V E R I F I E D V E R S I O N

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

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

Staff

Executive Officer: Ms V. Cheong

Witnesses

Ms A. Clark, Chief Executive Officer (affirmed), and

Mr D. Lau, Executive Director, Ophthalmology Services (affirmed), Royal Victorian Eye and Ear Hospital.

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 Royal Victorian Eye and Ear Hospital Ms Ann Clark, chief executive officer, and Mr David Lau, executive director, ophthalmology services. Members of Parliament, departmental officers and 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. I will save some time by saying that the important issue, just for the record, is that these proceedings are not being webcast.

All evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act, 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 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 within 2 working days and will then be posted on the website.

Following a presentation by the chief executive officer, committee members will ask questions relating to the inquiry. Generally the procedure followed will be that relating to questions in the Legislative Assembly but much less formal. I ask that all mobile telephones be switched off or turned to silent. I now call on the chief executive officer to give a brief presentation of no more than 5 minutes.

Ms CLARK — Thank you for the opportunity to provide the committee with some context for our written submission. The Royal Victorian Eye and Ear Hospital was one of four lead agencies to implement the Cerner clinical system within the HealthSMART program. The other three health services are large general, tertiary, multiple-campus hospitals, whereas the eye and ear hospital is a much smaller statewide, specialist, tertiary hospital. We specialise in eye, ear, nose and throat health care.

Given the specialist nature of our services, we have particular and specific requirements for our clinical systems. The Royal Victorian Eye and Ear Hospital is a mainly ambulatory service. We have 30 overnight and 29 same-day beds, but we see over 250 000 patients a year. We have high volumes of patients seen in a mainly ambulatory setting within our outpatients clinic, where we see approximately 190 000 patients annually, and we have approximately 46 000 attendances at our emergency department each year. The specialist nature of our service means that we have a very fractional, part-time senior medical workforce and relatively fewer full-time medical staff members than other hospitals.

The health services that were part of the lead agencies worked together with the Department of Health and Cerner to develop the statewide footprint for the clinical systems. At the commencement of the project each of the individual health services were at different stages of ICT maturity in terms of their ICT infrastructure and the other software applications that they had in use. In particular, at the eye and ear hospital we had few complex IT systems — they were mainly bespoke — and we had a patient management system that had been customised for use at the eye and ear hospital. We found that we needed to strengthen our ICT infrastructure and our ICT support to implement a sophisticated clinical system such as Cerner. We also had the need to interface with external providers of services which had their own systems, such as pathology providers. All of these factors added more complexity to our involvement in the project than was probably originally anticipated when the business case was prepared in 2007.

The CHAIR — Thank you very much, Ms Clark. By way of introduction, I am going to reiterate something I have said to all witnesses, which is essentially that the committee's interest in drawing evidence is to better inform itself about a number of aspects of major projects. Obviously in relation to this hearing it relates to HealthSMART. We are looking at issues of accountability, transparency, relevant skills and capacities, and lessons learned. It is really on that final point that essentially we are trying to draw out commentary.

Leading to your particular involvement in this project, your response to the committee's request for what was in effect a formal questionnaire indicates that the hospital had extensive involvement in the initial implementation of the clinical application. I am interested to know about this. Did it include input into the development of specifications as to what was required in your facility? And how extensive were the discussions, bearing in mind your preamble about the complexity of the whole-of-health-system design of this program?

Ms CLARK — I will have to answer that in the context of my personal knowledge. I was employed at the eye and ear hospital from August 2008. The work that was done to develop the business case was done in the lead-up to the business case being completed in I think 2007, so I am not personally aware of exactly how much involvement the hospital had in a formal sense.

The CHAIR — I want to go beyond the business case issue. I note you have made it clear elsewhere that you grossly underestimated, or the hospital grossly underestimated, the investment infrastructure that was going to be required. But beyond that business case stage, presumably in the development of the implementation there was a level of engagement with the hospital and you were involved in various working groups. To what extent were the specific needs of your hospital taken into account — we are talking about the clinical application — or were the design features essentially more generic?

Mr LAU — My understanding of the process is that the specifications of the HealthSMART system were conceived within the HealthSMART program but with substantial contribution from clinicians throughout the various health services, beyond the initial four. It was designed at that stage as a statewide footprint, and so the specifications were really built for the state rather than for a specific hospital at that stage. My understanding is that those specifications were built before the final lead agencies were chosen.

The CHAIR — Did that inevitably then lead to difficulties with the implementation phase for your hospital? Given it was not designed specifically for you, given it was a generic platform, in effect you had to adapt your systems to integrate with the HealthSMART designed model.

Mr LAU — Yes, that was the case. As we have stated in our written submission, issues like the pathology and radiology functions, which are eminently suitable and appropriate for a general health service, offered difficulties within our particular service because our radiology provider, for instance, did not have the other side to connect to and we had multiple pathology providers. Yes, there were issues specifically within our hospital.

