STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

INQUIRY INTO PEEL HEALTH CAMPUS PAYMENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 19 NOVEMBER 2012

SESSION THREE

Members

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

Hearing commenced at 3.51 pm

GRAY, DR SUZANNE
Director of Emergency, Emergency Department, Peel Health Campus, sworn and examined:

The CHAIR: Good afternoon. On behalf of the committee, I welcome you to the hearing this afternoon. Before we begin, I am required to ask you to take either an oath or an affirmation.

[Witness took the affirmation.]

The CHAIR: Please state the capacity in which you appear before the committee. What is your current occupation?

Dr Gray: My current role is I am director of emergency at Peel Health Campus. I am an emergency consultant.

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

Dr Gray: Yes.

The CHAIR: The proceedings this afternoon are being recorded by Hansard and a copy of the transcript will be provided to you. If you do quote from any document, could you give us the full title for the record if you are quoting from a document. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a statement in confidence in this afternoon's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media 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 you leave the hearing.

I should also indicate that if you wish—I assume the gentleman sitting behind is counsel for you.

Dr Gray: Yes.

The CHAIR: Counsel is welcome to sit beside Dr Gray if he prefers, if that is easier. If there is a conversation, it is probably easier to be to hand.

I might start with some questions, and other members will no doubt join in. I might just introduce the committee: at this far end, Hon Philip Gardiner is a Nationals member for Agricultural Region; Hon Liz Behjat is a Liberal member for North Metropolitan Region; I am Giz Watson, Greens member for North Metropolitan Region; Hon Ljiljanna Ravlich is an ALP member for East Metropolitan Region; and Hon Ken Travers is an ALP member for North Metropolitan Region.

I wonder if you could please tell the committee what your job at Peel Health Campus entails.

Dr Gray: My current role as director of emergency department, I have both clinical shifts, where I am a senior consultant there, and I have, obviously, non-clinical administrative-type work as well, where I review guidelines and protocols, look at the staffing levels of the department. I talk to other departments about our role and liaise with them—basically, just oversee the running of the department from a clinical side.

The CHAIR: It is my understanding that you were employed at Peel Health Campus at the time that there was a clinical decisions unit operating there.

Dr Gray: Yes, that is correct.

The CHAIR: Could you tell the committee about your involvement in the clinical decisions unit?

Dr Gray: At the time the clinical decisions unit was implemented, I was employed on a part-time basis. I had a casual contract. I was working one to two shifts a week, still in a role as a consultant emergency physician, and I partook in the clinical decisions unit in that I would have shifts where I was the consultant for the clinical decisions unit.

The CHAIR: And what did that involve in that role?

Dr Gray: In that role it involved admitting patients from the emergency department and overseeing their inpatient care and disposition. I was also on call in the evening for admissions, and many times, because I was taken out of the emergency department to oversee CDU, I would be asked to assist the emergency department, from a senior point of view, if they needed it, because we then would often backfill that consultant position by a more junior doctor. So, the understanding would be that —

Hon LIZ BEHJAT: Is that where we understand the acronym FACEM or —

Dr Gray: That is right.

Hon LIZ BEHJAT: That is what you were.

Dr Gray: That is an emergency consultant; that is a fellow of the Australian college —

Hon LIZ BEHJAT: We have seen all these acronyms, and we kind of need to get across those.

Dr Gray: Sure.

Hon LIZ BEHJAT: So you are a —

Dr Gray: Yes. So a FACEM is an emergency consultant.

The CHAIR: Could you tell us what your involvement, if any, was in the development of the establishment of the CDU? Did you have any role in that?

Dr Gray: No, not really.

The CHAIR: Could you tell the committee when the CDU was operating and when that was concluded—the sort of time frame we are looking at there?

Dr Gray: My understanding, and from what I remember, we started it in about May 2010, and it went through till early 2011.

The CHAIR: And why did it cease to operate?

Dr Gray: It ceased to operate because the hospital was able to recruit physicians down, who then actually set up a more structured medical unit for the hospital.

Hon LIZ BEHJAT: One of the reasons that the CDU, in your opinion, was set up was that you did not have enough physicians to cope with the number of people presenting at ED, so this was seen as a way of streamlining that process or —

Dr Gray: At the time we had one physician, Dr Desai, who managed patients more as a long stay—more sort of chronic medical problems—and he was in charge of the rehab unit as well. He would often have 30 to 40 patients under him and did not have the capacity to admit any more sort of acute medical patients. The CDU, therefore, was set up to provide a unit to admit these sort of acute medical patients into, because at the time we really had no other option. It was Dr Desai, GPs who were slowly pulling out of admitting to the hospital—they sort of were pulling out of that service—or sending them to Fremantle or keeping them in the ED for hours and hours. They were our options, so the CDU was set up to provide another option for admissions to the hospital.

Hon LIZ BEHJAT: Who looked after them once they went to the CDU?

Dr Gray: We did not have any physicians to do that, which is why the emergency physicians were asked to take on that role and lead the CDU. We were asked to come out of our role in the emergency department and look after CDU as well as still helping ED when needed.

Hon LIZ BEHJAT: So you had RMOs in ED and —

Dr Gray: Registrars, some senior medical officers and residents in the emergency department.

Hon LIZ BEHJAT: And then you, as the FACEM, would be in charge of all of those and had to look after the CDU as well.

Dr Gray: Yes.

Hon LIZ BEHJAT: A big workload.

Dr Gray: Yes.

The CHAIR: Were you aware of the circumstances that doctors were being paid an additional amount of money for admitting patients to the clinical decisions unit?

[4.00 pm]

Dr Gray: Yes, I was aware.

The CHAIR: Okay. What did you understand about those payments? They have been variously described as incentives or bonuses or a fee for service. Do you have an opinion? What best describes those payments?

Dr Gray: My understanding of it, and the way I saw it, was a fee for service. It was extra money for extra work.

The CHAIR: Did it operate in that way or were there issues raised around whether it was actually a fee for service?

