allegations to that effect?

Dr Williams: I think people have made allegations that the computer-recorded time that the doctor clicked on was not in sequence with the admission time recorded by the clerical staff. That is why we instituted the process of having the time stamp.

The CHAIR: And did the audit highlight this issue? I mean, did the audit find evidence of this issue with admission times and whatever failing there was in the system, whether it was deliberate or inadvertent?

Dr Williams: The audit was really meant to look mostly at whether the patients were compliant for billing to the health department or whether they did not reach compliance. The reasons around the confusion around the admission process was a four-hour rule process because that was part of the admission process to the hospital. So, Sarah was primarily responsible for that.

The CHAIR: But I understand that money had to be repaid and that would seem to me an admission that something had been done incorrectly; is that not so? Why else would Health Solutions repay money if they or the doctors —

Dr Williams: Repay money to the health department?

The CHAIR: Yes.

Dr Williams: Why would Health Solutions repay money to the health department?

The CHAIR: Yes.

Dr Williams: Because they had erroneously billed for patients who, whilst having a having a clinical reason for coming into hospital, did not meet the billing criteria.

The CHAIR: So when that became apparent, did the board consider calling in the fraud squad in relation to that making fraudulent claims?

Dr Williams: I am not aware that they did. I was not involved at that level at the time.

Hon KEN TRAVERS: Or the executive—any executive group?

The CHAIR: Yes, or any executive group under the board, I guess, consider calling in the fraud squad, because, in effect, there is certainly a case to be made that that activity could be fraudulent?

Dr Williams: I do not recall anyone making that —

Hon KEN TRAVERS: So, you have never been a party to a discussion where the question of whether or not the fraud squad should be brought in to investigate this matter—you have never been a party to a discussion with other people at Peel Health Campus about whether or not the fraud squad should be brought in to investigate this matter?

Dr Williams: I do not recall. I do not recall any conversations like that.

The CHAIR: So, in terms of the payments that had been made that were in breach of the health department's requirements, were payments recouped from any doctors?

Dr Williams: Yes, payments were recouped from doctors.

The CHAIR: And why was that?

Dr Williams: Well, payments were recouped from doctors for patients who did not comply with the billing criteria for the health department—the technical guidelines for the health department.

The CHAIR: Who brought this to your attention and when was that?

Dr Williams: Which part, sorry?

The CHAIR: The doctors billing for—was that as a result of the audit or was there other information brought forward to you?

Dr Williams: The audit identified the patients who did not comply. We were then directed to recoup fee-for-service payments from the doctors who had charged for those patients and that was done—quite a long and laborious process—by the medical practice team.

The CHAIR: Are you aware also of allegations that doctors took incentive payments and then it was actually other doctors that looked after these patients in the unit?

Dr Williams: I am unaware of it. No-one has made those allegations to me.

Hon KEN TRAVERS: On the recouping, did you oppose the money being recouped from the doctors? Have you ever opposed the money being recouped from the doctors; and, if so, why were you opposed to it?

Dr Williams: Well, the recoup of the money was a decision that was made by the chairman of the board at the time.

Hon KEN TRAVERS: That is not my question. My question was: have you ever opposed the money being recouped from the doctors; and, if yes, why did you oppose the money being recouped from the doctors?

Dr Williams: This was a long—this was a few, a couple of years ago; I do not entirely recall all of the circumstances and discussions that happened at the time.

Hon LJILJANNA RAVLICH: Well, do you recall anything of those discussions? Not all of them, but do you recall some of them?

Dr Williams: I do not recall any conversations about where I opposed recouping money. I think one of the issues is that the doctors, potentially, were doing what they thought was in the best interests of the patients at all times.

Hon KEN TRAVERS: The other one is: are you aware of doctors, in terms of the audit—that it turned up—that patients had been admitted to the hospital prior to the doctor even starting their shift; that the paperwork suggested that the patient had been admitted to the hospital before a doctor had even started their shift?

Dr Williams: That was one of the things that Sarah said might have happened, which is why we instituted the process, so that there was fair process.

Hon KEN TRAVERS: And did the process identify that that had occurred?

Dr Williams: I do not recall the process going back to audit the times. What we did was introduce a process so that there could be no confusion about the admission process going forward.

Hon KEN TRAVERS: Once the allegation was made, did you ever investigate whether that had actually occurred? If Sarah has raised it with you, was there any attempt to try and work out whether there had been paperwork showing the patient being admitted prior to the doctor even commencing their shift?

Dr Williams: What she said was that there were a lot of issues around the paperwork and how the paperwork worked, so we needed to —

Hon KEN TRAVERS: Why would those matters not have been investigated, though? Why would you not have had an investigation into those sorts of issues—are not they fairly serious?

Dr Williams: As I say, there was a lot of confusion about the process and how it worked. There were different timings on different systems—paper-based and computer-based crossing over. We just introduced a process so that there could be no confusion about the sequence of events.

Hon KEN TRAVERS: I understand why you would do that, but I would have thought that you would also make some effort to try and work out whether that allegation or that potential has happened or not. If someone is suggesting to you as the medical director of the hospital that there is paperwork that suggests someone was admitted to the hospital before the doctor had even started their shift that you would make some attempt to determine whether that was true or not?

Dr Williams: As I say, there was a lot of confusion around the time and we just thought we had fixed —

Hon KEN TRAVERS: But do you not try and resolve the confusion by having an investigation?

Dr Williams: We resolved the confusion by issuing clear instructions as to the process and introducing things like the time stamps so that everybody understood the process.

Hon KEN TRAVERS: So you looked forward to what you would do in the future. You did not look back to see what had occurred in the past?

Dr Williams: We did not analyse every case where there could have been confusion, no.

The CHAIR: With regards to the audit, how did the audit come about? Who called for it?

Dr Williams: The audit was instituted internally by us. It was when we realised that there was an issue with the difference in the billing; we, as I understand it, notified the health department. Then the terms of the audit were—I did not personally notify the health department, but this is what I am informed. The audit was then instituted and the terms of reference that were agreed between Catherine McKinley and Paul Mark—I am not sure if you have the terms of reference of the audit with you, but they were jointly agreed with the health department and then applied to the patients.

The CHAIR: And when exactly did that occur?

Dr Williams: The agreement of the terms of the audit were some time in—I do not know the exact date, but it would have been in February, early to mid-February.

Hon PHILIP GARDINER: February 2000 and?

Dr Williams: Sorry, 2011. Yes.

[4.15 pm]

The CHAIR: And was there an audit by PricewaterhouseCoopers as well?

Dr Williams: There was a subsequent audit by PricewaterhouseCoopers that audited previous financial years, I believe back to 2009.

The CHAIR: And who initiated that particular audit?

Dr Williams: That was initiated by the south metro health.

The CHAIR: Was the health department aware of the $200 payments that were being made to doctors?

Dr Williams: The health department were made aware, I think, in a letter on 20 June with Ashton Foley. At the time of the audit, they were not made aware.

The CHAIR: So, that would be the first point when they were made —

Dr Williams: Yes, correct.

Hon LIZ BEHJAT: On 20 June when? Which year?

Dr Williams: Of this year, I believe.

Hon LIZ BEHJAT: That is the first time the department became aware of the $200 payments?

Dr Williams: It is my belief.

Hon LJILJANNA RAVLICH: So, 20 June 2011 is the first time the department was made aware. On 3 August, as I understand, yourself, Mr Fong and Ashton Foley met with Minister Hames at West Perth. Can you advise the committee whether the issue of the overpayment was in fact discussed at that meeting?

Dr Williams: I do not recall it being discussed at that meeting. That was not the purpose of that meeting.

Hon LJILJANNA RAVLICH: Okay, so can you recall yourself ever meeting with the minister in relation to this particular matter?

Dr Williams: Of the audit or the fee-for-service payments?

Hon LJILJANNA RAVLICH: The audit and the payments—the $200 payments.

Dr Williams: I do not recall a meeting with the minister as a result. We have discussed it with executives of the south metro health as we went through the process.

Hon KEN TRAVERS: Can we just provide Mr Williams with a copy of that document of 20 June—the letter, from 2012, to Mr Strachan at the south metropolitan area service?

Now, is this the document where you say was the first time that the $200 payment was disclosed to the health department, or is there another letter of that date?

Dr Williams: It says "fee for service". I do not think, I am unsure whether the actual figure, $200, was disclosed to the health department here. Fee for service was the arrangement.

Hon KEN TRAVERS: Can you tell me: do you know who prepared that summary?

Dr Williams: The summary?

Hon KEN TRAVERS: The summary that is attached to Ms Foley's letter.

Dr Williams: It was me.

Hon KEN TRAVERS: It was you?

Dr Williams: Yes.

