VERIFIED VERSION

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Effective Decision Making for the Successful Delivery of Significant Infrastructure Projects

Melbourne — 23 August 2012

Members

Mr N. Angus	Mr D. O'Brien
Mr P. Davis	Mr M. Pakula
Ms J. Hennessy	Mr R. Scott
Mr D. Morris	

Chair: Mr P. Davis
Deputy Chair: Mr M. Pakula

Staff

Executive Officer: Ms V. Cheong

Witnesses

Dr P. Philip, Secretary (affirmed),

Mr L. Wallace, Executive Director, Finance and Corporate Services (affirmed),

Ms L. Price, Director, Capital Projects and Service Planning (affirmed), and

Mr T. Lubofsky, Royal Children's Hospital Project Director (affirmed), Department of Health.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the inquiry into effective decision making for the successful delivery of significant infrastructure projects. On behalf of the committee I welcome from the Department of Health, Dr Pradeep Philip, secretary, Mr Lance Wallace, executive director, finance and corporate services, Ms Leanne Price, director, capital projects and service planning, and Mr Tony Lubofsky, Royal Children's Hospital project director. Members of Parliament, departmental officers, members of the public and the media are also welcome.

In accordance with the guidelines for public hearings, I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Only officers of the PAEC secretariat are to approach PAEC members. Departmental officers, as requested by the secretary, can approach the table during the hearing to provide information to witnesses. Written communication with witnesses can only be provided via officers of the PAEC secretariat. Members of the media are also requested to observe the guidelines for filming and recording proceedings in the Legislative Council committee room. I advise, for the record, that these proceedings are not being webcast.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act 2003, attracts parliamentary privilege and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is taken under oath or affirmation and is being recorded. Witnesses will be provided with proof versions of the transcript within 15 working days of this hearing, which are to be verified and returned to the committee secretariat. They will be posted on the committee's website.

Following a presentation from the secretary, committee members will ask questions related to the inquiry. Generally the procedure followed will be that related to questions in the Legislative Assembly, with a little less formality. I ask that all mobile telephones be switched off or at least be silent. I now call on the secretary to give some introductory comments of no more than 5 minutes.

Dr PHILIP — Chair, I do not propose to make a presentation, but I do want to thank you, as I have raised with you previously, and the committee, for the extra week extension in making the submission to this hearing. I was new in the job, and I wanted to make sure that I had gone through the materials. I appreciate the leeway you have provided to this department.

The CHAIR — Thank you for those comments. I take the opportunity of congratulating you on your appointment to this august role, and I wish you well for an enduring period of service as Secretary of the Department of Health. It is one of the more challenging roles in the public sector.

As witnesses will know, our areas of interest in relation to this inquiry relate to accountability, transparency, relevant skills and capacity and lessons learned. The questions that the committee will direct to witnesses will relate broadly to those themes and an examination of the experience with projects that have been identified as being at under the umbrella of the Department of Health. I particularly wanted to go to a significant issue that has come out in the course of the hearings related to the starting point for the HealthSMART project, which was highlighted in the Ombudsman's report of November 2011. On page 23 at paragraph 84 the Ombudsman says:

> HealthSMART had no business case, despite seeking over $300 million in funding. Instead the funding submission was based on a high-level strategy document and a 14-page implementation plan.

One of the deficiencies I think the committee has identified through the course of its examination of the implementation of major infrastructure projects is insufficient planning, and in particular in the ICT area there are consistently significant time and cost blow-outs, and HealthSMART is no less an example of that. It is important that the committee has an understanding about why it would be that such a significant project could be developed by the department without a proper business case being developed at an early stage. Bearing in mind the chain of accountability, notwithstanding, Dr Philip, that you have only been in this role for a brief time, the committee is seeking that the department collectively advise the committee on this particular point.

Dr PHILIP — You would recall that this was a project started in 2003. That is where it has its genesis. In many respects, in hindsight, perhaps, there are different ways of doing things, but if we go back to 2003, it is quite possible right around the country that large projects were developed with various degrees of planning involved or various instruments of planning that may have been involved. By and large, this project started out with an idea of change, and it had a number of components to it, one of which was that there were already

systems in the health sector that needed to be updated and replaced. Secondly, there was a new component of looking at how you might in fact improve safety by having a management system around prescriptions, the prescribing of medicines within hospitals, and better information transfer of patient details so that wherever a clinician picked up the notes they would be able to see the history. As part of that, it was envisaged that if we were going to replace what are pretty standard, basic systems in the health service, that a reform ought to be added to it, which was to make them interoperable. That was a decision of the government and there was funding allocated for it.

One of the features of this project is that it is not a single project per se. There is not a single application that is the core of this program. There are a number of components to it, which range from financial systems and resourcing, client management and patient management systems and the one that has been the most problematic, the clinical system. One of the features of this has been that when individual health services have wanted to adopt one of these things, they would have been required to go through their own boards for approval and would have to develop their own case for taking on board one of the systems. But it is a fact of this project that a formal planning tool was not employed to develop a formal business case, because it was a decision of government based around a number of components of a program, and in hindsight there are a number of things to have been learnt, and which we could explore.

The CHAIR — Thank you for your explanation and for your valiant attempt to explain that there was in fact no business case developed. I regret to pursue this with you, particularly given the brief time you have been in the role, but you do have the resources to seek advice from your officers. I need to understand why it was that a project that at the outset, notwithstanding the significant blow-outs in cost, was a $300 million bid to government for funding could have been developed without a business case. I note that at a governance level the individual health services developed their own business cases, but that does not excuse in effect the department from failing to do its due diligence in preparing a business case.

Dr PHILIP — I do not intend to try to explain any of the components. I have read material and I have spoken to people as much as they have a knowledge of this, because a number of the key people who were involved are no longer in the department — former secretaries. However, I have attempted to go through as much material as possible.

There is a key question that a department always faces — that is, at what point in time are you brought in, do you engage strategically on something that is longer term with a broad vision, and then on the details of a project? My understanding of this project is that there was a policy decision made by the government about what it wanted to do, and a submission was then prepared to reflect what the government wanted to do in a tight budget context. Decisions were made about the project and funding was allocated.