Dr Gray: From my understanding, all the doctors that were involved took it as a fee for service.

Hon LJILJANNA RAVLICH: But was there any extra work being done?

Dr Gray: Yes, there was. My normal role as an emergency physician would be that I work in the emergency department, I admit patients to the ward under another team, and they take all the responsibility for that patient, for their ongoing care and their disposition. I was not normally on call overnight, but now I was in this role where I was expected to help ED if they needed it—you know, if they had a resuscitation or a sick child, they would call me for assistance—plus take all the new CDU admissions, plus be on call, and then on the weekend also look after Rohit Desai's medical patients if they needed any other care as well, so on a weekend there was even more responsibility. So I think I would not have done that job if there was not more remuneration. It was a difficult job.

Hon KEN TRAVERS: But if the CDU had not been implemented, where would those patients have been in the hospital? Would they not still have been under your care as the FACEM for the emergency department?

Dr Gray: No. They would have been sitting in the emergency department under my care. So then the emergency department gets busier and busier; we get bed blocked; we cannot get them out, which is called access block. Our "did not wait" times go up, and you have a very dysfunctional emergency department—either that or we try and get them up to Fremantle. We were having to refer large numbers to Fremantle Hospital, and they themselves have their own—they are busy as well, or we try and admit them under Dr Desai, who was at capacity.

Hon KEN TRAVERS: If they are just sitting in the emergency department, as the emergency FACEM, they are under your care.

Dr Gray: Yes.

Hon KEN TRAVERS: You admit them to the CDU; they then become under your care. The only person in that scenario that does extra work, surely, is the medical officers left in the ED department that now do not have you as the FACEM to provide guidance unless they go and call you out of the CDU. Is that not the way it would have worked? I am trying to work out where the additional

workload was, and the only people that I can see doing additional work would have been those that remain in the ED department without now a FACEM to assist them, unless they call you.

Dr Gray: I think it was a significant additional responsibility as well, and the on call was additional work, and I was much busier than I would have been if I was just working in the emergency department. I agree; normally, if I work in the emergency department, I admit them and they go to the ward, but with the CDU, I am then looking after them on the ward; I have to review them. Ongoing management, ongoing investigations, disposition issues are all now my responsibility.

Hon KEN TRAVERS: Right.

Dr Gray: It is a different job that we do not normally do, and I think they knew fully well that they were not going to get any staff to do this job without remuneration.

Hon KEN TRAVERS: So why was it not part of just the ordinary salary—an additional salary? Why was it done as a separately billed item? Do you know? Was that ever explained to you?

Dr Gray: No.

Hon KEN TRAVERS: Was it of benefit to you, as one of the doctors receiving it, to have it separately billed, or was it more of a pain?

Dr Gray: Probably more of a pain. We are normally on an hourly rate. We are not on a salary. We work on an hourly rate, and I do not know why our rate just was not increased. I do not understand. When I asked about that, my understanding was it was only going to be a short-term solution while we attracted physician staff.

Hon PHILIP GARDINER: If I can just clarify that again, you said that you worked on an hourly rate. So if you worked longer hours, you would get paid for those longer hours under the new arrangements for the CDU? Is that correct?

Dr Gray: Yes, for the hours that we were at the hospital. We just log—this is pretty standard for all shift workers. You do your shift, you put in your template and put down the hours that you work, and you get paid for those hours.

Hon PHILIP GARDINER: So if it was 10 or 14 hours, you would get paid the same rate, but for the 10 or 14 hours?

Dr Gray: Yes.

Hon PHILIP GARDINER: So with the CDU, you talked about the additional work and so on. Did you get paid extra, but not per hour—it was just for the extra hours, then? So you got more per week, if you like?

Dr Gray: I think also—it was not that I did more hours. It was an increased workload. It was just that the hours that I was there were extremely busy —

Hon PHILIP GARDINER: More intense.

Dr Gray: More intense, more responsibility, plus unpaid on-call.

Hon PHILIP GARDINER: And $200 was enough to attract you to stay and do the extra work? Even though it was on call, that was sufficient to satisfy you?

Dr Gray: I was a bit different, because I had been at Peel since 2007. I had seen it grow. I had seen us come into this really difficult time where our presentation rate had just been going up. Two years before, our presentation rate was at 30 000. Two years later, we were at 40 000. We had moved into the new department. Our sort of medical staffing, the physicians, and the ability to admit patients had really dropped off as the GPs were pulling out, and we were just in a really difficult time, and I had some loyalty to Peel to stay there and try and help to get through that while we recruited extra staff. So that was why I stayed and did it. The money thing, that was a proposal that was made to me. I had nothing to do with it. It was just the way it was developed.

Hon PHILIP GARDINER: And your hourly rate, if I can ask you—I know it is a personal question—did your hourly rate change in the course of 2010–11?

Dr Gray: No.

Hon PHILIP GARDINER: So it was the same rate?

Dr Gray: During that time it was the same hourly rate, yes.

Hon PHILIP GARDINER: So the same rate, and roughly the same hours of work, with the difference being that this $200 covered the added intensity of the work during the day?

Dr Gray: Yes.

Hon LIZ BEHJAT: You were doing one to two shifts a week, part time?

Dr Gray: Yes.

Hon LIZ BEHJAT: Were you working at another hospital?

Dr Gray: I was. I was employed at Armadale two days a week, working in emergency there.

Hon PHILIP GARDINER: Can I ask whether the Armadale rate and the Peel rate are the same?

Dr Gray: No. The rate at Peel —

The CHAIR: The answer is no; they were not. Sorry. It is just the way you phrased the question!

Dr Gray: No. Peel does pay more than the public system, but not much more, to honest, when you work it out. It is a little bit complicated, because Peel, being a privately-operated, pays at an hourly rate, whereas when you work in the public system, when you work in Armadale, for example, which because it is not one of the inner city tertiaries, they have added incentives for consultants to go out there.

Hon PHILIP GARDINER: Do they?

Dr Gray: Yes.

Hon PHILIP GARDINER: That is the advantage of being regional?