Hon KEN TRAVERS: Do you still believe that that is an accurate reflection of—an accurate summary of—the issues surrounding the clinical decision unit?

Dr Williams: Could I take time to read it?

The CHAIR: Yes, please.

Hon KEN TRAVERS: Yes, of course you can.

Dr Williams: I believe that is reasonable accurate.

The CHAIR: Sorry, to do what?

Dr Williams: Sorry, I believe that is reasonably accurate insofar as the questions that have been posed, which was just to outline a brief summary of the clinical decision unit. Obviously, one could write pages and pages and pages about it.

Hon KEN TRAVERS: Yes, but do you believe there are any issues that, if you were to rewrite it today, you would include in it now that you did not include at the time that you wrote this?

Dr Williams: Such as?

Hon KEN TRAVERS: I am asking if you believe there is anything else; if you were to rewrite it today, whether there are other issues that you might now include in it if you were giving a full summary of how the CDU had operated.

Dr Williams: Is that a question I can take on notice, so I can look through all the issues?

Hon KEN TRAVERS: Yes, if there is nothing that readily springs to mind.

Dr Williams: I mean, it is not in as much detail as we have discussed today.

Hon KEN TRAVERS: All right. Why did you describe it as a fee for service in this, when in a range of other documents it has been described as an incentive payment?

Dr Williams: In communications with doctors, it has always been clear that this is a fee-for-service arrangement. I believe that there are a couple of documents in the early planning phases where the word "incentive" is used by some people. But it is very clear, and I think there is an email from Mr Fogarty that says very, very clearly that let us be clear here: what we are talking about in "incentive" is additional work for additional pay.

Hon KEN TRAVERS: All right, but also referring to additional admissions for that additional pay as well—that letter from Mr Fogarty.

Dr Williams: I mean, the work involved in looking after the additional admissions.

Hon KEN TRAVERS: It also suggests that it is about getting additional admissions into the hospital, rather than just additional work.

Dr Williams: I mean, there is a range of reasons why we wanted to have additional patients in the hospital; we were falling well below many benchmarks and there were many people who needed to be admitted. I mean, they have had to be transferred out up the road to other hospitals. One of the good things about CDU was it would allow us to provide much better care by allowing us to admit more patients that we did not have the senior staff to do before this. As I say, we worked hard throughout the whole time to recruit doctors, salaried physicians, to phase the fee-for-service model out.

Hon KEN TRAVERS: Okay, if you go to the top of the second page —

Ideally, the FACEM on for CDU was an additional … resource to the —

One in the duty ED.

Dr Williams: Yes.

Hon KEN TRAVERS: Then it goes on to say —

… due to staff shortages this was not always the case …

How often was it not the case? Let us put it another way: how often did you have a FACEM both for the CDU and for the ED?

Dr Williams: In the initial months of the CDU, most week evenings and nights.

Hon KEN TRAVERS: You had one for each?

Dr Williams: No, we had to double up. This was really because of shortages of staff; it was very, very hard to recruit people to do this.

Hon KEN TRAVERS: So I guess I go back to my question: how often did you have FACEM on in both the CDU and the ED?

Dr Williams: Quite often in the early stages. I mean, in the first few weeks it would have been four evenings and days a week.

Hon KEN TRAVERS: So when you say "the early stages", what time period are you talking about there?

Dr Williams: The first few months.

Hon KEN TRAVERS: But from what date?

Dr Williams: Sorry, from when the whole project started in May, the first few months.

Hon KEN TRAVERS: Right, and then it dropped away?

Dr Williams: As we were able to recruit physicians and, in fact, a medical registrar as well, which is a middle grade of doctor that does a lot of work.

Hon KEN TRAVERS: So then who was providing the senior medical advice at that point?

Dr Williams: When we recruited the physicians?

Hon KEN TRAVERS: Yes.

Dr Williams: It was the physicians, so they are another group of specialists—emergency physicians and general physicians. The general physicians were the ones who were then providing the care, and the emergency physician would refer the patient to the general physician. The general physicians, as I say, they were all—from when we first started getting them, which I think would have been around July or August—they were always on a fully salaried basis. The intent was always to transition to a fully physician-led model, which, in fact, we did continue to run until quite recently as a fully salaried, fully physician-led model.

Hon KEN TRAVERS: Right, but some of the doctors that were getting a fee for service were also salaried doctors, though, in the —

Dr Williams: Yes they were; yes.

Hon KEN TRAVERS: — initial period as well, were they not?

Dr Williams: Yes; correct.

Hon KEN TRAVERS: So, why did those salary doctors need an incentive payment and the later salary doctors not need an incentive payment?

Dr Williams: It was a question of recruitment. It was a question of the timing and the recruitment. At the beginning, we tried very hard to recruit physicians and there were just none around; they were like gold. Part of the reason that our admissions started dropping away, or our inability to admit to the hospital, was we had one physician who dropped back to half time, so we were losing on the recruiting game. The physicians that we recruited, you know, there is a different market for a different doctor, I guess you could say. The physicians who we recruited were happy to come and work on a purely salaried basis; they almost all still work at Peel Health Campus on a purely salaried basis. But the rates that were being paid for emergency physicians, at the time we set it up, in other hospitals were very high and we had to be competitive with those rates.

Hon KEN TRAVERS: So why would you not have just increased the hourly rate for those doctors that you wanted, rather than introducing this incentive payment?

Dr Williams: Yes, I mean, in many ways in retrospect that would have been a good thing. I do not think it would have changed the numbers of patients coming through necessarily, but I think in a hospital where we are paid on, essentially, a fee-for-service basis, we wanted to kind of link it on a fee-for-service productivity basis for doctors. So, if they were sitting around not doing very much, then they were getting paid something but they were not getting paid a very high rate; if they were very, very busy and looking after a lot of patients, then they were getting paid more.

Hon KEN TRAVERS: All right, and if you go down to the fourth paragraph, it starts off there —

It also became clear that some FACEM and senior ED staff had become questionably efficient at admitting patients.

Dr Williams: Yes.

Hon KEN TRAVERS: What do you mean by "questionably efficient"?

Dr Williams: Well, I mean senior doctors are very good and fast at admitting patients; they can assess patients very, very quickly and admit them.

Hon KEN TRAVERS: But that is not questionably, though. What do you mean by "questionably efficient"?

Dr Williams: Well, I mean there were queries being raised—the ones that Sarah was talking about.

Hon KEN TRAVERS: But you are talking there about some, so was there a problem that some doctors were admitting lots of patients compared to other doctors doing the same role?

Dr Williams: Well, the numbers of patients that doctors admitted tended more to be to do with what shift they worked; you know, evenings, nights, weekends, you tend to get more patients in than during the day.

Hon KEN TRAVERS: Right, so those doctors that got large, significant sums of money through the incentive payment system, they would have been working what shifts?

[4.30 pm]

Dr Williams: They tended to work evening shifts and night shifts.

Hon KEN TRAVERS: So when you write "questionably efficient", you are not suggesting in any way that they were admitting patients that they should not have been admitting?

Dr Williams: I was not suggesting that they were admitting patients that did not have sound clinical reasons for coming into hospital, but when we realised that there were some queries, we took immediate steps to correct the issues of the queries.

Hon KEN TRAVERS: Can we provide the document dated Friday, 11 June from Janice Vickery?

The CHAIR: We will just give you a minute to familiarise yourself with that.

Hon KEN TRAVERS: I guess my first question will be: have you seen this document previously?

Dr Williams: Recently, yes. Again, in searching for these documents, we are looking at documents that I have not seen for years, potentially.

Hon KEN TRAVERS: Did you see it at the time, back in June 2010?

Dr Williams: You know, I honestly do not recall seeing it at the time—June, 2010. This was one of several documents which were in evolution at the time, and I am not sure what the distribution list on this was. When I was trying to go back to find all the documents on my computer, I could not find this on my computer; I think Sarah Ward found it on her computer, so that is how we found it and provided it to you.

Hon KEN TRAVERS: How would a document that is an initial project proposal trial of a clinical decisions unit be produced and not be shown to a person holding your position?

Dr Williams: It may have been at that time; I do not recall. Certainly, it would have been more for discussion with the CEO and for elevation up to the board.

Hon KEN TRAVERS: You mentioned that you have seen it recently; have you had the opportunity to read it?

Dr Williams: Could I refresh my memory? Thank you.

Hon KEN TRAVERS: Do you think that accurately describes the way in which the CDU operates?

Dr Williams: No. This was an early draft; there were a couple of early drafts around of how the system was proposed to work, and this does not really reflect accurately at the CDU worked.

Hon KEN TRAVERS: What are the significant differences between what actually happened and this proposal?

Dr Williams: Just in terms of the business case or the day to day management?

Hon KEN TRAVERS: Anything that you think is different between the two.