In hindsight could the department have done more? It is arguable, and we have had the Ombudsman and VAGO look at it. If the project was provided to us today, would we do things differently? Would our advice be different? Yes, our advice would be different partly because of our understanding of ICT now, and not just in terms of the technical aspects of implementing an ICT project but also, I think, in terms of the significant cultural issues that are associated with it. I think the Ombudsman and the Auditor-General have borne out those things in their various reports. At the end of the day you need people to also be involved in this change process. They have got to change behaviour, and that was a significant issue which led to delays in HealthSMART and probably lead to the cost issues around clinicals in particular.

Can I definitively answer the question you posed to me? It is very difficult. At the time there was a government decision and a request for a proposal to be made to the expenditure review committee for funding, and that was duly followed.

The CHAIR — I do not want to labour the point, but I think the committee has an obligation to pursue this a little and so I will persist just for a moment. I will pursue two aspects of the inference of your evidence. One is the general nature of your commentary that in effect people have moved on, and that goes to the issue raised in discussion yesterday with the Deputy Ombudsman in relation to what I summarised at the end of that hearing as the chain of responsibility and accountability, and that that clearly in regard to major projects and the delivery of major projects and the impost on taxpayers is broken by the fact that within the process of delivery people leave the project team and therefore there is a void in accountability, because when things go bad, however that is

defined — time delays, cost blow-outs — those people who were charged with implementing the project are not able to be held accountable because they left the project before it becomes embarrassing, perhaps.

I am not going to pursue that with you. It is a governance issue which, in my view, the committee will need to address in its report and findings. But I really want to drill into your commentary around the government decision on this project, because I find it incredible that cabinet would not have been briefed by the department before it made a decision to agree to proceed with this project. Your evidence seems to infer that there was a cabinet decision, without a briefing by the department, and then the department backfilled and simply put in a implementation proposal together.

It seems to me that that is unlikely. No matter what partisan position one has on this committee, I think, bluntly, there would be no member of this committee who would think that cabinet would sit around the table and take such a significant decision without being properly briefed. Therefore I do not find the evidence you have given the committee credible in that sense.

Dr PHILIP — If I could clarify that. In my experience it is not the usual practice for departments to provide separate advice. Normally when something goes to cabinet it is a minister's submission that they take to cabinet, and it is their work that is effectively presented to cabinet. In my experience I have come across a number of ministers who take that to a greater extent than others, and it would be the case that this project, because it did receive funding, would have been the subject of a presentation to cabinet or to the expenditure review committee outlining the case for funding.

The CHAIR — I have absolutely no doubt that cabinet submissions are signed off by the relevant minister. In this case I have no doubt that the minister at the time would have signed the cabinet submission. It would have been his responsibility. However — —

Ms HENNESSY — It was actually a her, Chair.

The CHAIR — I was using the generic term. Let us be clear, Ms Hennessy, I am not wanting to be pejorative about the minister who had the portfolio responsibility at the time, who I acknowledge was Minister Pike. But that is not the issue here. The issue here is the process and the probity of the process with respect to the accountability of the Department of Health for a project that the department is giving evidence to this committee about, which infers there was no business case done before a significant submission was put to cabinet and BERC, or ERC as it was. What I am trying to get to is: what briefing material was provided to the minister before the minister signed a cabinet submission or indeed an ERC submission? If it is the evidence of the department that no work was done on financial modelling before a submission went to ERC, or indeed to cabinet, then I would accept that as evidence and move on to the next issue.

Dr PHILIP — I am not definitive in saying that the work was not done. What I am saying is that a formal business case, as we understand business cases today, having gone through the project, was a failure in where this project has ended up when you look at it in hindsight. Was some financial modelling done? I am sure there was some financial modelling done because a costing was arrived at for a budget allocation of funds and, as has been gone through with the Ombudsman and the Auditor-General, the Auditor-General, I think, has made comment that the objectives of HealthSMART were actually very good and it was about taking the system forward.

It is a fact that the majority of systems that were part of that have met their objectives. Yes, they were delayed, but the critical component, the clinical systems, is the one that has been found lacking. There were a whole range of reasons for that. Since we have now been able to analyse the project we would do it differently, but I could not say to you that there was no financial modelling done because there was a budget allocation which for the majority of the project has been broadly correct.

The CHAIR — Before I conclude, I will accept that there is no evidence that the financial modelling was done to satisfy what we would regard today as —

Dr PHILIP — A formal business case.

The CHAIR — Yes.

Mr PAKULA — I am wondering whether, to the extent that it is appropriate, Dr Philip, we could hear from Mr Wallace, because he has obviously been involved in this project for longer than other people around the table. I want to make sure that the committee is fully apprised of this matter to the greatest extent that it can be. The Ombudsman has found that there was no formal business case, which you have conceded, but I do not think we necessarily want to assume that means that there was absolutely no planning done. Sometimes these things can be a matter of terminology.

To the extent that they can, could those that have the best corporate memory take us through what did occur: what planning was done, what briefs were provided to the Minister for Health, what the role of the Department of Treasury and Finance was in pulling it together and what kind of oversight occurred? I think it would be more beneficial to the committee for us to, rather than just accepting that there was no formal business case and assume from that it means that nobody did anything, to actually get a proper understanding of what that means and what did occur.

Mr O'BRIEN — In the context of the timing — —

Mr PAKULA — Mr O'Brien, it is my question.

The CHAIR — Everybody relax. We are here for quite some time. Dr Philip?

Dr PHILIP — I might ask Mr Wallace if he would like to answer.

Mr WALLACE — I am happy to try to help on this matter. The first thing I need to say is that I was not involved in the original business case preparation. I was not there at that particular time. If those officers of the department were in the department at the present time, we would have brought them to the committee hearing, but there is not anybody who was involved in that original — —

The CHAIR — Could I just intervene? I want to say that you are reinforcing the point that the Ombudsman made yesterday about this problem which the committee is wrestling with, which is the chain of accountability and responsibility.

Mr PAKULA — You cannot stop people quitting.

The CHAIR — No, but there must be a lot of parachutes in the public sector.

Mr WALLACE — One thing I would like to take up, though, that I think is of interest to the committee is that there is a genuine issue in ICT, which is a little bit different to construction, in the way that submissions are brought to government. There was a strategy and direction for ICT, and generally the strategy and direction had been considered by independent people to be a reasonable strategy. If you have a strategy, and you are then going to pursue ICT products in the marketplace — that is, you have taken a decision not to build your own product but to purchase products in the marketplace, and the health area is an international marketplace for health ICT — then you have a decision about when you go to government and when you go to market for that product selection.