Dr Gray: Yes.

Hon LIZ BEHJAT: Does Armadale have a CDU?

Dr Gray: No. At the time I was working at Armadale, we had a 12-bed emergency short-stay unit that had a dedicated emergency consultant staffing it, and they had a very robust medical unit, with physicians. They did not have a CDU. They just had a medical unit that had an ability to take patients.

Hon PHILIP GARDINER: I recall seeing a table of the doctors at Peel and the number of patients that they had introduced to the CDU, and if my memory is correct, you actually had very few patients compared to your peers that you were introducing to the CDU.

Dr Gray: Right.

Hon PHILIP GARDINER: Was that just simply because you were working part time?

Dr Gray: I suspect so.

Hon PHILIP GARDINER: And no other factor? Can you explain why others might have had so much higher, and even varied, numbers of admissions to the CDU?

Dr Gray: I certainly think if any of those doctors were doing evening and night shift, they would be admitting more. It is classic that the patients who come in requiring admission to hospital are—it is more sort of streamed towards the evenings that patients get admitted.

Hon PHILIP GARDINER: So it might have been when you were working those shifts?

Dr Gray: Even though I was doing one to two shifts a week at Peel, that second shift was not always CDU. Occasionally I would be back in the emergency where I would be doing a non-clinical shift, admin, paperwork.

Hon PHILIP GARDINER: And the fact that you had much fewer admissions, was that reflective of anything else except the time that you were working—the part-time that you were working? It was not that you did not want to put them into the CDU?

Dr Gray: I hope not, no. No. I certainly was not resistant to admitting patients. No. That is the only reason I can think of.

Hon PHILIP GARDINER: I think I also recall that you did not have any admissions which on review by the hospital and PricewaterhouseCoopers there was a pay-back of the $200. Am I correct on that?

Dr Gray: Yes. I never had to pay back any money.

Hon PHILIP GARDINER: Why were you different, do you think, to the others who did have a lot to pay back?

Dr Gray: The only reason I can think of is that during the day, patients who generally were admitted to CDU were appropriate admissions from a billing point of view. The admissions that were deemed inappropriate tend to be more the social admissions and also any patient needing mental health review. Those types of patients tend to come in in the evening. If they come in during the day, we tend to be able to sort it out during the day. But it is rare to get intoxicated patients during the day. Most of our mental health patients come in late afternoon, evening. With the social admissions, you do not need to do it during the day; you can get them home. I am talking about the little old lady with a urine infection who lives on her own. During the day, you can sort that out. You can get family to come and pick her up. But at eleven o'clock at night, you do not really have much choice. But from my understanding, that is not a billable admission. And, to be honest, from a doctor's point of view, we do not ever admit from that point of view. We admit under duty of care or need—clinical need.

Hon PHILIP GARDINER: Are you aware that some of the repayments that doctors had to make—are you aware that there might have been changes of dates on some of their admission forms or whatever you fill out to get them into the CDU?

Dr Gray: I was not aware of that at all at the time.

Hon PHILIP GARDINER: So as far as you are aware, everything was done pretty uniformly as far as understanding the admission rules and was not tampered with at all?

Dr Gray: Yes, that is my understanding.

Hon LJILJANNA RAVLICH: Ms Gray —

The CHAIR: Doctor.

Hon LJILJANNA RAVLICH: Dr Gray, sorry. I am going to refer to an email that you sent on 9 July 2010. It is from you to Phil Hatt and Paul Bailey.

The CHAIR: Just hang on; we will get a copy.

Hon KEN TRAVERS: Earlier you said—I might have got it wrong—when I was asking you questions earlier you said that one of the things you did with the CDU was that you were on call.

Dr Gray: Yes.

Hon KEN TRAVERS: So was the $200 for your on-call work, or were you paid separately for being on call?

Dr Gray: We were not paid for being on call. It was just an understanding; part of being on for CDU was that you would also agree to be on call without any payment.

Hon KEN TRAVERS: Were you ever able to admit people when you were on call? Is that something you could do—be able to approve someone for admission whilst you were on call?

[4.15 pm]

Dr Gray: Yes, we could approve someone for admission while we were on call, which is not uncommon in most hospitals.

Hon KEN TRAVERS: Yes, but I am still intrigued. In that circumstance, it was being on call. Rather than getting paid an on-call fee —

Dr Gray: With the understanding that the next day we would come and do the work that was required.

Hon KEN TRAVERS: Although was it not the intention that the people who went into the CDU would be there for more than four hours but definitely less than 48, and preferably even less than that?

Dr Gray: Yes, but if we were the admitting doctor, they were not allowed to be discharged without us reviewing them and seeing them and sending them home.

Hon KEN TRAVERS: So once someone was admitted by you on call, they had to stay there until—how did that work if you were only there part-time?

Dr Gray: We would hand over—whoever was the CDU consultant the next day would come and take responsibility for the CDU patients.

Hon KEN TRAVERS: Is there not a risk then that people are actually being held in the hospital longer than is required because you have admitted someone and at that stage the whole point of the CDU is to be examining them and monitoring them? You admit them and then they have to stay there until the next day, and of course that would guarantee that they clock up the four hours that gives the hospital the DRG payment.

Dr Gray: There are a few issues there. The first thing is: overnight, if a patient is admitted under a medical team, you refer them; it does not matter whether it was CDU or I refer them to our medical team or I refer them to the surgeon. In the evening, if I refer them and the doctor who takes the referral is happy for them to come into hospital, then the patient does not have to stay if they do not want to, but the nursing staff do not discharge that patient without that consultant reviewing their patient and being happy for them to be discharged.

Hon KEN TRAVERS: But there are not too many patients who would leave hospital without being discharged by the doctor. I know there are some, but the majority—I know that if I went to a hospital, I would not want to leave until I had been discharged by a doctor, and if the nurses say, "I can't discharge you," I am not going to leave.

Dr Gray: Exactly.

Hon KEN TRAVERS: So I have to wait until the CDU FACEM comes in the next morning to discharge me, under what you are outlining to me.