Dr Williams: This model describes several options and trials for how things should work. As I say, the way the CDU worked in the trial model really was more of a combination of option 2 and option 3; a hybrid model, rather than option 1.

Hon KEN TRAVERS: In fact, it was probably closer to option 3 than option 1 or 2 was it not?

Dr Williams: It was somewhere between option 2 and 3, I think would more accurately reflect how it was.

Hon KEN TRAVERS: Now that you have raised that issue, you note that under option 3, option 3 being the utilisation of available underutilised beds in general wards such as Whelan and Barker, I think you mentioned both of those earlier that those beds where used from time to time. It says that this was seen as problematic from the perspective of traceability of CDU patients. How did you address the problems of traceability of CDU patients in terms of the actual administration of the project?

Dr Williams: This was more to do with how ward rounds worked, so when the CDU doctor came on in the morning to start going around the patients, they needed to know where all patients were, so they would get a sheet printed out to say which patients had linked to the name of CDU, and they

would go with their junior from ward to ward; they would basically have to walk around the hospital to find all the CDU patients.

Hon KEN TRAVERS: Did you ever receive complaints from any doctors that that was causing problems because they were not aware of where their patients were?

Dr Williams: Yes.

Hon KEN TRAVERS: What was done to address that problem?

Dr Williams: It is a difficult thing and remains a difficult thing, both in our hospital and many of the hospitals as well, of where patients are. I think doctors perhaps rather slangingly refer to the ward rounds as "safari" ward rounds, when they are required to walk all around the hospital to find their patients. It is not ideal, but sometimes it is the most effective way to use the beds. It means that the doctor has to walk a bit, though and organise themselves bit better to get around all the patients.

Hon KEN TRAVERS: Are there any other variations between what was outlined in this proposal and what actually occurred?

Dr Williams: Obviously we did not use the Rivers unit in the CDU program. Part of the original idea was to buy monitors to put in Rivers unit so that we could put higher acuity patients into the Rivers unit. Obviously the remuneration model was quite different to what was proposed there; it was more a hybrid. I think there were two potential models proposed there—fully salaried or a full fee for service, with a higher rate. We had the RMO; generally they are the support. I cannot comment on the additional nursing staff that was required, or the support staff that were required. As I mentioned, the monitoring equipment was not the same. I think in some of the later documents the expected outcomes were listed differently and the objectives, particularly in justification of the CDU to the doctors. The objectives were very different to what was written in this model.

Hon KEN TRAVERS: So things like reduction in overnight stays in ED were not required from a clinical perspective? Those sorts of things? Which ones?

Dr Williams: I do not have it in front of me, but I think some of the data to doctors would have had different priorities, like getting senior level care quickly. I think in the admission process the word "incentive" is used in this early document; I think there was one other document where the word "incentive" was used. The word "incentive" was never used in any communications with doctors, as far as I am aware. This is a business type briefing, I guess, with people who are not probably entirely aware of the process or the intentions, and it was made very, very clear, I think, by us all.

Hon KEN TRAVERS: So you are saying that even though there was an incentive payment paid, it was not an incentive payment to admitting medical officers linked to CDU admissions to encourage a proactive approach to appropriate and timely utilisation of the service? That was not part of the reason that the $200 was being paid?

Dr Williams: The $200 had been paid for them to admit and look after the patients —

Hon KEN TRAVERS: I understand that is what you are saying here. In this document it says it was an incentive payment to encourage a proactive approach to appropriate and timely utilisation of the service, so you are saying that is not why the $200 was paid, even though this document says that is why you should make an incentive payment. You are putting it to us that that was not the reason for the payment of the incentive?

Dr Williams: The reason, in my discussions with the doctors, was to look after—in the course of it, part of the doctor's duty would have been to try to admit patients to decongest the emergency department as quick as they possibly could.

Hon KEN TRAVERS: The bit under the introduction suggests that it is a trial until the end of June 2010, or earlier should available funds be exhausted due to patient demand being greater than anticipated. In terms of the initial trial stage of the CDU, is that statement correct?

Dr Williams: I am sorry; can you —

The CHAIR: Can you just repeat the question?

Dr Williams: No, I am just trying to find where it is.

Hon KEN TRAVERS: It is under the introduction at the very beginning of the document.

Dr Williams: My understanding was that the initial trial of the clinical decision unit was going to be a six-week trial, regardless of whether funds had run out or not.

Hon KEN TRAVERS: So the initial trial was not in any way linked to making sure that the hospital got its billing up to the MPA?

Dr Williams: The MPA was supplied by the state for us to be able to provide the services to the regions that the state believes we should be providing. As I mentioned before, the level of activity on the medical side, because we had lost our capacity to admit medical patients, had been decreasing. This was to bring it back up or to allow us to get back to the level where we should be. Part of our contractual obligation is to be able to admit these patients and look after them down in Peel and not transfer them out to other hospitals.

Hon KEN TRAVERS: What I was asking was: was the initial trial, prior to the end of the financial year in June 2010, established as a way of getting your billables to the health department up to what you were allowed to claim under your MPA? Is that what happened?

Dr Williams: We had unused funds in the MPA so that we could allocate a budget to do a trial for this project, the CDU.

Hon KEN TRAVERS: And if the trial exceeded the MPA, it would have still continued, in your view?

Dr Williams: That would have been my view, yes. The agreement, in my understanding, was that we would review it after a six-week trial, and then decide whether it had worked, whether it had given us the parameters of decreasing ED congestion, decreasing wait times, decreasing transfers out, and then we decided whether we would continue it, and we subsequently did.

[4.45 pm]

Hon KEN TRAVERS: If you turn over to page 3, under "Funding/Costs" it says there —

> It is proposed that available unallocated MPA funding for this financial year be utilised for the trial.

Dr Williams: Yes.

Hon KEN TRAVERS: Then you go on a bit further —

> In addition to the clinical benefits, this trial will give the organisation the opportunity to diversify in utilising allocated MPA funds prior to the end of the financial year. Currently this workload and associated pressures are managed solely by the surgical services.

Is that statement correct?

Dr Williams: What happens is you have an allocation for the whole year, and they divide it between medical and surgical depending on the activity in the areas. So what that is saying is that if we did not use them on the medical side, we would use them on the surgical side. But this was a need that was identified so a budget was allocated to it so that we could do the project; the alternative would have been to allocate them to the surgical side.

Hon KEN TRAVERS: But what this is suggesting is that traditionally if you are under your MPA as you are coming to the end of the financial year and you want to get it up to the MPA, that is traditionally done by doing more surgical work. This is suggesting that the CDU and the admissions

through the CDU, through an incentive payment, is about diversifying how the Peel Health Campus can get their billing up to the MPA. Is that not what that says?

Dr Williams: That could be an interpretation of it, certainly. As I say, this was not a document that I was terribly familiar with at the time, and this was not my understanding of how it was meant to be. A lot of hospitals do manage their budget by altering surgical services; medical services are a lot less predictable. With us, the main reason was we did not have the capacity to admit on the medical side because we did not have the specialists and we had fallen way below what we should have done.

Hon KEN TRAVERS: Why, if it was a fee for service in the early days, was that term never used to describe it in any of the documentation that went out?

Dr Williams: I did not write much of the documentation that came out to the doctors; I am unsure why Paul did not use that. I think the word I used probably more frequently was "additional clinical payment" when I started writing more of the memos after Paul had left.

Hon KEN TRAVERS: Again, in terms of if it was a fee for service —

Dr Williams: Yes.

Hon KEN TRAVERS: — why then was it not included as part of their normal salary in terms of just paying them additional money? Why was it needed to be a separate billing and for them to set themselves up as a separate company or a separate ABN number? Why was it not able to be—I am sure you have plenty of systems where you pay them overtime and penalties —

Dr Williams: Yes, we do; yes.

Hon KEN TRAVERS: —why was this fee for service not just simply another addition to their normal remuneration?

Dr Williams: That is how fee-for-service arrangements usually apply with doctors who work in other hospitals in the fee-for-service arrangements, whether they are surgeons or physicians in other public or private hospitals and have fee-for-service arrangements. It is billed through—they have an ABN number or a practice, and —

Hon KEN TRAVERS: But that is where they are providing purely fee for service, not on salary?

Dr Williams: It was a hybrid model of the two, so the fee-for-service part was seen as separate to salary.

Hon KEN TRAVERS: Why would you have set it up like that—if they were salaried officers and they were just doing additional work—that you would pay them as part of their salary for that additional work?

Dr Williams: It was thought to be simpler to administer it this way as well. They could submit a list of the patients, the reasons for their admission, and the dates and times of their admission and draw up a tax invoice for it; a simpler system.