The difficulty you have is that if you do not have funding approval, then you stand in the marketplace without genuinely having the funding to deliver a tender. If you have not selected the product and there are three or four different products in the marketplace which you can select, it is quite difficult to do very detailed due diligence work on each of those products, working through the full implications of cost and time for each of those products before going to the market.

This is a genuine issue. There was no real solution. Very major ICT projects were still relatively unsophisticated at this particular period of time. There was not a great history in Australia or around the world. As to the clinical systems that we were putting in place, I think at that point in time there was almost no site in Australia. There may have been one site in Australia that had undertaken that piece of work, so there was very little history to garner. Work was undertaken. Work was genuinely undertaken by the people concerned to assess the cost of projects. There was a reasonable amount of history in replacing resource management and financial systems and a reasonable amount of history in replacing basic patient administration types of systems, because they are second and third generation systems, but clinical systems were very, very new and there were few reference sites to undertake robust time costings.

I am not justifying what they did, but the team at the time thought the best thing to do was to go to government with indicative costs and times to allow them to go to the marketplace. What then unfolded was that after they went to the marketplace, chose a product and had the opportunity to work through in a great amount of detail what it would take to change an international product, a US-based product, for the Victorian marketplace, with the changes in the way that health is delivered in Victoria, there was a discovery that the originally forecast cost and time estimates were not accurate.

Mr PAKULA — I am trying to get my head around this. Given what you say about the state of the ICT market at the time and given the need to test the market with, as you said, these overseas producers of software and the need to customise the software for Australia, I am trying to understand how possible it would be in that environment and at that point in time to accurately construct a fully costed business case without first going to the market, as you did, and testing it. I do not know the extent to which you are able to answer that, given the fact that you were not involved back then, but it sounds from what you are saying that there were certain particular challenges in terms of understanding what was out there which would have made creating a fully costed business case prior to market testing quite difficult.

Mr WALLACE — My conclusion, from the experiences I have had over this project, is that the original people who were involved in submitting to government would have been much better off getting approval in principle, having not confirmed costs and time at that point, not locking that in. They would then have been able to go out to tender and have the engagement with the tenderer to develop a more robust time line and budget, based on talking to the people involved and knowing which product they would choose. In hindsight, that would have been a much better pathway, and I suggest into the future that is a much better pathway to go down.

Mr PAKULA — Approval in principle, rather than approval?

Mr WALLACE — That is correct.

Dr PHILIP — If I could just add to that, I think that is a more general comment, but it is an issue accentuated in ICT. There is a general lesson that has been learned across the country in infrastructure projects about how locked in governments should be about dollars and scope when they announce a project. Now the innovation that we have in our process is that we tend to go and get market soundings on various components, because a market will often tell us a lot more. That has been an evolution in the process of infrastructure more generally. In ICT this issue is accentuated even more, mainly because of the generational issue with ICT in that the obsolescence of software and technology is quite fast.

Mr PAKULA — Can I just follow that up? As someone who has been in central agencies before, you would understand this dilemma well. How do you say government protects itself against cost creep or from private sector adventurism when you go to market without having an envelope? How do you guard against the private sector ratcheting up their estimates when there is no discernible envelope that government goes to market with?

Dr PHILIP — That is part science and part art, I suspect. There are new ways of engaging infrastructure through alliancing et cetera where you can talk about various risk allocations, and the market will respond accordingly. I think that is probably the answer to your question, and I think the art in all of this is coming to the fore more and more.

Mr O'BRIEN — I just want to pick up one other aspect that you touched on in your answer to the chairman's opening question which was partly my interjection. A lot of this relates to the timing of the government policy decision as opposed to the work of the department in either preparing in advance of a key decision or responding to it afterwards. You said that in this instance, if I heard you, once the policy decision had been made the department then had to work to implement it to some extent, as it does, without fear or favour.

Just to draw some context into that, the Ombudsman's report also identifies at paragraph 85 that some of the assumptions of the decision in the business case or the lack of the business case did not turn out to be true. We heard evidence yesterday from various witnesses that the key thing in the reasons to do a business case is that it actually locks in or fleshes out the validity of those assumptions — namely, what is the response of the clinical users in this instance. In particular whether there would be funding from partner agencies is an assumption identified at page 23. Again just on the Ombudsman's report, it identifies at paragraph 94 that effectively the

actual decision or work that went to government was either a 'Do nothing' or a 'You must adopt this', rather than a full range and a feasibility or business case approach.

With that in mind, could you outline for the committee what work the government or the department then had to do once that initial decision had been made without the benefit of the business case up-front?

Dr PHILIP — There would have been work done in the government making a decision on the project and the funding. Whether that ticks all our boxes of a current modern business case being cleared with the Ombudsman and the Auditor-General, I do not know.

Mr O'BRIEN — I am not sure if it ticked many then, either, the 14 pages and the $300 million, but we will let that pass.

Dr PHILIP — Sure. I think as Mr Wallace has highlighted, in hindsight it would have been better to have got approval in principle rather than approval before going to market. I suspect — it is always hard when we were not there at the time — it would have been hard to have foreseen some of the elements that the Ombudsman has raised around changed management and culture and how difficult that may have been for one component of the project. But it is the case certainly for the finance, the patient management — the client management — that there was very little choice for government. These are basic systems in our health services which needed to be replaced and would have had to have been replaced whether it was HealthSMART or not.

A key element of this project was that given that there was no choice and you had to do this, could you do it in a way that for the first time built a bit of interoperability between our systems. I think you would have heard from some of the users of this that there are benefits from that system, and it is part of our general evolution in how we build such systems. But I think some of the key elements that the Ombudsman highlighted as being problems back in 2003 would have been very hard to pin down in terms of dollars and time lines. I suspect even greater thought having been given to them may have led to a variation in time lines and budget, but that does not mean we could not have done more.