Dr Gray: Which is the case with most specialties. If you get admitted under neurology, you will not see your neurologist until the next day. If you are admitted under the gastro team at Freo, you might not see them until two o'clock the next day. If you get admitted under a surgeon at a private hospital, you may wait till five o'clock the next day to see them. That is standard. We do not have consultants that come in at three in the morning to discharge patients, so yes, they have to wait for the consultant round the next day to be seen and discharged. That is pretty standard. The other thing is that CDU was not simply just a monitoring unit; it was not just for observation and monitoring. These were patients that had an illness that either was not differentiated, or a diagnosis had not been made, or they needed further investigation the next day, or they needed senior input. It was not simply just for some monitoring and then you are right to go home; these are patients who had

illness that needed treatment, whether it be that they had an infection or pneumonia, asthma or renal colic, or they had chest pain that needed investigation or they needed an ultrasound the next day. These are patients who needed ongoing investigation and care.

Hon KEN TRAVERS: But before the CDU, what happened to those patients?

Dr Gray: As I said, depending on each specific patient, they may have been sent up to Fremantle, they may have just been kept in the emergency department because there was nowhere else for them to go. For example, someone who needed an ultrasound the next morning would just wait in ED overnight.

Hon KEN TRAVERS: But one of the medical officers in ED, if there was not a FACEM on, could they have then said to the person, "We've got all your tests back, there doesn't seem to be any problem, you're all right to go home now"? Or did it require a FACEM to do that in the ED department?

Dr Gray: If the medical doctor was just managing the ED department, they could certainly discharge them. If they admitted them to the ward under CDU, then they had to wait for us to come and see them, but we were around during the day. It was seven days a week and then we sometimes had an evening consultant on as well who could do that. It was just three evenings a week between 5.00 and 8.00 pm, but there was not a consultant on overnight on the weekends, which was pretty standard. But for the rest of the time, there were consultants around. Does that clear up anything for you?

Hon KEN TRAVERS: I still think that once there was this incentive—that is how it is described in all of the early documentation that I have seen—I do not know whether you are aware of any documentation that describes it as a fee for service when it was initially being established.

Dr Gray: I have not seen any of the documentation from the executive about what it was all about.

Hon KEN TRAVERS: I am asking you as a FACEM at that stage: did you receive any documentation that talked to you in the language of fee for service? All of the documentation I have seen that was distributed to doctors like yourself referred to it as either a bonus or an incentive payment.

Dr Gray: I just remember it being said that we were getting an additional $200 per patient. I do not remember them specifically saying it was an incentive or specifically what the payment was. Certainly, if there was any incentive for the admissions, from a medical point of view it was purely to try to take the pressure off the emergency department.

Hon KEN TRAVERS: I have seen other documents where they refer to it as getting an incentive for people to go and hunt for patients in the ED department, or go and spot patients in the ED department, to admit them to the CDU. I just think it unusual language.

Dr Gray: I never heard any of the doctors talk about it in that way. I do not think we needed to hunt or look for any patients to admit; there were plenty, we were so busy.

Hon LIZ BEHJAT: Admitting people into the CDU, can you just confirm that the FACEM who did the admission into CDU was not the person who made the decision as to whether or not that admission qualified for a DRG payment—that would have been done somewhere else?

Dr Gray: That is correct.

Hon LIZ BEHJAT: So it was really of no—You just knew that you were getting the $200 payment because you were then going to be looking after that patient on an ongoing basis; whether or not the hospital got extra money was of no bearing to the doctor?

Dr Gray: That is correct, and back then none of us had even heard of DRGs. I had never heard of a DRG.

Hon LIZ BEHJAT: You make notes about when you are seeing patients and you scribble on things and talk about times and stuff like that; is it an unusual thing for that time sometimes to be changed? You might have written down that you saw somebody at 2.00 but you got it wrong, it was actually 3.00, and somebody then went back and changed that, or you changed that later on? Does that ever occur because you are so busy that people get confused?

Dr Gray: Not that I am aware of. What does happen is we see a patient, we click on the patient on the computer that this is the time we are going to see them, and then we do all the paperwork and part of the paperwork is an admission slip, and on that we are required to write down the time that we made the decision to admit the patient. At the time we are doing all our four-hour rule process mapping and we were asking the doctors to put down the accurate time that, in their head, they decided that patient needed to come into hospital. We were trying to work out what the delays were from when you thought, "This patient needs to come into hospital and be admitted", to then actually being admitted to hospital. So then, for example, I might see a patient and by the time I get all my paperwork done, that time is actually half an hour or 45 minutes ago.

Hon LIZ BEHJAT: So could it be that you have clicked on that you are going to go see patient A, and just at that time you do it, an emergency arrives and you have a code blue or whatever it is, and you all then rush to that and deal with that, so you do not actually see patient A when you said you were going to, and then you go back later on and think, "That's not the time I saw patient A because something else came along"?

Dr Gray: Yes, that happens quite frequently.

Hon LIZ BEHJAT: That happens quite frequently?

Dr Gray: Yes, it does, especially for senior doctors. We get pulled in many different directions.

Hon LIZ BEHJAT: So that would create a change of times?

Dr Gray: Yes.

Hon LJILJANNA RAVLICH: Dr Gray, I just want to go back to that email of 9 July 2010; I understand you are going to get a copy of it. It was sent to Phil Hatt, Paul Bailey, Aled Williams and cc-ed to Sam Larmour. Basically, after a three-day weekend where you worked in the CDU, you obviously felt strongly about your experience and so you put this email together to address some of the concerns that you had with the model. I just want to go through some of those concerns with you and I wonder whether you might elaborate for the committee on some of those concerns. Firstly, that the CDU had effectively become the "dumping ground" for difficult patients and that there was no admission criteria being followed. Can you just explain why you thought it was a dumping ground, why the admission criteria was not being followed, and on what basis a doctor would not be required to follow the admission criteria as set out in bulletin 17/3, I think it is.