Hon KEN TRAVERS: That never worked out to be true in the end though, did it, in terms of it being simpler? It became probably more complex.

Dr Williams: No, no; it became incredibly complex—incredibly complex.

Hon PHILIP GARDINER: Just following on from Hon Ken Travers, when did you first become aware of the discussion about this so-called fee for service or incentive?

Dr Williams: Oh, gosh.

Hon PHILIP GARDINER: Bearing in mind that it was introduced in early May 2010.

Dr Williams: Early May, yes.

Hon PHILIP GARDINER: So how much before that were you involved in discussions?

Dr Williams: I do not recall exactly how long. Certainly, something like this does take a fair bit of discussion to work out—to knock around some ideas and see how it might work. I think most of the early discussions were with Paul Bailey and other members, but I do not recall. Certainly I was involved in discussions before the project started, yes; but when was the first discussion? I do not know.

Hon PHILIP GARDINER: Okay. Were you one of the drivers of this idea? Did you grasp this idea and think, "This is a good idea" because it is a better service you are going to provide for the patients? Were you a driver of it?

Dr Williams: I supported the idea for the reasons it was intended to do, which was to attract the appropriate specialists down so that we could provide a higher quality of clinical care. I do not think it was the best system to do that; it was done as an interim solution to address the issues at the time. As you see perhaps from some of the emails, I tended to be keener on a pure salaried service, which is why I pushed hard to recruit physicians into the pure salary model throughout the course of 2010 and 2011.

Hon PHILIP GARDINER: I have not seen that, I am sorry; maybe that is in your emails. But I will come to that later on.

Dr Williams: Yes.

Hon PHILIP GARDINER: So you see as it being a fee for service, whereas elsewhere in your organisation—I presume you could say the management, let us say—they saw it as being a business-driven purpose. So you have mentioned that there were two purposes—you mentioned one purpose—but throughout the emails it is pretty clear to me that the other sector in your organisation saw the purpose differently from you. Were you aware of that?

Dr Williams: I would not want to speak for them, but I am not sure they saw it as a completely different thing. They were —

Hon PHILIP GARDINER: Why is it that in the emails I have from these other people they are using different terms and justifications for this $200 per patient?

Dr Williams: I am sorry; is it possible to see the emails? I am sorry.

Hon PHILIP GARDINER: You sure can. I think they have been referred to; I referred to one earlier. This is between Mr Bailey and Mr Fogarty —

To save the potential "expense" of paying an extra $200 / patient, you are risking missing "revenue" in the order of $3000 / per patient.

That is pretty clear to me to be an economically driven comment.

The CHAIR: Honourable member, I think we might just need to get a copy of that particular document.

Hon PHILIP GARDINER: Maybe I did not give that to you before.

The CHAIR: Reading the body language, that document might not be with the witness, so just bear with us for one minute. We received this documentation only very recently.

Dr Williams: I know; it has all been a bit of a hurry, has it not?

Hon PHILIP GARDINER: The document has 27 May at the top.

Dr Williams: I only have to speculate on what the context of the issue was. I think, potentially, it was the confusion of separating between the two classes of patients that may have led to doctors not admitting patients, and therefore them not coming into hospital and the hospital missing out on revenue. Because there was then a distinction between patients who are coming to the CDU and then are subsequently admitted to another unit, and patients who come into the CDU and are

discharged from the CDU. So I think he is talking about an administrative process to make it simpler.

Hon PHILIP GARDINER: I accept that you did not write that.

Dr Williams: Yes.

Hon PHILIP GARDINER: But what I am saying is that this was the terminology being used in the organisation for which you work, which is different to what you understand; that is what worries me. So somewhere there seems to be a disconnect between the medical part and the management part. Can that happen?

Dr Williams: All too frequently, unfortunately, it does.

Hon PHILIP GARDINER: I can see Dr Fong in the back nodding his head back to front, like that; but can that happen?

Dr Williams: I think sometimes they are striving at different goals.

Hon PHILIP GARDINER: But you are on the executive committee, are you not?

Dr Williams: Yes, I am.

Hon PHILIP GARDINER: So being on the executive committee in a normal organisation is part of the key part that makes the organisation work under a board, as you would well know.

Dr Williams: Yes.

Hon PHILIP GARDINER: So I am bit surprised that being a member of the executive committee meant that you were not really talking the same language.

Dr Williams: As I say, I was very intermittently present on executive committee meetings because I was only there two days a week when this started, and I probably was not across as much of it as I should have been.

Hon PHILIP GARDINER: That may be the case, but I would presume you would have got the minutes and so on of the executive committee meetings?

Dr Williams: I perhaps was not very good at —

Hon PHILIP GARDINER: Or did they not have minutes?

Dr Williams: I think perhaps they were intermittent.

Hon PHILIP GARDINER: I beg your pardon?

Dr Williams: I did not see regular minutes; no, I did not read regular minutes —

Hon PHILIP GARDINER: Were there minutes taken of those meetings?

Dr Williams: I cannot assure that minutes were always taken of those meetings because I do not know.

Hon PHILIP GARDINER: Can we find out whether there were maybe; would you mind?

Hon LJILJANNA RAVLICH: Yes, can we have the minutes of all the meetings for 2010 and 2011?

Hon PHILIP GARDINER: Of the executive committee.

Dr Williams: I guess the thing is, was I good at reading them or keeping myself up to date them with them? As I say, this was very much a part-time —

The CHAIR: I think the committee is saying that we would like copies of those minutes made available as soon as we can have them.

Dr Williams: Yes.

The CHAIR: Thank you.

Hon LJILJANNA RAVLICH: Can we just get the years right? Can we have it for 2010 and 2011?

The CHAIR: Yes; 2010 and 2011.

Hon LJILJANNA RAVLICH: Of all the meetings.

Hon PHILIP GARDINER: This document, about which you were speaking to Hon Ken Travers, is the one dated 20 June 2012, which, I think, is to Mr Shaun Strachan of the South Metropolitan Health Service, and it is the clinical decisions unit CDU summary.

Dr Williams: I think that was taken back.

Hon PHILIP GARDINER: It was taken back? It is the same one to which Ken was referring.

[5.00 pm]

Dr Williams: I am sorry; if I could beg you for a moment, Chair, to clarify a point with regards to the minute taking. There was minute taking, but I am not aware of—as I say, I was not there a lot. I may not have kept up to date with reading and keeping up to date with the minutes, but there would have been minute taking and I am sure you will see them shortly.

The CHAIR: We will await the minutes with interest. Could we also have any emails that relate to those minutes?

Hon LJILJANNA RAVLICH: In fact all emails.

Hon PHILIP GARDINER: This memorandum "Clinical Decisions Unit (CDU) Summary", I believe you have a copy of that?

Dr Williams: Yes.

Hon PHILIP GARDINER: Yes, that looks pretty much the same.

Dr Williams: Yes.

Hon PHILIP GARDINER: You said earlier that you were the author?

Dr Williams: Yes, correct.

Hon PHILIP GARDINER: Were you the sole author?

Dr Williams: Yes.

Hon PHILIP GARDINER: There was no earlier draft of this document done by someone else?

Dr Williams: A draft of the document done by someone else? This is a document that I did, that I sent to Ashton so that she could answer the queries that Shaun Strachan had posed to her. I am unaware of any other versions of the document.

Hon PHILIP GARDINER: No, no, I am not saying other versions; I am saying earlier drafts. Were others involved in the earlier drafts of this document?

Dr Williams: No, not to my recollection.

Hon PHILIP GARDINER: You are the sole author of this document?

Dr Williams: I have to compare it, I guess, to the one I have on my computer to see if someone has subsequently altered it, but I did not get advice on how to write it. I was trying to convey what had happened in the clinical decisions unit. Part of that process as well was to find some emails, documents and memos and pass them on to Ashton so she could be briefed on the issues around the clinical decisions unit.

Hon PHILIP GARDINER: I see this is couched in language which I suspect is yours, but that might have been because you were the final drafter. I just wanted to know whether there are any earlier —

Dr Williams: Did someone tell me what to write?

Hon PHILIP GARDINER: No, not telling you what to write, but earlier drafts as this document developed?

Dr Williams: I would have made some corrections along the way, I guess. I am sorry, I am not quite sure what you are getting at. Is it earlier drafts that I referred to somebody else to get back to correct or —?

Hon PHILIP GARDINER: Yes; someone wrote an earlier draft and then you worked on the earlier draft to produce this document.

Dr Williams: Corrected an earlier draft or?

Hon PHILIP GARDINER: Corrected or modified.

Hon LJILJANNA RAVLICH: Copied.

Hon PHILIP GARDINER: Structured this document from an earlier draft given to you.

Dr Williams: May have—given to me or that I had done?

Hon PHILIP GARDINER: Or done for you —

Dr Williams: No.