Mr O'BRIEN — Specifically building up, you identify yourself on page 14 under the heading 'A stronger business case was needed' that the complexity in implementing the planned clinical system warranted piloting a lead site implementation to gather data required to inform a statewide business case, which is not a practice that is necessarily novel. That is the pilot process rather than a big, broad announcement. I do not think you have addressed this concern about retrofitting. To pick up Mr Pakula's line of questioning in a sense, if you have a policy statement that, 'We are going to implement a $300 million project', if that is the approach that the political side or the government side takes, is it not the role of the department to then provide frank and fearless advice that, 'Hello, you may have a problem and you should be providing a pilot and test case'? Did the department in this case to your knowledge adopt that role, and in retrospect, should it have done so?

Dr PHILIP — If we were doing the project today, given the sophistication now of understanding trials and pilots, we would recommend pilots. In 2003 generally in the policy debate — policy formulation and policy design — pilots were still coming up and were just starting to be utilised. In hindsight, yes, we should have implemented a pilot, but I cannot speak for the people back in 2003 in terms of their stock of knowledge of the understanding of pilots. Certainly if a project or something like this was being delivered today, yes, we would pilot it.

Mr O'BRIEN — Could you finally elaborate on that element of retrofitting that occurs after the announcement has been made? I think you touched on that in response to the chairman.

Dr PHILIP — I think it would be erroneous to interpret my comments as that there was no work done, that there was a government decision that the department just retrofitted or implemented. I do not think that was the case. The government had a strategy and a funding discussion and a decision made and there would have been analysis provided as part of that for the government to make the decision.

Mr O'BRIEN — Is that something you are assuming should have taken place or is that something you know took place?

Dr PHILIP — The Ombudsman highlights the fact that there was a submission and a budget decision was made. I think he says it was around 14 pages and that there were two options provided. Whatever one thinks of those options, it is clear that there would have been some analysis provided in that.

Mr O'BRIEN — Just to be clear, I was not directing you to the work before the decision; I was directing you to the work after the decision. If you are not aware of any factual work done, I would prefer you to say, 'I'm not aware', than inadvertently say there must have been work done if there was not.

Dr PHILIP — It is hard to imagine that there was not planning work done in implementing a policy like this and there were the appropriate governance structures. As the Ombudsman has made clear, there were governance structures put in place and there were tenders that were put out for the various components of this. So it is clear there was planning involved, there were costings involved and there was a problem mainly with one of the, I think, four or five components of this project.

Mr O'BRIEN — It was a key political component.

Dr PHILIP — It was a key component and one which the department would have had very little experience in, because by and large this was the future component of the project. As Mr Wallace has highlighted, there may have been one example in Australia where this was being looked at.

Mr SCOTT — In discussing the Ombudsman's report, there are a number of matters. I note in the evidence given yesterday Austin Health on one matter vigorously disagreed — I think the term they used was 'strongly' — with findings of the Ombudsman. I take you to the issue of patient safety first. I would like to go through those and deal with them one by one. The Ombudsman made some findings in relation to patient safety that particularly Austin Health — and I would say the department perhaps less vigorously — very vigorously disagreed with. What is your view regarding patient safety and the implementation of HealthSMART and the impact on patient safety?

Dr PHILIP — If I could clarify, was that relating to the prescribing component of it?

Mr SCOTT — There are two components. Yes, I think it is. Paragraph 294 on page 73 relates to the negative impact on patient safety, and there is further comment about medications being out of date at another section, so there are two separate sections relating to I suppose more generally patient safety.

Dr PHILIP — It is clear that while there is a system put in place which is, by definition, for everyone to use, and therefore you lose some of the nuances at the margin because you are actually trying to get everyone onto the same system and there are benefits from that, nothing in the implementation or operations of the system takes away a clinician's view of treatment — that is, anything we do in the health service, we generally do not tamper with that, and none of these systems tamper with the ability of a clinician to provide clinical advice for the treatment of a patient, especially when it comes to quality and safety. The system does not bar clinicians from treating patients in a safe and clinically acceptable manner. In terms of the prescribing — —

Mr SCOTT — Medical data, medication data.

Dr PHILIP — Medication, it is not clear to me where that came from. Certainly I have not been provided with any evidence that there was a problem, because the system in the department does update far more regularly than the allegation that is made in the Ombudsman's report — I think that is reflected in the department's response to the Ombudsman — and to date I am unaware that that has been an issue.

Mr SCOTT — So there is no evidence that you have from any of the various health services relating to that matter that would give you any cause of concern?

Dr PHILIP — Not that I am aware of.

Mr SCOTT — In the Ombudsman's report there is a difference in the matter of the cost of the system. There is a difference in costings. The costing in the Ombudsman's report was, I think, about $471 million and the costing from the department was, I think, around $353 million. It would be useful to flesh out the nature of the difference in the assumptions lying behind those different costings.

Dr PHILIP — I think the main difference is whether you include the operational elements or not. I think the project cost for HealthSMART was in the order of $333 million. Separate to that, once it was up and running — and it had been acknowledged earlier on that there would be operational costs, I think, to be funded — I think it was in 2008–09 that the government provided the operational funding for the running of the system. I suspect the difference between the health figure and the Ombudsman's figure is that the Ombudsman has included the additional — —

Mr PAKULA — Conflated — —

Dr PHILIP — The operational funding that was subsequently provided to the project.

The CHAIR — When you say 'provided to the project', does that include to the health services? So does it include or exclude the direct costs to the health services?

Dr PHILIP — If I could just double-check — I think it would include funding for the health services.

Mr MORRIS — Just on that point, it would include funding to the health services but not any further funds they may have made available internally or from internal sources?

Dr PHILIP — Sorry, would you mind clarifying that for me?

The CHAIR — Hospital-own funds?

Dr PHILIP — Okay, yes.

Mr MORRIS — I am drawing a distinction between funds that may have been made available by the department and funds supplied from the health services themselves.

Dr PHILIP — Sure.

The CHAIR — I will give an example to help clarify this. We have had significant evidence led by health providers during these hearings that they underestimated significantly, for example, the upgrading of their IT systems.

Dr PHILIP — Sure.

The CHAIR — That and also other operating costs that they have incurred.

Dr PHILIP — So there was a component for replacement of some systems, but by and large we provided what we thought was adequate funding if they needed to backfill staff for the operational system. But it is the case that individual health services may have needed to do other things to link in with this system, and they would have taken the opportunity to upgrade their systems, which was not part of our remit.