The CHAIR: We will just give Dr Gray a chance to read that.

Dr Gray: Sorry, what is bulletin 17/3?

Hon LJILJANNA RAVLICH: That is the admission policy for WA hospitals that all public hospitals in Western Australia have to comply with.

Dr Gray: Firstly, my comment that it had become the dumping ground was a reflection that I felt that the emergency department was lacking leadership and senior leadership in the department. At that time we had junior doctors, some registrars and some senior medical officers who did not really have good clinical leadership to go to, to ask for advice about how to manage patients. So overnight the path of least resistance was to admit these patients to the CDU so that the consultant the next day would sort it out. I did not personally mind those patients ending up on the CDU because at least it meant they would then get consultant input and have appropriate care. My concern was that it was just making the job of the CDU doctor that much harder and challenging. The comment that there is no admission criteria, I certainly was not referring to any Department of Health criteria; I

was referring to the fact that we had not developed a set of our own admission criteria from a clinical point of view—that is, what patients are suitable for the CDU from a clinical point of view; for example, patients with abdominal pain probably should not come under the CDU, they probably would need to be worked up for abdominal pain and possibly come in under the surgeon. That is just an example; I am not talking from a billing point of view or the Department of Health policy.

Hon LJILJANNA RAVLICH: Are you saying that the technical bulletin criteria as put together by WA Health is not clinically based? You are not talking about the clinical criteria for admission, you are talking about other criteria—that there should be a separate criteria, if you like, is what I understand you are saying, for the CDU, apart from —

Dr Gray: Yes, that is correct.

Hon LJILJANNA RAVLICH: Are you saying that it should be this plus the additional criteria, over and above what is contained in this bulletin that would govern —

[4.30 pm]

Dr Gray: I think for all our admissions we always follow what is in that bulletin. I mean, that is just part of what is doing right for the patient in clinical care. I think, generally, most of the admissions are appropriate from the point of that bulletin. I am not talking about patients coming in there that do not need to be in hospital. I am saying that CDU is not exactly the right spot for them. They need to be either under the surgeon or under rehab or under oncology or up at Fremantle or under another team that is more appropriate than the CDU, which has limited services and limited resources. At that time because admission was so difficult and we had so few resources, it was easier for them overnight—and, again, overnight we did not have available CT scans or ultrasounds. It was just easiest for them to put them under CDU. This clinical decisions unit, even though it is meant to be for undifferentiated patients, it is not meant to be for obvious surgical patients or obvious renal patients or urology patients. It is meant to be more medical, in and out, 48 hours, acute sort of medical care. But we did not really have strong guidelines saying that. That is where the difficulty lay. It was really hard for those doctors at 2.00 am to admit an undifferentiated under a surgeon. They did not want a bar of it because they did not have a diagnosis. So the option was just lie in your ED all night, get the CT in the morning and then give me a call. By then it is midday, one o'clock by the time you have got the report back and that poor patient has been lying on a trolley for 12 hours. So they would bring them in under CDU and I would sort them out in the morning.

Hon LJILJANNA RAVLICH: What difference would it make if they were sleeping on a trolley or sleeping in CDU unattended either way?

The CHAIR: Have you ever slept on a trolley?

Hon LJILJANNA RAVLICH: No, I suppose I have not slept on a trolley.

Dr Gray: For the patient it is highly unpleasant. The lights never go off. It is noisy. There are alarms. It is uncomfortable. It is probably a bit cold. It is not private at all. For the staff, the more patients you have waiting on trolleys for hours and hours means less patients you can bring into your department and it chews up a lot of nursing time as well, because they are now having to provide nursing care for patients that could be cared for on the ward.

The CHAIR: You mentioned in answer to that question a little while ago that you had some concern about the clinical leader. Do you remember who that was at that point in time?

Dr Gray: Paul Bailey was the director of the emergency department at that time, but he was employed purely in a non-clinical role. He did not —

The CHAIR: When you referred to the clinical leader, was that —

Dr Gray: I am referring to an emergency consultant who is rostered for a shift in the emergency department who can provide clinical leadership on the floor—a team leader on the floor. In most emergency departments —

The CHAIR: There was not one of those?

Dr Gray: No, we were now doing CDU.

Hon LJILJANNA RAVLICH: In that same line, you talk of the workup of the patients by the ED staff of being extremely variable and sometimes very poor with inappropriate tests and management occurring. Can you explain that to us and how frequently this occurred?

Dr Gray: I cannot exactly say how frequently it would be. Some of the medical staff were not as good as others. When I talk about inappropriate workup, for example, the classic would be someone who presents with chest pain. That can be a multitude of things, so they do a batch of tests rather than trying to narrow it down from a history and a clinical exam. That comes, however—this is a really important point—with experience. When you have been working for many, many years you can nut down—you can really get your differential narrowed right down just on a good history and exam, but when you have got junior staff who do not have that experience, they are nervous and they are a bit frightened and they do not know. So the way they make themselves feel better is to do more tests.

Hon LJILJANNA RAVLICH: Does it heighten risk to patients?

Dr Gray: No, I think it does not heighten the risk to patients. It probably makes it safer for the patient. It just costs the hospital more money and —

Hon LJILJANNA RAVLICH: It costs the patient more money.

Dr Gray: It is a public emergency department at Peel so they do not pay more.

Hon LJILJANNA RAVLICH: For any tests?

Dr Gray: That is correct.

Hon LJILJANNA RAVLICH: Madam Chair, I am going to go through that list, but I assume you stand by the criticisms that you made in this email at that point in time.

Dr Gray: I do, absolutely, and the main driver was to try to let them know how we really needed to improve our staffing within the emergency department. I was worried about the emergency department.

Hon LJILJANNA RAVLICH: I have to say that point that you make at 3 that CDU patients are being sent to the ward without confirming with the CDU consultant that they are medically stable for the ward and, in addition, the CDU doctor is not being informed when and where the patient is going, which you claim is a really unsafe practice—you say that there are times when it is inappropriate to have patients sent to a ward before they have had their investigations. Do you want to make any comments in relation to that?