Hon PHILIP GARDINER: Or done in the organisation? If not done for you, done in the organisation which, in the end, essentially you —

Dr Williams: No. I copied and played around with it a bit and altered paragraphs and changed words. I do that —

Hon PHILIP GARDINER: Of course; we all do that to our own document. It was your own document at the beginning and your own document at the end?

Dr Williams: Yes.

Hon PHILIP GARDINER: There is another document that I would like to talk to you a little bit about, which is this one here.

The CHAIR: Just one moment while that comes across.

Dr Williams: Thank you.

Hon PHILIP GARDINER: Have you seen that document before?

Dr Williams: It is prepared by Sam Larmour, the practice officer. That is how she prepared the summary of payments; yes.

Hon PHILIP GARDINER: What intrigues me about this document is that there are some for each of the months going from January to June, I think it is, but there is no year on it, so I am presuming this is 2011.

Dr Williams: This would be 2011, yes.

Hon PHILIP GARDINER: As we see in that column "total that didn't meet criteria of claims", that is a healthy proportion of the total claims —

Dr Williams: Yes.

Hon PHILIP GARDINER: — in the previous column.

Dr Williams: Yes; for some doctors

Hon PHILIP GARDINER: In discussions about this earlier in this hearing, I think you have given an explanation about clinical reasons why that may have given reason to those that did not meet the criteria and administrative difficulties associated with the dates and so on, which you then found in August 2011 and changed—sorry, not changed, but set up new procedures.

Dr Williams: In February.

Hon PHILIP GARDINER: February 2012, was it?

Dr Williams: 2011.

Hon PHILIP GARDINER: That may be the case, but I have got here a similar document for March and April where the same thing is occurring, not to the same extent but there is a total that did not meet the criteria which is occurring.

Dr Williams: Yes. That was because the admissions from February were prospectively audited to see if they met the technical bulletin criteria. This would have been from February 2011, when really we became aware of the technical bulletin criteria, and then we prospectively audited every admission into the clinical decisions unit against those technical bulletin criteria to see if the admission was just for clinical reasons or to see if the admission was also a billable admission under the technical guidelines.

Hon PHILIP GARDINER: I think I hear what you say, but I do not understand what "prospectively" means in relation to this, when it is to do with admissions into the CDU. These are amounts of $200 paid for each admission to the CDU, is it not?

Dr Williams: Yes. Once the files were audited to see who complied with the criteria and who did not, then it was—I guess what you have got here is a breakdown. If you add all this up, this would have been the total number of admissions into the CDU that did, and did not, meet the criteria. The ones that did not meet the criteria would not have been billed to the health department. The ones that did meet the criteria would have been billed. It is split out by the doctors who claimed them, who had admitted —

Hon PHILIP GARDINER: I think I understand that. I think we are agreeing that this can only be done after the event, so it was done in June, July or August some time in 2011.

Dr Williams: No. The February audit was done at the end of February when all the files came in.

Hon PHILIP GARDINER: So we have monthly audits as we go through, do we?

Dr Williams: Yes, monthly audits as we go through these.

Hon PHILIP GARDINER: Fair enough; I understand. When you have that total that did not meet the criteria—we talked a little bit about the doctors not being told the $200 was an incentive—for those who have had some involvement in business and so on, it would be pretty quick for any doctor to pick up what was going on, I would have thought. It is an incentive. You may not call it an incentive but in actual fact the $200 per patient you moved to the CDU is implicitly an incentive.

Hon KEN TRAVERS: They did call it an "incentive" in some documents.

Hon PHILIP GARDINER: And it has been called an incentive—no, not by Dr Williams as the medical side, I think is the point he is making, but by the management side it has been seen as an incentive just about, as far as I can tell, all the way through.

Dr Williams: In some of the earlier documents, yes.

Hon PHILIP GARDINER: I have not found where it has not been referred to as an incentive, in the management documents I have read. But you are telling us that it was a fee for service; I hear what you say. But I am sceptical, I am afraid, because the $200 per patient is an implicit incentive, is it not—you do not have to spell it out?

Dr Williams: It was a fee paid for looking after those patients.

Hon PHILIP GARDINER: I know what you are saying, but there really is an implicit incentive. There is something which financially is an encouragement at least, if not covering my effort—if it was me—it is an encouragement which gives a direction for my behaviour.

Dr Williams: Similar arrangements are in place in many other places. Almost all surgeons work under a fee-for-service arrangement as well.

Hon PHILIP GARDINER: And a lot of businesses work under incentives. We can all call it "doing the job" but we get an additional fee or additional reward as a result. I am concerned that some of these doctors' behaviour reflected something different to the others. If it was a fee for service, some were seeing the service differently to others.

Dr Williams: I cannot comment on what individual doctors would have thought.

Hon PHILIP GARDINER: Fair enough, but you are also managing them, are you not?

Dr Williams: Yes.

Hon PHILIP GARDINER: In a way you are accountable. You are accountable for the behaviour. Whatever is involved, you are accountable for the way these doctors are behaving. What has happened here is you have got a number who have picked up pretty quickly there is something in this, or they have got a wonderful view about the services to the patient.

Dr Williams: There is a big difference between the number of hours that these doctors worked as well and the shifts that they covered, too. To be fair, some of the doctors on this list may only have worked one or two shifts during the whole month whereas some of the doctors were working as many as 60 hours a week, in nights and evenings, in the emergency department.

Hon PHILIP GARDINER: Just look at the proportions of the total that did not meet the criteria to the total claims. Let us not look at the absolutes. That covers that point, I think.

Dr Williams: Yes.

Hon PHILIP GARDINER: Some of them are very high. One is a third, others are a quarter—25 per cent—another is about 28 per cent. Apart from one, which is zero, but that is only two claims, the rest are quite high percentages. I would have thought that as a manager of the doctors that would be a little bit alarming, when the audit came up in February, and then in March it is not quite as bad because the absolute numbers are smaller but there are still some pretty big numbers there. What was driving these people?

Dr Williams: I cannot really speculate what was driving them.

Hon PHILIP GARDINER: Was it that it was more changing of dates than you might have been concerned with?

Dr Williams: I am sorry, could you repeat that?

Hon PHILIP GARDINER: Was it that there might have been more manipulation of dates, for example, than you might have been aware of?

Dr Williams: That is a possibility.

Hon PHILIP GARDINER: If that is a possibility, that is a pretty serious possibility because it is fraud, if it was, is it not?

Dr Williams: It is about confusion of the system and whether they understood how to put things in. As I say, we did take immediate steps to clarify the process as well as clarify the technical criteria, which is why the noncompliant patients do drop off very, very quickly after February. It was really by the end of February, early March, that the doctors were fully made aware of the technical criteria.

Hon PHILIP GARDINER: But did you ever —

Dr Williams: I am sorry to interrupt: being aware of the technical criteria, though, may not have stopped them still admitting patients who were valid clinical reasons to be admitted. It is just that they could not —

Hon PHILIP GARDINER: No; that is fine. I am just worried about the ones where the criteria were not met. That is all I am worried about. What I am even more worried about as a manager of it is if you have doctors, where there is a demonstration of an irregularity, that you would not have checked to see how the irregularities were coming out.

[5.15 pm]

Dr Williams: Would not have checked —

Hon PHILIP GARDINER: You would have checked why it is that a couple of these doctors especially had very high proportions of those who did not meet the criteria for claims.

Dr Williams: We did prospectively by auditing all the files that went through.

Hon PHILIP GARDINER: Yes, but you said you did this at the end of February.

Dr Williams: Yes.

Hon PHILIP GARDINER: Yet it was still going in March and April to a lesser extent, I accept, and even in June there was some. Maybe you are going so long may be an explanation, but I think if I were a manager and saw that irregularity there, I would be asking some pretty serious questions: What are you doing? Why are these claims invalid? If you did that, I suspect maybe you may have been surprised—I do not know. Because really what those claims are that did not meet the criteria, is that those—that is representing money drawn from the government to go to the hospital.

Dr Williams: The claims that did not —

Hon PHILIP GARDINER: These claims I know affect the doctors' income, but the behaviour results in money being paid by government to the Peel Health Campus.

Dr Williams: The claims that did not meet the criteria in February —

Hon PHILIP GARDINER: Refunded.

Dr Williams: Well, in February not billed to the government.

Hon PHILIP GARDINER: At the end of the day, that is right. They were not. So, then you have got a behavioural issue or even worse a cultural issue. That is what I am trying to get to. What were the cultural drivers in your part of the organisation at the Peel Health Campus? Were people not being truthful about these claims?

Dr Williams: About the claims? I mean, I do not have any reason to suspect that the doctors did anything that was not in the best interests of the patient in terms of admitting them and looking after them.