Mr MORRIS — Now to the question I was going to ask. I would like to get a better appreciation of the intended scope of the project and the interface between the department and the HealthSMART organisation. At page 1 of the HealthSMART response, towards the bottom of the page, you say:

> The scope of works was to:
>
> > replace approximately half the existing major … (ICT) systems across hospitals and virtually all —

the community health centres. Was that always the intention, to simply replace half? Or was that a revised intention?

Dr PHILIP — I was just checking with Mr Wallace; that is the case. It was always the intention that it would be roughly around half that we would go and try and do.

Mr MORRIS — That seems rather a strange decision, to say, 'We're going to fix half the — —

Dr PHILIP — Mainly because of the size and scope and scale; that is mainly why you would do that. In some very small places you would not want to impose a standard system — they have got adequately operating systems and you would not need to do that. And not all of them were up for change at a point in time.

Mr MORRIS — The other aspect was the role of the department versus HealthSMART. One of the things that has not been clear, whether we have been talking to or hearing evidence from the networks or from the Ombudsman, or whatever — and this is in terms of accountability — is how the accountability plays out from the HealthSMART project through to the secretary of the department through to the minister. I think the Ombudsman or the Auditor-General — I cannot recall — talks about your predecessor, Dr Philip, talking to Cerner in the US and basically saying, 'Get your finger out — —

Dr PHILIP — That was the Ombudsman.

Mr MORRIS — That was the Ombudsman, thank you. That is commendable and seems to be an action that has not been taken by other secretaries in other problematic areas. But on this whole line of accountability really what I am interested in knowing is whether that was simply because that secretary had her finger on the pulse or whether there was in fact accountability built into the process so that those issues were flagged at secretary level and appropriate action was taken.

Dr PHILIP — Chair, you might recall that in, I think, the material we have provided we have a diagram of the government structure, and you will recall that the secretary of health was chair of the board of health information systems — and I think in that position has taken that role very seriously. And given how important these systems were for the health sector — rightly, in terms of accountability and appropriate governance — they took on the role of ensuring that relevant vendors, and one in particular, Cerner, came to the party as quickly as possible. I think that is an appropriate role for the chair of the project board to take.

Mr MORRIS — So in other words, with the accountability in that particular case there was a close link between the head of the agency and — —

Dr PHILIP — Yes.

Mr MORRIS — Thank you.

Mr PAKULA — Just to follow up on that, we had evidence from the deputy ombudsman yesterday with regard to this project being — I think in his words — the one where the secretary, who I think was Ms Thorn at the time —

Dr PHILIP — Yes.

Mr PAKULA — got on the phone and spoke to America —

Dr PHILIP — Yes.

Mr PAKULA — and intervened in a personal way. Do we have any background about the process that caused that to occur? Was the project on watch? Was the secretary acting alone? Was there intervention from others? I mean, how did that occur?

DR PHILIP — In terms of this project, and I suspect you will find in a number of other projects — and the Ombudsman makes it clear with this — there were complex relationships between the department, the vendor and clients, the health services. One of the issues that had been raised at the time was whether the vendor, particularly on this component of a project where they need to tailor something that was off the shelf to the Victorian context around definitions, nomenclature and processes, was concerned as to whether they had the appropriate staff here versus in the States. As you will find for most projects, issues like this do come to the surface. Given this was a critical matter, as chair of the board the secretary would have taken the decision to make the call. I think this is not uncommon in a number of projects that occur around the country.

Mr ANGUS — Dr Philip, we have heard a lot about the front end and the whole business case, or lack thereof. Your response talks about the point that the initial intention was to replace obsolete systems with off-the-shelf systems. Once you got into it, it was found that that was unable to be done for a number of reasons and for the adoption to Australian conditions and so on. I suppose my question to you is in relation to the role of the department in all of that. When did they realise that, and what was their role in the midst of all that?

Dr PHILIP — Whilst government decisions have been made and you are out to market, I think for most projects, even when you go for an off-the-shelf project, there is some contextualising that is required. For some

projects there would be a lot more than others, but here we were talking, by and large, about finance and resources and client management systems where you would not expect significant variations to occur, which is why most of the components of HealthSMART were able to be delivered, albeit a little bit later than the original time lines. Those decisions would have been made quite early in the piece as you went to market and looked around at the various products that existed and then made decisions about which one was best suited for the Victorian system. Then there would be an iterative process as you go through.

Mr ANGUS — Right. So that would have been the department liaising with the proposed sites as well — with staff?

Dr PHILIP — With the vendors and the health services. That is what you would normally expect.

Mr ANGUS — Leading on from that, in terms of the time lines, you have said in your response that in 2003 the program was projected to be completed in four years, and you have just mentioned the time line. The fact is that that has blown out 100 per cent, to eight years, and we are still in progress essentially. Can you make some comments around the delays?

Dr PHILIP — In hindsight, as I think I made comment in answer to the question from the chair, for some of these systems — we recall that by 2010 most of them were in place, so there was a six to seven-year gap, but from recollection they started progressively being implemented from 2007. The one that faced the greatest difficulty was the clinical system, because it required the biggest behavioural change. One of the things where ICT projects require significant change in behaviour — and this is probably the case both in the private sector and the public sector — is that we have underestimated what it takes to get that change in behaviour. But I think it is fair to say that as policy-makers we are all learning what are the incentives that make people change behaviour.

Our understanding of that is not all that sophisticated, but increasingly we are understanding what it takes to change behaviour. But it is the case that some of these things did take longer. We had underestimated the complexity and time involved with individual health services going through their own processes — getting their board approval and making sure that the product that they were after was what was on offer — and as a result time lines did blow out.

Mr ANGUS — It would seem from your evidence and your comments to other questions that everything leads back to the cornerstone of the lack of a business case in terms of just not enough work was done at that stage.

Dr PHILIP — It is a fact that there was not a proper business case. Whether all things lead back to it is arguable, because even if we had done a proper business case — being quite genuine about it, even today if we were to do a proper business case about things that involve changing people's behaviour, I suspect we would still struggle, because our understanding of that is not as sophisticated as it ought to be.

Mr O'BRIEN — If you had a better understanding, it would be comparatively a better way to go?