Dr Gray: No, it was part of the admission processes. I was trying to encourage them that they needed to tighten them and up have more strict guidelines on when and where.

Hon LJILJANNA RAVLICH: Did that occur, just out of interest? Was there any response to your stated concerns?

Dr Gray: Yes, they certainly acknowledged them and understood them. It still took months, though, for things to improve. It was only when more staff were recruited that it started to improve.

The CHAIR: Did you have concern for patients' safety? Was that an issue?

Dr Gray: There were never any incidents or any adverse events that occurred during that time. I certainly think the CDU improved patient safety overall, but there were certainly teething problems with it.

The CHAIR: I might just provide you with another —

Hon LIZ BEHJAT: So you are happy with the processes that are in place today?

Dr Gray: Yes.

Hon LIZ BEHJAT: Much different, is it?

Dr Gray: Much different. We have done a 180, really. The staffing of the emergency department is just so much better now. We have increased our staffing across the hospital—medical staffing—by 50 per cent if not 60 per cent overall. We now have three ED consultant shifts every day that are filled every day. So we have consultants from 8.00 am to 11.00 pm on site in the emergency department solely and then on call overnight.

Hon LIZ BEHJAT: You are meeting the four-hour wait rule without the need for a CDU?

Dr Gray: We have two medical units now that operate with four physicians and they have staff with four registrars and six residents. Staffing is just incomparable really. So now we certainly run a very efficient, safe hospital, which is good. I think from the four-hour rule we do better than a lot of the tertiary hospitals.

Hon LIZ BEHJAT: Are you still employed at Armadale?

Dr Gray: No.

Hon LIZ BEHJAT: Would you say that Peel Health Campus is similar to Armadale as it was when you worked—presumably when you worked at Armadale before you were happy with Armadale procedures?

Dr Gray: It was a combination of—at that time I felt I needed to touch base again with some of the public ED consultants. During that time, because we did not have a lot of other emergency consultants at Peel, I felt out of the loop, so I wanted to engage and have part of that ongoing education and be involved in teaching. So, that was my reason to go to Armadale as well. Since then things have changed a lot at Peel and we now run a really robust teaching program and we have full time emergency physicians, so it is quite different.

Hon LIZ BEHJAT: With regard to Peel Health Campus, you would have no hesitation now recommending to anyone to present themselves at Peel Health Campus in an emergency situation?

Dr Gray: That is correct.

Hon LIZ BEHJAT: They would be very well looked after?

Dr Gray: Yes. Armadale was a busy department. I personally think we are better staffed and run a more efficient, safer department at Peel than they were doing at Armadale.

Hon KEN TRAVERS: Does that go for both the doctors and nursing staff when you make those comments?

Dr Gray: I cannot comment for the nursing staff.

Hon KEN TRAVERS: Right.

Hon PHILIP GARDINER: Being much better now implies it was not so good two years ago.

Dr Gray: That is correct.

Hon PHILIP GARDINER: The deficiencies two years ago were mainly what in comparison? You mentioned doctors, I think. What else was there?

Dr Gray: So it was doctors from the emergency point of view and medical doctors as well. I think one of the biggest things was we did not have a full-time head of department. Even though I am now employed three to four days a week I also do clinical shifts as well, so I touch base with the staff, the nursing staff and the medical staff in ED a lot more than our previous head of department. So, I understand the problems a lot more. With our increase in staffing it means we can now offer

really good teaching and we have regular teaching sessions. We can do sessions for the nursing staff so they get emergency consultant sessions monthly. We do a four-hour session with them, which they really appreciate. Given our staffing now is more—I cannot think of the word—stable, it is much easier to implement guidelines and protocols when you have a stable workforce. In 2010 most of our workforce was locum staff coming and going—here for a few shifts then they are gone. It is really hard to implement guidelines and policies with staff that come and go. When you have full-time staff that you know, you can have meetings with and you can implement guidelines a lot easier. So, that makes the whole place a lot safer.

Hon PHILIP GARDINER: Does LocumForce still hire staff for Peel?

Dr Gray: Not that I am aware of, no.

Hon PHILIP GARDINER: You were not hired or under agency of LocumForce?

Dr Gray: I took a few shifts via LocumForce back in 2005, 2006. I think it was I did a couple at Peel and some shifts at Swan Districts and that is how I was introduced to Peel. Then when I came back, I took some time off at the end of 2007 and then came back to Peel off my own back and was employed directly since the beginning of 2008.

Hon PHILIP GARDINER: Okay. Because the turnaround with doctors to which you have referred—what has caused that turnaround?

Dr Gray: I think it has just been recruitment. We are on a recruitment drive. I think also being in the new department with some regular senior doctors it is much easier to recruit junior doctors who feel they are working in a place where they are well supervised and supported.

Hon PHILIP GARDINER: Why were the senior doctors leaving in 2010 as opposed to staying out?

Dr Gray: It was a combination of it was a frustrating place in work because admitting people to hospital was very difficult. Trying to refer someone to Fremantle is not a pleasant process. It usually involves three or four phone calls, half an hour on the phone, a lot of paperwork and faxing and pleading your case, which is just really frustrating for many consultants. In addition, we were competing with other jobs in Perth and fly in, fly out to Albany and Kalgoorlie that were paying a lot more than we were.

Hon PHILIP GARDINER: What was the difficulty in admissions in Peel in 2010?

Dr Gray: There was not anywhere to admit them to, unless you had the CDU.

Hon PHILIP GARDINER: So, the beds were full.

Dr Gray: The beds were full and there was no-one to look—yes, there was no consultant that you could admit them under until we opened the CDU.

Hon PHILIP GARDINER: But even so, the opening of the CDU seemed to, from what you have said, I think, personally, and I saw in another email here, still did not alleviate the staff issue.

Dr Gray: Not initially, no; it took months and months.

Hon PHILIP GARDINER: And yet after months, there was a huge increase in admissions. As you recall, back towards the last quarter of 2010 and into 2011, admissions increased, did they not?