The CHAIR — That leads me to some of the evidence you have provided in your written submission. I turn to page 3 of your written submission, where you refer to dysfunctional consequences specifically, and I quote:

> The initial loss in outpatients medical productivity was 13.5 per cent, which has since been reduced to 8 per cent.

You further go on to say:

> This loss meant the RVEEH needed to employ more medical staff to continue with the same patient throughput. The system has also increased workload for the pharmacy.

That follows with the paragraph:

> There have been a number of staff concerns regarding the system, mostly from members of the senior medical staff who believe that the system is not intuitive and easy to use.
>
> However, with experience and familiarity with the system, dissatisfaction and inefficiency have reduced somewhat.

I read that in so that we get the context within the transcript. By its nature any system for a statewide footprint is not going to meet the specific needs of any hospital. We understand that, but having said that, what I am interested in is the capacity for the hospital to adapt the template to its own needs

I was interested in your observations about the in effect decreased efficiency as a consequence of rolling the system out. I am really curious about that issue — about experience informing, if you like, a better acceptance and understanding of how to use this applied system in your hospital. Is the trend of hands-on learning bringing the efficiency of an activity back to where it may otherwise have been? Because the impression one is given is that for all of the investment, this might not have been a brilliant idea. I just want to clarify that, particularly because we have had other evidence to say that in terms of patient outcomes it is a very significant development. I want to tease out your hospital's experience.

Ms CLARK — I think there are a number of factors there that have influenced our experience, and that is why I really wanted to put in context that we are in a different situation to a number of the other health services which have implemented Cerner — for example, the loss of productivity in our outpatients departments because of the nature of ophthalmology and ENT services. We tend to have very busy clinics with high throughput. We may book in 30 patients in a single clinic with multiple doctors, which actually involves them seeing a patient

very quickly. Other health services have different patient loads. They may have more complex, chronic patients to see, with multidisciplinary teams involved, so their throughput can be a lot lower. The impact in a system in a health service such as ours, which has a rapid throughput of patients, is that if you are adding, say, 1 minute, which it actually takes you to do an electronic script, or 3 minutes, if you multiply that by 30, it has got a much bigger impact in a session than if you are only multiplying it by three patients. In terms of the loss of productivity, the nature of our health service had an impact on that, which is why our experience was different.

The other thing to note is that our patient load is mainly ambulatory and often with a surgical intervention, so the average length of stay in our health service is between one and two days, with many day stays. We do not have a lot of people coming in with complex medications where we have to make sure we have got all the alerts embedded in. The risk profile of our patients is very different. A lot of the benefits and value of the clinical system are probably not quite so obvious in a health service such as ours.

The CHAIR — Okay, that is good. Your evidence is contrasting with that of the Austin, whom we heard from yesterday about moving in that sense to a paperless system. You are obviously not finding the efficiencies that the Austin has.

Mr PAKULA — I really just want to pick up on the point that the Chair has been pursuing. To the extent you can, I just ask you to take us through the journey, if you like. I understand that when a new system is implemented it will be a lot more difficult for you than it might be a year down the track when people have become familiar with it. You have noted in the same paragraph that the Chair referred to that the literature would suggest that whilst an initial productivity loss is typical, there are compensating benefits occurring elsewhere as a part of the change.

Above that paragraph you talk about the assessment of benefits and prescription legibility, which I understand, but you also talk about other benefits and outcomes assessed to be delivered somewhere between 0 and 80 per cent. I do not want you to go chapter and verse through all the benefits but just take us through the journey and the extent to which familiarity with the system has changed the experience for staff and how it has improved or perhaps where it may not have over the period.

Ms CLARK — With any new system there is always resistance to change because people become used to operating in a certain way. I think we experienced that, as did everyone else, in the natural course of events. Because of the subspecialty nature of our health service, some of our clinicians, particularly our senior medical staff, may only come into the hospital once a week or once every two weeks. I think that becoming familiar with quite a complex system when you have not used it for a couple of weeks certainly created some issues with the medical staff. That was one of the factors.

Mr LAU — I can add a bit more. Because it was the first time it was done in Victoria, certainly within a public hospital environment, there were many things that we did not know at the start. As a result of the experience at the start and what our staff were experiencing, we undertook a number of steps to improve the experience. We ensured that there were more and faster computers available. We overhauled the entire fleet to put in larger screens so that the busy Cerner screens could be seen in one shot without having to scroll up and down. We improved the speed with which you could access the system in the morning, so when we turned it on and logged in we were using smartcards. We are now using face recognition technology, which means that if the computer sees your face, it will stay on rather than turning off. Yes, there were concerns with the software specifically, but there were many, many complaints about the way you had to access it, so we have put a lot of effort into making sure that that has improved.