Dr PHILIP — The passage of time has taught us a number of things. There are a lot of debates still in the public policy literature about what are the things that make people change behaviour — more carrot, more stick — and that is not resolved. Increasingly we are getting more tools that we can use that help us better understand and effect behavioural change. It is true that there was not a full business case prepared at the time, as we would define it now, but I would not say that all roads lead back to not having a business case, because even if we could transplant our knowledge of what we know today back then, there are things that we would still not be able to get quite right. I hope that is not condemning us for failure if we had a new project today, but it is the case that we do not know fully.

Ms HENNESSY — Dr Philip, just to continue on with that theme in terms of lessons learnt, what do you think were the essential elements that contributed to the successful procurement vis-a-vis the Royal Children's Hospital?

Dr PHILIP — The Royal Children's Hospital is a very different project. It probably is the type of project that moves back towards an area where we have a lot more expertise in: construction, procurement et cetera. There are some key features about the Royal Children's and this department. One of the things that is a very

good feature of the Department of Health and its project teams is that we have now got people there who have been across a number of projects. The more projects you are involved with, the more you learn, the better you get at it, the more you are able to understand the market and the more you are able to anticipate the sort of question that people might have et cetera.

There are some key things about the team. It is skilled in commercial procurement, health planning et cetera. They have been across a number of various hospitals and various PPPs, again keeping the core team together. They are good at project management.

There are lessons learnt out of previous projects, such as how you get functional and technical briefs right, get your scope right and get your relationships right. One of the things with the Royal Children's was for a project that size there was a remarkably low number of variations involved and open channels so that problems are identified early and fixed early. The PPP process identified a lot of innovation, so there are a lot of positive things.

I note, Chair, one of the issues you have raised throughout this inquiry has been about the type of people you have and the skills, longevity and accountabilities. RCH demonstrates a lot of very positive features that in my view is a little bit of a model for a number of other projects.

Mr O'BRIEN — I just want to return to one aspect of HealthSMART that follows from some of your answers. Regarding this concept of the clinicians and the problems that have been experienced there, is there an element that part of the underestimation, arising effectively from working without a trial and without a business case, is a failure to actually build the system up from the needs and practising requirements of clinical doctors who are very experienced, specialised and busy with their time? You talked about change management, and I know that is important, but I know there was resistance at the hospitals because the doctors, it seems from the evidence we have heard, felt that it was not suitable for their needs. Maybe there was an underlying problem with infrastructure. Regarding that clinical aspect, was it also a cultural problem in the sense of imposing a solution for the users from the top down rather than from the ground up?

Dr PHILIP — There was a lot of consultation — —

Mr O'BRIEN — With the hospital board so much — —

Dr PHILIP — With clinicians also, I understand. It is the case that no-one disputes the fact that having a single system for patient records and prescribing is a good thing. In fact I think we would be hard pressed to find clinicians who would say it was a bad thing. Most would say having a common system is a good thing, because it affects their work. Patient X comes in, and it would be nice to be able to electronically pull up all their records. It would be nice to input their records electronically so that when they move from one part of the health service to another it is clear what their history and treatment is. It is a good thing for safety in that it can minimise adverse treatments. No-one will disagree with that until they as an individual have to change slightly what they do. That is a clear lesson in every project, whether it is ICT or something else, where someone has to do things differently to what they have done before.

The real question is how much more you could do in terms of socialising the new system. Any new system you implement which requires a change needs you to go and hold people's hands and help them through that. I have not been advised that clinicians find the system is wrong. I think the issue is how quickly they can learn the new system and whether it meets all their requirements. A common system will never meet all of their requirements, because that would be impossible to account for the variation of every individual clinician. To that extent, yes, you can always expect people to be concerned when they have to do something slightly differently.

Mr O'BRIEN — On the decision in relation to the building of the clinical application, which was done from scratch as opposed to an off-the-shelf product — —

Ms HENNESSY — That is wrong.

Dr PHILIP — It was off the shelf, and there were modifications made to suit the local circumstance.

Mr O'BRIEN — Okay, there were extended modifications, but it was a different team with, for example, the CSC or what was iSOFT. I am just querying whether in hindsight it would have been better to have greater

work done building the system up from the ground in a sense as opposed to from the top down in relation to the clinical aspects.

Dr PHILIP — That is a fundamental policy conundrum for which there is very little guidance on how to answer.

Mr O'BRIEN — That is what I am seeking from you, I suppose.

Dr PHILIP — We have a lot of examples of systems in a lot of different areas built from the ground up and people then say, 'Why did it cost so much when you could, in fact, get this off the shelf?'.

Mr O'BRIEN — Sorry, I am talking about in the consultation process. I am not saying, 'Don't purchase off the shelf'. I am talking about finding the needs rather than working with some external consultant or vendor process through the department, HealthSMART, the hospital board. I am talking about clinicians really getting out there and finding where there can be efficiencies and working that back up the system.

Dr PHILIP — It is not my understanding that there were significant issues raised about the lack of consultation. I understand there was a fair bit of consultation. I think there are issues if you are in a smaller, specialised hospital — —

Mr O'BRIEN — That is certainly the case with the ophthalmologists.

Dr PHILIP — There is the issue of whether the system suits you more than if you are in a generalised hospital. You would have heard evidence about and talked to people in this inquiry relating to that. That is something we could have learnt.

Mr PAKULA — Just to follow up on this, we have heard from the deputy ombudsman about his inquiry into a bunch of ICT projects, including myki, LINK and HealthSMART, and it strikes me that the challenge with health is — and I have asked others about this — in some respects even greater. With myki you are taking one common IT system across the network and replacing it with a new one. The same with the police system; every police station had one system and they all got a new system. With health you have a completely devolved governance structure and you have got completely uncommon legacy hardware and software. Then, for the reasons you have identified, you try to implement a system which, for the patient's and practitioner's sake, is going to have some common architecture amongst it. The governance structure of the health system is unlikely to ever change. Even though you have now got some common architecture, there will still be differences from hospital to hospital and health network to health network over which you want to have some common overlay. It is a challenge different to the public and police networks and matters of that nature. Going forward, whether it is about IT or anything else, how does the health system deal with this issue of wanting to provide some commonality in an environment where nothing else about the system is common?

Dr PHILIP — Some of these issues will be played out in a review that we will have of ICT in health more generally. However, the comment you have made goes to the issue of what you have common standards and platforms on and what you allow for variation. That is an age-old policy question when you have a tiered structure and devolved governance. I think there are some key principles that are now coming to the fore around interoperability, standards, safety and quality. Perhaps as system managers that is what you focus more of your attention on. You can adopt whatever systems you like as long as there are certain benchmarks that you meet or principles that you adhere to. I suspect that is the evolution that we are moving into.