Dr Gray: I do not really know, to be honest. I was not aware of exactly how many admissions were occurring to the CDU or what the numbers were.

Hon PHILIP GARDINER: Okay.

[4.45 pm]

Dr Gray: I am aware of that from reading the transcripts that that happened, but I was not aware of it at the time. But I do know that towards the end of that year, we did have some physicians coming on board and we recruited medical registrars as well, so I do not know if that had a role.

The CHAIR: Dr Gray, I just refer you to another bit of correspondence that the committee has, which is from Mr Justin Walter who was the acting CEO to Mr Paul Grove, the contracts manager from the Department of Health. I will just give you a minute to look at that. There are a couple of issues I want to ask you about, when you have had a chance to read that.

There seems to be some confusion around the four-hour rule, which came in around about the same time. Was it your understanding that part of the objective of implementing the CDU was to meet the four-hour rule?

Dr Gray: No, in my understanding it was not; it was not at all.

The CHAIR: It was completely a separate issue.

Dr Gray: It was; it was separate.

The CHAIR: With regards to the last dot point on the first page of that letter, where there is an example of —

> … groups of patients who fell outside the business rules included:
> … Elderly patients who could not be safely discharged in the night.
> … Patients who could not be accepted back to low care facilities or nursing homes due to low staffing levels.
> …
> … Mental health patients waiting to see the psych liaison in the morning.

Have those issues been resolved as the unit is now operating at Peel Health Campus or are those people still being admitted?

Dr Gray: They are still being admitted. I do not think the hospital bills for them, though. So, clinically we still admit those patients and we are not responsible for making that decision whether this is a billable admission or not. It just will confuse staff and end up making some inappropriate decisions on discharging patients, I think, if we start asking doctors to do that. So, no, at the moment, we admit purely on clinical grounds and it is up to the hospital executive or whoever to decide whether it is a billable admission or not.

The CHAIR: So, I assume some of those people would not meet kind of a clinical assessment of needing to actually be in hospital.

Dr Gray: That is correct.

The CHAIR: But I understand the issue of people who might not have anywhere else to go or it is inappropriate to discharge them at that time of night. You have touched on that before. It seems to me that if there were other services available, then those people would not occupy the hospital. Is that correct?

Dr Gray: That is correct. These types of patients occupy a lot of hospital beds in a lot of hospitals; we are not the only one!

The CHAIR: Yes, so they do —

Dr Gray: It is not a unique problem to Peel Health Campus; it is across the board.

Hon KEN TRAVERS: The issues around some of those understaffing issues and the pressures that were on because of the understaffing, had they been around from the time you arrived in 2008 at Peel, or were they only around in 2010?

Dr Gray: I think it just slowly—the dynamics of the hospital changed. In 2008, as I said, our presentations were only at about 30 000. We were in fact operating out of the day surgery unit while

the new department was being built. Also at that time, most of our admissions to the hospital—we did not have a physician back in 2008; all admissions came in under the general practitioners who still were very much involved in the hospital and admitted their own patients. We had a couple of other physicians who were very happy to admit any other patient under them; they were happy to sort of look after lots of different patients; they did not mind. So back then, we admitted a lot to the hospital under the GPs and everyone else was sent to Fremantle. Over the next sort of year and a half, we got busier and busier, we moved into the new department, and if you build it, they will come, and they did. As we got busier, the GPs also were getting busier and were pulling out of the amount they wanted to admit and a lot of them were starting to refuse to look after anyone else's patients but their own and some just flatly said, "We've had enough. We're too tired; it's too much hard work. We're not admitting anymore." So, all of a sudden, we had Dr Desai, who was running the long-stay medical unit, which often was at capacity, and he was saying, "I can't take any more; I'm full. I'm doing as much as I can." So, that is why we struggled; it was just a really difficult time. It was interesting in that time as well, places like Armadale and Swan District and Rockingham were desperate for emergency physicians. We were, like, thin on the ground.

Hon LIZ BEHJAT: In the hierarchical structure of the hospital, who do you report to?

Dr Gray: I now report to Aled Williams who is the director of medical services.

Hon LIZ BEHJAT: And do you have any direct report to the board at all?

Dr Gray: No, I do not.

Hon LIZ BEHJAT: Are you aware who the board members of the hospital are?

Dr Gray: Yes.

Hon LIZ BEHJAT: But you do not come into contact with them in your —

Dr Gray: No, I do not.

Hon LIZ BEHJAT: So, everything goes through Aled Williams?

Dr Gray: Yes, that is correct.

The CHAIR: Are you, Dr Gray, aware of any concerns raised about the infection risk posed by lack of replacement floor coverings?

Dr Gray: It has never been brought to my attention. I am aware of the allegations made. Personally, I never saw any, you know, problem. Carpets get stained, they do; that is just part of nature when you have carpets in a hospital, which many hospitals do, and it is being slowly replaced.

The CHAIR: As to allegations of patients being kept in ED longer in order to meet the requirement before being transferred?

Dr Gray: As far as I am aware and from my point of view, that is completely untrue.

The CHAIR: You have not got any evidence of that?

Dr Gray: No.

Hon KEN TRAVERS: I know Hon Ljiljanna Ravlich read out some of the comments you put in writing at one stage, and you obviously worked the day shift, did you ever have cause to be concerned that the FACEM on for the night before for the CDU had been admitting patients that should not have been admitted?

Dr Gray: Not that I was aware of.

Hon KEN TRAVERS: So, you never had any instances when you came in and got your handover in the morning you wondered why that person had been —

Dr Gray: No.

Hon KEN TRAVERS: That was never a concern.

Hon PHILIP GARDINER: Simone Bartlett, does that name ring a bell?

Dr Gray: Yes.

Hon PHILIP GARDINER: What was the role of Simone Bartlett?

Dr Gray: She is an ED consultant, she is a FACEM, and she was also doing CDU issues, as far as I am aware.