Hon PHILIP GARDINER: Is that an assumption you are making or did you have a thorough investigation of your colleagues, albeit openly, to make sure that there was no fraud here?

Dr Williams: I do not understand, sorry. Could you repeat?

Hon PHILIP GARDINER: I understand you may have great faith in your doctors and your team, but when you have an irregularity of this kind, it is dangerous, I think, to assume that it is all fine, because what you have set up here with that you say is the payment for service—others say it is an incentive—has got some behavioural consequences as they always do in any organisation. You always have to be on the watch for it. What I am a bit surprised about is that you did not investigate to see why there were so many claims that did not meet the criteria.

Dr Williams: You mean going backwards?

Hon PHILIP GARDINER: At any point in time—January, February, March, April, May, June. Even at June if you had gone backwards to February and you found this and found that there was untruths in there, I would be very concerned.

Dr Williams: Untruths?

Hon PHILIP GARDINER: Fabrication of dates, altering dates so we can get more income—that is fraud.

Dr Williams: We put systems in place so that the admission process was a lot clearer to people. We put systems in place so there were time checks and time clocks as we went throughout the whole thing and then we went back and audited all the files for noncompliance. I mean, I cannot speak for the doctors or necessarily—they are professional people. I have some trust in their judgement on what patients needed to come into hospital.

Hon PHILIP GARDINER: You are also part of a business. When you have got an irregularity to that extent, as the responsible doctor, if you like, and executive if you can allow me to swing that in, then, I think you actually have an absolute responsibility to investigate whether there was deliberate untruths being perpetrated here to get money both for themselves and for the company or whether you can be absolutely sure that it was an accident. Why I am questioning this is that an accident can occur a few times, but this is almost epidemic.

Dr Williams: We inform the doctors of how the process was meant to go and what the criteria were. Part of the reason as well that the claims started to decrease very quickly in subsequent months too is that we had a lot of non–fee-for-service doctors —

Hon PHILIP GARDINER: Sorry, a lot of?

Dr Williams: More doctors who were not fee for service. The number of patients admitted—I do not have your sheets—did not actually decrease. The payments decreased substantially over the next few months because we had different doctors admitting patients. In fact, in the next year of the CDU's operations when there were no fee-for-service arrangements at all, there are still invalid patients because people are admitting them on clinical grounds and by prospective audit they are deleted and not billed to the health department. That is a process that is still going to this day.

Hon PHILIP GARDINER: All that is fine. I do not think I am making my point clear. My point is at the points of time, be it January—not January because there was nothing there, but February, March, April, May, June, were the actions of people at that time absolutely truthful or were there untruths being perpetrated so that we would get the data that I have and you have in front of us? That is the question. What is the answer?

Dr Williams: I cannot say for sure.

Hon PHILIP GARDINER: But you did not investigate. I am very surprised you did not investigate. When you saw this data, I am surprised you did not investigate.

Dr Williams: We did have lots of issues around governance. The governance of this unit was not good. There were errors in governance throughout the year.

The CHAIR: Members, I am slightly mindful that we do not want to be here at midnight. That is no criticism of members asking questions, but we do have to finish some time. I have two members who have indicated they have questions.

Hon LJILJANNA RAVLICH: Just very quickly, in terms of technical criteria, are you saying to the committee that you had no understanding of what the admissions criteria was?

Dr Williams: At the beginning of the setting up of the CDU, yes, that is correct.

Hon LJILJANNA RAVLICH: I have just gone on to the internet and I have just flicked on to technical bulletin 17/3, which is "Admissions Policy for WA Hospitals". Do you really expect the committee to believe that you hold such an important role within that hospital that you could not look up the admissions criteria or indeed get clarification from the WA health department in terms of the admissions criteria that you should be applying at the Peel Health Campus?

Dr Williams: We were not aware of the admissions criteria. When I asked senior colleagues in other hospitals —

Hon LJILJANNA RAVLICH: Really should you be in the position —

The CHAIR: Let us hear his answer.

Dr Williams: There are many people who are not aware of the admissions criteria or even the subsequent admissions criteria. Coming from the public sector, when we admit people to hospitals—I have worked mostly in the public sector—it does not actually make any difference. There is no billing that goes on, so no-one takes any notice. It does not matter. But no, I was not aware. Yes, I should have been aware. I think that though I would not be the only person in that category.

Hon LIZ BEHJAT: Are you saying you were not aware of technical bulletin 17/3?

Dr Williams: Yes, until February of 2011.

Hon LIZ BEHJAT: When did you write this?

Dr Williams: That was written —

Hon LIZ BEHJAT: You refer to technical bulletin 17/3 in that.

Dr Williams: Yes, that is correct. That was written in June 2012. So, more than a year later that briefing note was written.

Hon LJILJANNA RAVLICH: Do you believe that as a director of a health service provider you are in breach of your duty of care to the public let alone the patients by not making yourself aware of something so fundamental?

Dr Williams: The director of medical services is really about clinical quality of care and looking at doctors, recruiting the right doctors, making sure we deliver the right level of services. The technical governance of the aspects of admission is more on the clerical executive side of the thing.

Hon LJILJANNA RAVLICH: Let me just say we heard today from a number of people who presented before the committee. We also received some written evidence from witnesses and in response to, I think, a request for a response to the audit findings, I understand that Mr Stowell advised one of our witnesses to have you prepare the draft response because "you had gotten us into this mess". In other words, you stand accused of creating all this mess according to written documentation handed to us by one of our witnesses. What do you say to that?

Dr Williams: Could I see the document? I have not seen it.

The CHAIR: I think given that that is not an original document, it is an allegation, I think it would be reasonable if we have something to put to you, we provide you with something that documents that rather than an assertion.

Hon LJILJANNA RAVLICH: Madam Chair, can I just say that according to one witness you were right here in the centre of the creation of all of this, yet all the evidence that we have heard from you today is that you were a bystander over here somewhere at arm's length from what was going on, which is really inconsistent with what we have here. What I am asking from you is to explain or provide a response to what has been alleged here.

Dr Williams: You mean in the formation of the clinical decisions unit in the first place?

Hon LJILJANNA RAVLICH: In terms of the comment that "you had gotten us into this mess".

Dr Williams: I think that, as I have mentioned, there were failings of governance of the clinical decisions unit from the beginning. The responsibility for those failings of governance does not rest with one person. They are a responsibility across the executive of the campus.

Hon LJILJANNA RAVLICH: The allegation here, of course, is that it largely rests with you. It may not entirely rest with you, but it largely rests with you. Madam Chair, just another point, in the same document it is alleged that Sarah Ward, together with one of our witnesses, had identified the spike in admissions several months before it was identified at the South Metropolitan Health

Service contract meeting and that she and Catherine McKinley had approached you with proof that patients were being unnecessarily admitted and that doctors involved were altering time stamps on the records; is that correct?

Dr Williams: From Sarah's recollection she approached me in February with her concerns and we acted immediately. I had a bit of a hazy memory of the time, but that was what she said recently. I mean, her response is we found the issues, we fixed the issues in the clinical decisions unit.

Hon LJILJANNA RAVLICH: How did you fix them?

Dr Williams: First of all, prospective audit because there are always going to be admissions that are not going to comply with technical criteria; by getting better systems in place so that admission pathways are clearly understood; and having things like time stamps so that it is all clearly documented; ensuring that there is an audit process around the documentation of the admission process; and by recruiting staff so that we could properly staff the unit so we could provide services to the area.

[5.30 pm]

Hon LJILJANNA RAVLICH: Is it true that you told Catherine McKinley and Sarah Ward not to worry about it—that is the time sheets, or the offering of the time sheets—because you said, allegedly, "My guys wouldn't do that", and just left it at that?

Dr Williams: I do not recall saying that.

Hon KEN TRAVERS: Earlier in the hearing today, you made a comment, when we were discussing it, that the systems were slow to pick up the increase in admissions. What systems were there in place to pick this up?

Dr Williams: I think part of the problem is that there were not very good governance systems around picking up the activity, and certainly information was not quick in coming and was not shared widely around the executive group.

Hon KEN TRAVERS: So what systems were in place?

Dr Williams: Very few at the beginning.

Hon KEN TRAVERS: I understand you are saying very few, but what were those very few?

Dr Williams: All there was, really, was the retrospective ability to see how many patients had come in, essentially, and to look at admission numbers and compare them to previous admission numbers, medical and surgical. So it was fairly rudimentary.

Hon KEN TRAVERS: All right. Why would that not have picked up the spike in admissions, then?

Dr Williams: It did, but it took a while for it to come to people's attention. I mean, the reporting on a month could not come to people's attention for many weeks afterwards, unfortunately.