The CHAIR — In the remaining time that I have available I want to look at the RCH project rather than deal further with HealthSMART. I go back to the evidence that you gave the committee a little earlier in relation to a question from Ms Hennessy about the take-out of what was a good process. Your written response to the committee refers to the success of the RCH project flowing from an excellent partnership with the private sector and its shared vision and commitment to quality outcomes. I would like to develop that a bit. Could you advise the committee of the key elements in developing such a relationship and ensuring that the goals and objectives of the project are commonly understood? In so doing, could you also touch on your comments in your submission on an output-based brief and advise how the brief encourages and or rewards innovation and whether, in relation to other projects, the department has used a similar approach?

Dr PHILIP — I think one of the features of this project was clarity of scope. What are we trying to achieve here both in terms of construction and also in terms of outcomes? A great deal of credit goes to the fact that we have, as I mentioned before in a previous answer, a team that has had experience in dealing with such projects and also with the financing model of the PPP. I think that is something that should not be underestimated. Why? Because such a team, through learning by doing and through doing it in a number of different contexts, has learnt lessons about where you look for problems and where you look for opportunities for innovation.

The functional and technical briefs that were prepared on this have resulted in a good proposal, a good tendering process, good bids and the final selection of a preferred tenderer. I think it has then been in the management where there has been quite an open dialogue so that — and I think this is one thing across most infrastructure projects — the relationship can generate incentives for both parties together to resolve issues.

It is a common trait in a lot of projects around the country where the relationship is not great and therefore there is no incentive on the part of a construction consortium to highlight problems ahead of time and work constructively with the client to resolve them. I think RCH is a good example where relationship has mattered, not just with people building but also with other stakeholders who have an interest. Public consultations on this were quite extraordinary in terms of bringing the community along with us.

The CHAIR — Just to develop that a little further, in relation to this model have you factored your experience into other projects that the department is overseeing? I assume if we operate on the basis of lessons learnt, it is a positive lesson. How will it be applied?

Dr PHILIP — Just a couple of elements. Firstly, we are retaining our staff as a high priority, particularly in this area, and secondly, in the department we have a major projects board that we have created to try to ensure that across our major projects there are lessons learnt. We increasingly have staff who move between major projects so that they can take lessons that they have learnt from one into another or what has worked well in one into another.

Mr SCOTT — I will follow up on one matter that was touched upon by the chair's questioning to which you responded stating that the public consultations were extraordinary. We have heard evidence in other projects of — how would I put it? — a less than optimal relationship between stakeholders and the project itself. I will be careful in what I say, but persons living in those areas in the inner city have been known to take strong objection to infrastructure and other projects, and there are some matters currently in the public discourse about that. But what were the particular aspects that allowed you to engage with the community in such a way that, frankly, is not part of what we have been looking at? The absence of it in such an environment is interesting in itself.

Dr PHILIP — There are a couple of features of this. The precinct matters, I think. I think there is widespread recognition of the value of the precinct, and people are quite used to change in the area. So that is one, and I do not think we could ever downplay it. There are a number of other projects that just appear and the people around there have never had an experience with a major development. A lot of these things are new, which of course works on the flipside in that you can be highly organised as well in a precinct like this. So I think that is one.

I think the subject matter is another. The building of the Royal Children's Hospital is widely recognised as a good thing, and I think people generally want to be involved in making commentary on that. That said, effective public consultations, in my view, are not just all about getting agreement; they are about allowing people to have their say and to be up front with them about what changes are being made, which from an individual's point of view may be good or bad, but at least there is clarity and transparency about what is going on.

Mr SCOTT — What were the particular mechanisms used to engage with the community?

Dr PHILIP — There were a number of workshops that occurred. There were public forums. For the further development there has been a mail-out in the area and opportunities for people to comment. So a number of tools have been employed to provide information and enable people to provide a view.

Mr MORRIS — I would like to return to HealthSMART. In doing so can I just say in passing that when Mr Wallace last appeared before the committee I was probably a bit tough on him in seeking information about

the RCH project. Can I just say that I think the information we have in the response on the RCH process is very useful to the committee, so thank you for that.

To return to the HealthSMART issue, there has been some suggestion that perhaps the project was basically too large, that it tried to do too many things for too many areas. I simply mention that in passing. There has also been some speculation about the process, in that one of the reasons given for the delay was that the specific requirements of the health sector had to be determined post-selection, which is, I would have thought, the wrong way around.

As I said, there has been some discussion on the scope of the project, yet we heard from the Royal Victorian Eye and Ear Hospital this morning that the total package did not provide what it needed to develop a full electronic medical record system. Given all those things, can I ask you — and I know you have commented on time lines in response to Mr Angus — if the project was undertaken again, what are the key areas that would be handled differently?

Dr PHILIP — I might ask Mr Wallace if he wants to add anything to my response, but I think the Eye and Ear example is instructive. One of the things I think we have learned from this project is how you segment various parts of the health system. Eye and Ear is actually very different to a lot of the other services that have implemented some of these systems. It is a highly specialised hospital, not a generalist hospital, so the type of people who work there, the type of work they do and the systems they use are quite different to others. Therefore, implementing a system like this properly required more change management and more nuancing of the product for a specialist institution like the Eye and Ear.

Mr WALLACE — The Eye and Ear in short just emphasises what the secretary emphasised previously — that is, when you are actually undertaking these projects, how much diversity versus how much commonality do you provide? Not all health services are homogenous. The Eye and Ear is not particularly satisfied with the product, yet Peninsula Health, Eastern Health and Austin Health are all fairly satisfied with the project. Why is that? One of the reasons is that their health services are quite different. To enable some diversity for very specific differences in health services is something that we will need to consider in the policy context.