Hon PHILIP GARDINER: In an email of hers dated 29 June—this was before your email of 9 July, so maybe she was seeing some of the difficulties. In here there is, to quote —

> There are also doctors who are asking staff to keep patients here for 4 hours, so they will get money. (However, I think that main culprit has left).

The CHAIR: That is a quote from the email.

Hon PHILIP GARDINER: That is a quote from the email; that is not my position. Good chairmanship here! I was really referring to the first part of it —

> There are also doctors who are asking staff to keep patients here for 4 hours, so they will get money.

Did you see any evidence of that?

Dr Gray: Look, I did not, myself, personally, no. I did not see or hear any evidence of that.

Hon PHILIP GARDINER: Okay, and then there is another observation made —

> Overall, I think CDU must be generating a lot of money for the hospital.

Can you understand why it would be that the CDU is suddenly in six or seven weeks now generating much more money for the hospital? I know it is outside your clinical responsibilities, I know, but you did not have any sense that that could have been occurring?

Dr Gray: Look, I mean, I was aware that because we are privately operated, every patient that gets admission, we then bill the health department for that admission. So, clearly, if you have a new unit, which means that you have the ability to admit all these patients, then of course you will then make more money for the hospital. But my understanding was they were all pretty much appropriate admissions. Whether it made the hospital more money or not, they were patients who needed to be admitted. The other option was they just sit in ED. I understand that by developing this unit that, yes, it did make money for the hospital. I understand that, but from a clinician's point of view, the aim of it was not so much that, more to try and just provide a service for these patients.

Hon PHILIP GARDINER: Do the doctors talk very much at the Peel—around that time, 2010. I know that was a couple of years ago, did you chitchat amongst yourselves a bit?

Dr Gray: Look, certainly, and Simone is a good friend of mine and we would. But I think the other problem was because there were not many of us around, we never saw each other. I would work a Thursday, Simone would do a Friday; I would never see her. But we never had that kind of relationship where we would ring or email about things, no, and we did not socialise. I had a young baby and so it was not, you know—if we happened to see each other at work, then, sure, we would discuss issues. We were all concerned. We were all concerned about the emergency department and the lack of staffing. It was a difficult time and it was not an enjoyable job at the time.

Hon KEN TRAVERS: But it was more than just not enjoyable. I think in that email you mentioned that it was actually, from your exact words, that it was quite stressful and clinically unsafe. It had "become pretty unpleasant, quite stressful and clinically unsafe." So, it was more than just that.

The CHAIR: I was just thinking, following on that question about doctors talking to each other, obviously some doctors who received the $200, that money had to be repaid. Was there any talk about—you know, conversation among doctors as to why or was it considered fair that these doctors were being asked to repay the money?

Dr Gray: You know, I really have not spoken to them about it at all, and it has not come up in conversation. I do not know when it even occurred. I think because I did not have to repay any money, I did not even know that it had happened. So, I am sorry.

[5.00 pm]

Hon KEN TRAVERS: One of the things that has become clear to us is that this was driven—seems to from the documentation we have seen—by the fact that the initial trial was a mechanism towards the end of the 2009–10 financial year.

Dr Gray: Right

Hon KEN TRAVERS: So it increased the ability of the hospital to charge to get up to what is called the maximum payment amount.

Dr Gray: Right.

Hon KEN TRAVERS: I do not know if you are aware of that. That is basically a figure that is set by the government and that is the maximum that you pay to the hospital for that year.

Dr Gray: Right.

Hon KEN TRAVERS: And there was a view the hospital was running under budget by about $1.3 million and so the CDU was established as a way of increasing admissions so they could get it up —

Dr Gray: Okay.

Hon KEN TRAVERS: — to be able to claim the full MPA. Was that anything you were ever aware of at the time?

Dr Gray: No.

Hon KEN TRAVERS: So that was never explained to the doctors.

Dr Gray: No

Hon KEN TRAVERS: That was part of the genesis, for want of a better term, of the CDU.

Dr Gray: No.

Hon KEN TRAVERS: That that was one of the things that had motivated or, from the documentation, it would have clearly appeared to be the case.

Dr Gray: No. And I do not know if it was the way that the head of department at the time tried to convince the hospital to let us do it; I do not know, because, we, you know, needed a solution to our current issues with admissions, and —

Hon KEN TRAVERS: I mean, were you aware whether it was hard to get money out of the board to do things like that to deal with clinical issues at that time?

Dr Gray: I was aware that it was difficult, yes.

Hon KEN TRAVERS: And is that still the case?

Dr Gray: It does not seem to be. I cannot really comment actually, to be honest, because I do not deal with them directly. But certainly things are much better now and there seems to be a much bigger impetus and they seem to certainly provide us with more staff and we have now funding for education and other things, which are important to a department. So things certainly have changed from that point of view.

Hon KEN TRAVERS: And do you recall when that actually occurred; is there a specific point where that changed?

Dr Gray: I went on maternity leave at the beginning of 2011 and when I came back I noticed a significant difference.

Hon KEN TRAVERS: So when did you come back?

Dr Gray: I came back towards the end of 2011.

Hon KEN TRAVERS: I am sorry, when did you go on leave then?

Dr Gray: I went on leave at the end of February 2000 —

Hon KEN TRAVERS: And 2011?

Dr Gray: Yes, 2011, and started back sort of mid-August.

Hon KEN TRAVERS: In 2011?

Dr Gray: Just a couple of days a week.

The CHAIR: There are no further questions, which I think is the case. Thank you very much for your attendance, Dr Gray. You will be receiving a copy of the transcript in the next few days. Normally we ask if there are any corrections that you wish to suggest to the transcript that you do that within 10 days, but we would ask you to do it in five just because we are in a bit of a tight time frame.

Dr Gray: Okay.

The CHAIR: And there are not any additional questions. So thank you very much for your attendance and we will close the hearing and we also have to formally release you from your summons, which is a kind of very formal thing to say.

Dr Gray: Thank you very much.

The CHAIR: Thanks very much for hanging in there.

Hearing concluded at 5.04 pm