Hon KEN TRAVERS: Can we provide Dr Williams with a copy of the email of 23 August from Dr Williams to Mr Hatt? Have you had a chance to refresh yourself with that document?

Dr Williams: Yes, thank you.

Hon KEN TRAVERS: I am not sure that I understand the first one, because it seems to be two emails, both from you to Mr Hatt —

Dr Williams: Yes.

Hon KEN TRAVERS: — and no correspondence in between.

Dr Williams: I do not think I received a reply to the first one.

Hon KEN TRAVERS: Looking at this, it would appear that you were already by August, and fairly early on in August, looking at the whole question of the CDU unit and looking at that there

were problems with the way in which it was operating. That is my reading of this. Is that a fair reading of this?

Dr Williams: What I was trying to imply in this is that for it to be a sustainable model going forward, emergency physicians were still very hard to attract, despite the remuneration arrangements we had in place, so we had to look for salaried general physicians as a way forward, and that was what this was about—it was about recruiting them. During this time I was having lots of conversations with physicians to try to recruit them to come down and see whether they would be interested, how many hours they had to spare, all that kind of thing.

Hon KEN TRAVERS: I understand that you were looking at that. But at the bottom there are those four dot points. The first point is —

> The current model is not sustainable and close to collapse

The next dot point is —

> the current model is also placing a huge stress on ED leaving it exposed, at times dangerous and leading to low staff morale, poor productivity and increasing resignations and sick leave

The next one is —

> this all exposes us to unacceptable clinical risk

That says to me that you are clearly looking at that there are problems with the way in which the CDU is operating.

Dr Williams: Yes, there were. These are clinical problems that we were identifying in terms of the inability to get enough senior staff to adequately cover all the needs that we had. It was a problem that lots of emergency departments had at the time, and many still do. So the idea was to move away from an emergency physician-led CDU, move them back to being purely responsible for the emergency department, and to get salaried physicians to run the CDU—so emergency physicians running the emergency department, and general physicians running the CDU.

Hon KEN TRAVERS: Then if you go to the next page, obviously the whole thing is about an alternate proposal for attracting those doctors. It says —

Obviously there are some transition issues we need to need to address and the new system would not be operational overnight. In particular there are some issues we need to overcome with Dr Stephenson and his high levels of productivity and billing which skew current statistics.

What does that mean?

Dr Williams: Well, Arthur Stephenson was a doctor who worked many hours in the emergency department. He worked some 60 hours a week, covering evenings and nights. He is an emergency physician and an intensive care physician, and he is a very quick worker and very efficient and effective.

Hon KEN TRAVERS: So what were the issues that you needed to overcome with his high levels of productivity?

Dr Williams: I think what I was referring to is it was skewing the—because he was working so hard admitting patients when he was on, then at times when he was not on, there was not anybody to admit patients, and that was having an effect on how many admissions we could do at different times of the week. When he was there, there was a resource —

Hon KEN TRAVERS: But surely that is not a case of a problem with him. That means you need another Dr Stephenson, does it not?

Dr Williams: Yes, we did in many ways!

Hon KEN TRAVERS: But that suggests that there is an issue with Dr Stephenson and his high levels of productivity. I mean, why is that a problem?

Dr Williams: Well, the issue really was not with his high levels of productivity when I was writing this email. The issue really was in terms of the business plan—because this was attached to a business case—how we account for one doctor who is very productive.

Hon KEN TRAVERS: So what is the problem with that? When I look at that, it says to me that you did know that there was a problem with some doctors and their number of admissions, and the spike in admissions, in August. If we look at the records, in terms of the doctors who got the incentive payments, Dr Stephenson was, if not the top, within the top two, and well ahead of any other doctors in terms of incentive payments over this period.

Dr Williams: I think there are a couple of things there. The first one is that in August, there was no spike in admissions; in fact, admissions had dropped off quite dramatically in August. So there was no spike in admissions at that time, and Dr Stephenson did a lot more hours in the emergency department than anybody else did.

Hon KEN TRAVERS: So is the language that you used there wrong, then, to convey what you were trying to say?

Dr Williams: I think we are looking at different sides of it. What I am saying is if you take Dr Stephenson out of the clinical decision unit, the admissions will go down, because there is no-one to admit at the times when he is on—he is covering a lot of hours—and a physician model may not stack up from a business perspective because you have not got someone skilled and effective covering many hours after hours.

Hon KEN TRAVERS: You make the comment just then that in August there had been a drop in the admissions. Can you recall what the admissions were on a month-by-month basis?

Dr Williams: It tended to go up and down. Certainly in August the admissions were not in any way abnormally high.

Hon KEN TRAVERS: So when were the admissions abnormally high?

Dr Williams: They started to get abnormally high in October of 2010.

Hon KEN TRAVERS: All right. In terms of that business model, again, it seems to be very heavy focused on profit rather than clinical outcomes. Even though you raised a number of concerns about clinical outcomes in the text, I am not sure where the text is about how it addresses the clinical outcomes.

Dr Williams: I was requesting additional resources and I was trying to write a justification for the effect the additional resources would have.

Hon KEN TRAVERS: Can we now provide Dr Williams with the 1 December 2010 email from Sam Larmour?

The CHAIR: Can I indicate to all and sundry that we will certainly finish before six o'clock.

Ms ARCHER: Given that indication, Madam Chair, may I raise a point in relation to section 181 of the standing orders, with the honourable committee's leave? It is in relation to witnesses' entitlements, so may I ask a question?

The CHAIR: Yes.

Ms ARCHER: Thank you. I am very grateful. Standing order 181 gives the entitlement to a person examined before a committee to have a reasonable opportunity to rebut allegations of particular types. That is in subparagraph (e). Paragraph (a) refers to a person being entitled to have access to relevant documents before and during examination. I am not sure whether or not the committee's plan is finish with Dr Williams tonight or come back to him tomorrow. But if the plan was to come back to him tomorrow, then access to relevant documents would raise its head. My purpose for asking the question is in relation to HSWA itself, because it was the recipient of a witness summons. Dr Fong is here. Very serious allegations have been made against HSWA, and while he

obviously understands that the committee cannot sit forever and would not be interested in hearing from him to any length, he would be immeasurably grateful if the committee were to give him the indulgence of being permitted to make a very, very short statement in relation to one of the allegations—tonight, I mean.

The CHAIR: Thank you, Ms Archer. I think the best thing to do with that request is that we will conclude the hearing with Dr Williams, we will then deliberate on your request, and then we will come to a decision.

Ms ARCHER: I am very grateful. Thank you, Madam Chair.

Hon KEN TRAVERS: Do you have that other document, the 1 December one?

Dr Williams: Yes, I have it.

Hon KEN TRAVERS: That document highlights the jump that I think you have just referred to, in the third paragraph, the jump in CDU admissions—or it certainly lists the number.

Dr Williams: The third paragraph refers to—what they were trying to get at here was they were trying to forward plan for what fees would be charged, based on the number of admissions, so that there could be financial planning and there could be accrual, I believe, against it, and I think there was some confusion in that the fact was that the number of claims for the fee was less than the number of admissions.

Hon KEN TRAVERS: I understand that is the substance of the document. But what I am interested in is that you were clearly getting figures about the number of admissions in December for October. So why were the concerns that were not identified until February not identified on 1 December when you saw that figure?

Dr Williams: I guess this is not seen as part of a trend. This is just a number. I did not have a similar email telling me what the September number had been.

[5.45 pm]

Hon KEN TRAVERS: In your position, you did not, on a monthly basis, follow the trends?

Dr Williams: No.

Hon KEN TRAVERS: All right. Are you confident that the Peel Health Campus is clinically safe?

Dr Williams: Are you talking about right now?

Hon KEN TRAVERS: Right now or at any time that you have been there.

Dr Williams: Yes.

Hon KEN TRAVERS: It has always been clinically safe?

Dr Williams: Yes. I am confident the Peel Health Campus is clinically safe.

Hon KEN TRAVERS: Have you ever had concerns about the carpets or floor coverings and whether or not they are of the clinical standard that you would expect in a hospital?

Dr Williams: The carpets are currently being changed and changed for lino. It is an issue that we raised and has been addressed by Jon Fogarty agreeing to replace them all.

Hon KEN TRAVERS: When was it first raised?

Dr Williams: Gosh, I could not say for sure when it was first raised.

Hon KEN TRAVERS: A couple of weeks ago, a year or two years ago? A significant time ago?

Dr Williams: It was probably some significant time ago, but it would not have been raised with me.

Hon KEN TRAVERS: But did that never cause you concern—the state of the carpets or the floor coverings in the operating theatres; that has never been brought to your attention and it has caused concern for you as the head of medicine within the hospital?