Ms HENNESSY — Just on the Royal Children’s Hospital, obviously when you are scoping such a project you reflect upon things like demand forecasting. This committee has taken a whole range of evidence around hard-infrastructure projects, such as roads and tunnels interstate, and around the difficulties associated with demand forecasting. I suppose, unlike a tunnel or something where there is an ongoing private provider, the hospital system and the Royal Children’s Hospital specifically require operational funding. In terms of reports around challenges that the patients are experiencing in terms of accessing the sorts of services that they need at the Royal Children’s Hospital, what do you say about how you get a proper operational budget associated with a hospital like the Royal Children’s Hospital to meet the demand? When we built this great new big beautiful hospital how is it that we ensured that there was operational funding to support its effective service?

Dr PHILIP — The hospital was clearly built based on future demand, and clearly it has capacity for the future. When you think of the operational elements of a hospital and space you also have to take into account people to run it in a safe and effective manner in terms of staffing, both around clinicians and others, whether they are specialists, doctors, nurses or allied health staff, and you have to bring them on progressively as time passes based on proper planning. That is generally how we fund our health services — based on expected demand but also with a clear understanding of supply, and supply is not always the simplest of variables to take into account.

Ms HENNESSY — It is always frustrating and challenging, though, from the community perspective to understand that there is shelf space and bed space. It kind of has a *Yes Minister* ring to it when you build a hospital that people are not able to access. What is the projected bed demand at the RCH?

Dr PHILIP — I might have to take that on notice, but we have a service plan across the state. The RCH is one of a number of hospitals that provide services for children, and generally our modelling takes into account population growth, disease prevalence and things like that. It is very hard to actually develop a forecast of demand for an individual health service when it is part of a networked system. To go back to your earlier point, health is a very tricky business and the expectations of the community are very difficult to deal with. The more we explain and manage expectations around the health system by all players of the system, the better, I think.

The CHAIR — So the inference of your commentary is around the fact that this project is about a long-term view which will progressively ramp up as the need arises within a protected framework but — —

Ms HENNESSY — Or the funding arises.

Mr O'BRIEN — If we had not spent $1.4 billion on unnecessary blow-outs on projects.

The CHAIR — Thanks, Mr O'Brien, that has been helpful!

I lead back to the evidence you gave in relation to my earlier question in particular, and that was around the elements — the learning, I guess — you have had and how partners react. I am interested in the governance arrangements, and in your evidence you talked about the establishment of a major projects board, in effect. Could you advise us with a little bit more emphasis or detail on the arrangements for establishing the board, its particular role and responsibilities and its relationships with individual steering committees, project boards and the secretary's liaison group? Just flesh that out so we have a better understanding of how the department coordinates these various activities.

Dr PHILIP — With the RCH, as we have with most of our other projects, we have a project board which is in the government. Generally it would have representation from Treasury and the Department of Premier and Cabinet, and sometimes there may be someone else who may need to be involved, depending on the project. We would ordinarily have, then, a steering committee or a number of committees, depending on the nature of the project. With HealthSMART I think there were four committees that sat underneath the board. With RCH there is a single steering committee that is underneath the board.

Ultimate responsibility, in terms of the structure, rests with the project board in advising the government on the status of the project and making sure that all the technical requirements are adhered to. The steering committee's remit can vary depending on the project, but by and large it would delve into the details of ensuring that we have the right sort of tendering process and the right sort of scope attached to the project, and then it provides backup to the project board.

With the RCH there was a secretary's liaison group also established. Membership of that included the Royal Children's and a number of people from the Royal Children's. It was to ensure that as the project moved along in its construction and technical development phase the key stakeholder — the Royal Children's — and the various people within that were always kept up to date so that you create a little bit of a feedback loop into the project board and out the other way as well. I think it was a very good development and a good way of keeping an important client on board.

The CHAIR — We have time for just one last question.

Mr ANGUS — Just following on from Ms Hennessy's question, can you just clarify for me, Dr Philip, how many beds there are in the new hospital?

Dr PHILIP — In total — you have just stumped me. I have just lost the total number of beds. It is in one of our documents. I recall the Auditor-General had also indicated that there were around 50 additional beds than the previous hospital.

Mr ANGUS — That was my second question actually, how many more beds there were than the previous hospital.

Dr PHILIP — Off the top of my head I have given you the answer to your second question, because the Auditor-General had actually highlighted that in his report — that there were around 50 additional beds than the previous hospital.

Ms HENNESSY — So that means 50 beds open now or — —

Dr PHILIP — No, capacity for.

The CHAIR — I am sure Mr Angus will tease this out.

Dr PHILIP — If I could read from the Auditor-General's report on page 4:

> The new RCH has 50 more beds than the existing RCH, and DHS has demonstrated that this greater capacity — together with the inherent flexibility and potential capacity for growth in the design of the new RCH — should handle currently projected increases in service demand.

Mr ANGUS — Yes; that was in May 2009. If you could just give me the number — it does not have to be now. Perhaps you can take it on notice. I am happy for you to take it on notice.

Dr PHILIP — I might take that on notice.

The CHAIR — Can I just help here, because I am looking for some clarification too: the number in the former hospital and the number in the current hospital which are open, and the potential to open beds in the future.

Dr PHILIP — The differences.

The CHAIR — Yes.

Mr ANGUS — And the current occupancy rate. I also just go back to your response on page 4 in relation to that. It says that this includes things such as an additional 30-bed ward built in shell'. Could you just explain that?

Dr PHILIP — One of the features out of this project through the PPP was how we were able to get more out of the people building this than we had originally — if we were building it ourselves — budgeted for. It was additional space which could in the future accommodate an additional 30 beds. It is space in which, if you put beds in, you get another 30.

Mr ANGUS — I see. The other question I have is in relation to the financial side of things. Presumably we have started to pay for it as a state, and that will be reflected in the financial statements for the year just gone. We took over in November, I understand. Are you able to tell me what the quarterly payment amount is? Perhaps you need to take that on notice.

Dr PHILIP — I might take that on notice just to make sure I get the figure right. Apologies for that.

Mr ANGUS — That is okay.

Mr O'BRIEN — Have you got a devolved cost per bed — demand costs in terms of funding, not just physical structure?

Dr PHILIP — Given there is a life cycle cost built into this I would be hard-pressed to give you that.

The CHAIR — I think we will close the hearing at that point. I thank Dr Philip, Mr Wallace, Mr Lubofsky and Ms Price for their attendance today and their assistance in informing the committee. You will receive a transcript of the evidence for correction. If you could return that in a couple of days it would be very helpful. It will be posted on the website. This closes the hearing.

Witnesses withdrew.