Dr Williams: With areas like the operating theatre, when concerns were raised about it—again, this was not my area and more on a nursing side, but —

Hon KEN TRAVERS: No, I am asking you whether in terms of a medical perspective it was ever a concern for you that it was a medical risk—the state of the carpets or the floor coverings in the operating theatres?

Dr Williams: I do not think that there was a medical risk associated with the carpets. There are no carpets in the operating theatres.

Hon KEN TRAVERS: I am asking you about carpets in the wards and the lino or whatever it is in the operating theatres, bubbles and broken cuts within the vinyl floor coverings in the operating theatres. Did either of those ever cause you concern from a medical perspective?

Dr Williams: When people highlighted—well, personally, I am not an expert in infection control. I would take advice from infection control consultants.

Hon KEN TRAVERS: So has it ever been raised with you those concerns about either of those matters?

Dr Williams: About infection control issues?

Hon KEN TRAVERS: As a result of the carpets or the floor covers in the operating theatres.

Dr Williams: Infection control issues, no —

Hon KEN TRAVERS: Never been brought to your attention?

Dr Williams: More recently, yes, which is why we pushed hard to try to get them all—well, we are getting —

Hon KEN TRAVERS: So more recently being how long ago?

Dr Williams: In the last few months.

Hon KEN TRAVERS: The original concerns that were raised with you a couple of years ago, what were they in relationship to?

Dr Williams: I think staff were concerned that the place looked tatty.

Hon KEN TRAVERS: It was never raised as an issue to do with the medical safety of the patients?

Dr Williams: Not that I recall.

Hon KEN TRAVERS: Have you ever witnessed bullying at the hospital?

Dr Williams: Witnessed bullying? Can I ask in terms of the terms of reference?

Hon KEN TRAVERS: Obviously, one of the issues that has been raised is that allegations—when people want to raise concerns within the hospital structure, things like the CDU being one of them, that they are bullied. I am not asking specifically in relation to the CDU; I am trying to get an understanding of whether that is a cultural issues within the hospital that there is bullying and so whether or not you have witnessed bullying in the hospital.

Dr Williams: In relation to the CDU, the people who brought the CDU issues to the attention were promoted rather than harassed or bullied. That is a good example of somebody who brought issues to attention and is now currently the deputy chief operating officer.

Hon KEN TRAVERS: That is good. But that is not my question. My question was have you ever witnessed bullying in the hospital?

Dr Williams: In terms of not—I mean I guess the things it is hard to define "bullying". What is the definition?

Hon KEN TRAVERS: Bullying to a degree where it was of concern to you.

Dr Williams: I think certainly some robust discussions happened at the hospital, particularly at executive level around performance issues and that kind of—I would expect robust discussions myself. But if your question is: is there an endemic cultural of bullying at the campus, I believe not.

Hon KEN TRAVERS: Okay. Have you ever spoken to Mr Fogarty about removing other members of the executive team from the hospital, in terms of getting rid of them from the hospital or firing them or whatever term you want to use?

Dr Williams: To Mr Fogarty?

Hon KEN TRAVERS: Yes.

Dr Williams: I am trying to recall. I think we have had some discussions or in the past we had some discussions around the role of one person, the ex-director of nursing, Catherine McKinley, and whether she could do some work from home rather than be at the campus all the time. I recall that. Any other? Nothing else that I recall.

Hon KEN TRAVERS: So as a result of any of the issues that have arisen out of the CDU, you have never had a conversation with Mr Fogarty about removing that staff member from the campus; removing them from the employ of Peel Health Campus, Health Solutions WA?

Dr Williams: As a result of the CDU? As I said, the people who drew things to our attention —

Hon KEN TRAVERS: In relation to any of the issues that have arisen around the CDU.

Dr Williams: Not that I can recall. As I say, the person mainly responsible for bringing the problems up was promoted.

The CHAIR: Earlier in your evidence you talked about the intent of bringing in the CDU and the processes around that were to increase the number of patients, because your admissions were low and you wanted to bring it up. What I understood you to say was that now there were sufficient doctors—so you achieved that outcome, got more doctors and, therefore, it was back on —

Dr Williams: More benchmarked, yes.

The CHAIR: Can you tell the committee the number of doctors in 2010 and what they are now?

Dr Williams: I would have to take that on notice

The CHAIR: I am asking for evidence of that shift.

Dr Williams: I would have to take that on notice in terms of the number of full-time equivalents that there are. There has been quite a significant jump in that time.

The CHAIR: With regards to the payments of $200, do you know who certified that those payments were legal and met the criteria?

Dr Williams: What occurred in the early stages was that the doctors submitted tax invoices. They were submitted to Sam Larmour in the practice office, who checked them through.

The CHAIR: What was his role?

Dr Williams: Sam is the practice manager. He would check them through and check through for patients who did not comply with our first understanding of the patient compliance. Then I believe I signed off on them and submitted them. The process post-audit, there was a step in the middle where all files were audited first. I cannot recall if I was still signing off on them or not at that time, the post-audit time. The billings dissipated very, very quickly as we got more people in during that time.

The CHAIR: Who specifically brought to your attention the matter of the unauthorised payments to you and the board?

Dr Williams: Unauthorised payments to —

The CHAIR: The allegation that the $200 payments were unauthorised or outside of—did not meet the criteria.

Dr Williams: Did not meet the criteria? There were too many going around.

The CHAIR: Yes. Who brought that to your attention?

Dr Williams: I cannot recall if it was Sarah or Catherine. I cannot remember.

The CHAIR: You think it was one or other of those people?

Dr Williams: I cannot recall exactly, Madam Chair, who it was. This was two, two and a half years ago, I think.

The CHAIR: Would that not be noted somewhere? If you cannot remember now, would you not have made some record of that complaint or allegation?

Dr Williams: I would have to take that on notice and check. It may not have initially made directly to me; it may have been made to the chief executive officer at the time. It is a possibility.

The CHAIR: Any paper trail or documentation of how that complaint was made, if you could.

I will close this part of the hearing, bearing in mind that we will deliberate on your request, Ms Archer. The committee will forward any additional questions it has to you, Dr Williams, in writing in the next couple of days, if there are any further questions, with the transcript of the evidence. Responses would be appreciated within 10 working days of receipt of the questions. Should you be unable to meet this due date, please contact the committee in writing as soon as possible before the due date, and include any reasons as to why the due date cannot be met. Parliamentary privilege applies to your evidence of this hearing and that means that what you have said in evidence to the committee cannot be used against you in subsequent court proceedings or tribunals. The immunity afforded by parliamentary privilege, however, does not apply after the hearing if you repeat statements made in evidence publicly. Thank you for your attendance.

Proceedings suspended from 5.57 to 6.12 pm

The CHAIR: Dr Williams, I need to address you to complete the hearing. We went through that bit, but a further question has been raised. The committee has deliberated on the request. The committee is more than happy to tell you, firstly, that in terms of relevant documents, the only documents that are relevant are the documents that were provided to the witness to view during the course of the proceedings. The committee is more than happy to offer Dr Williams the opportunity to rebut any allegations. I consider that opportunities were provided within the hearing, but if there are specific things that Dr Williams would like to rebut now, he may, and, of course, we are open to further correspondence if you want to consider that and come back to us. But I give you the opportunity now for further matters that you would like to address.

Dr Williams: I would like the opportunity to rebut any allegations in writing so I can read and have a think about them if that is possible.

The CHAIR: Of course.

Dr Williams: I think if I can summarise the clinical decision unit, it was a project that produced very good clinical outcomes for the people in the region. It led to people having better care from more senior doctors at the campus, and it allowed us time to recruit the doctors that we needed to have the service that we have today with the increased numbers and the capacity, of which I will supply the details. We have a good group of doctors, a good group of staff—a happy group of staff. It is a place that I love working at throughout all the difficult times. The initial setting up of the

CDU was a very difficult time for everybody. We were short staffed in the emergency department; there was a lot of work on. As a result of that, the governance around, we made some errors—no doubt. But I believe we found the errors and fixed the errors, and it gave us the opportunity to get started in building the service that we have now. To summarise, those are the main issues for me. It was good clinically. There were governance issues around it. We found the governance issues and we fixed the governance issues. Peel is a place I love and I am very happy to work there.

The CHAIR: Thank you.

Just to the other request, which was from Dr Fong to present information to the committee, the committee makes it clear that Dr Fong was not originally summonsed to appear before the committee. We summonsed another person who has not been able to attend. But the committee is more than happy to accept a written document from Dr Fong and to consider that. In light of the time, we think it is reasonable to finish this hearing, but invite Dr Fong, if he wishes, to submit whatever he likes to the committee —

Hon KEN TRAVERS: Which can include a request to be heard before the committee.

The CHAIR: Absolutely—which can include a request to give evidence orally.

Hearing concluded at 6.16 pm