I think part of it is also getting used to the software as well. Some practitioners are not used to using computers in their daily practice. You have to remember that most of our clinicians work within the public system somewhere between half a day and one and a half days a week, which means they are not spending a lot of time in the system, so if they are not using a lot of computers at other times, it does take a while for them to get used to it.

Like the Austin, we are committed to a paperless hospital in the future. There are enormous benefits if you can create an electronic medical record, particularly in population terms. Understanding what is happening to your patients as a population is very difficult to do, and health ICT is littered with all sorts of examples, both good and bad. But the goal is a good one — it is an excellent one — and it is one that everyone will get to at some

point. Part of what the hospital is doing now is purchasing and implementing additional software that is absolutely fundamental to the way we practise at our hospital. Having those bits of functionality working as well changes the value proposition for our clinicians; it makes it more obviously valuable to them, to their practice and to the care of our patients.

Mr ANGUS — I would like to follow on from the Chair's earlier line of inquiry and cite the fact that on page 2 of your response you have identified this as a highly complex project — and everyone is acknowledging that. There are a number of challenges, including those we have just talked about and others, including privacy issues, Australian medicines terminology, systems compatibility and Medicare requirements — a whole range of things. My question to you is really in relation to those. Do you consider that those issues arose as a result of the nature of the project itself or as a result of insufficient research, planning and investigation being done up-front?

Ms CLARK — Again, I think there are a number of factors. One, I think this was a very ambitious program and the fact that it was developed for us as a state-wide system means that, as has been pointed out, it had to be fairly general in nature. I think as the project developed that became clear. Things that I think had probably been underestimated in terms of complexity include developing interfaces — for example, as we have said, our pathology system is run by an external provider and unless they are compliant with the HL7 requirements, you actually cannot interface it. So I think some of those things were underestimated.

I think that one of the other issues relates to the governance structure of health services in Victoria, where individual health services have boards appointed that have responsibility for the operations of the health services. So when you are actually working on a statewide project I think the complexity of the formal approvals process that is required for each individual health service — and you are working across a number of health services — had some impact in terms of time frames and those sorts of things, which were probably underestimated when the program was developed.

Mr ANGUS — Essentially, from what we know, out of the cohort that took up this project or were involved in the project, you are sort of the atypical one, if you like, given your specialist nature, which you cited this morning and which is well documented. I wonder if, with hindsight, it would have been more prudent for a specialist hospital such as yours to have waited and seen it put in across the hospital system more generally.

Ms CLARK — With hindsight, yes, but I think in the context of when the program was initiated it was probably a really good idea to put in a specialist hospital. If it was to be a statewide system, then I think it was a good idea to actually have a specialist hospital as one of the lead agencies, because it could then test out how well the system could be rolled out right across the sector, which includes a number of specialist hospitals. But it proved to be a fairly difficult and challenging journey.

Mr ANGUS — Yes, more problematic. Okay, thank you.

Mr SCOTT — Just to follow up on that briefly before I move to what I was going to ask you, is the essence of your evidence that there were some advantages to going to an atypical service which would highlight the difficulties of the system in the initial rollout and that although that created results which were below — how would I put it? — what other, more typical, services would be experiencing, therefore you were ironing out some of the real difficulties in the early stages? Is that the sort of view you are proffering there?

Ms CLARK — Yes, I think so.

Mr SCOTT — In terms of looking at improving practices across the system for the future, there was a really interesting piece of evidence in your submission which relates to prescriptions and how Medicare works. I thought it would be useful to elucidate that, although it is a federal responsibility. You raise the issue that Medicare requires a printed paper prescription in order to make a payment to the hospital, but of course in a paperless system the whole point is that you do not need such a payment. Could you explain the issues there? I think that would be useful.

Ms CLARK — I will leave that one for David.

Mr LAU — You can transmit a prescription electronically and have it dispensed, but Medicare rules require paper-documented evidence, which includes a variety of things like the doctor's signature, the patient's

signature indicating that they have received the benefit and several other aspects. Until the facility exists within Medicare to accept an electronic prescription, you will have to print out that prescription. If you have very busy outpatient clinics with very high volumes — and particularly if you have lots of mobility, with clinicians going in and out — trying to link specific printers appropriately to specific clinicians, having the prescriptions come out, finding them, signing them and working out if there is an error, in which case you have to change it and print it out again, takes time. Our clinic rooms were built at a time when computerisation did not exist at all, so fitting in more and more equipment is difficult. Fitting in a printer is difficult, as well as having it run out of toner, having paper jams — all those sorts of things are infuriating, as anyone who has ever fought with a printer in their life knows.

Mr PAKULA — That would be everyone.

Ms HENNESSY — Not to mention the photocopiers! The swear jar rule does not apply when it comes to dealing with talented printers.

Mr LAU — It is really quite mundane, but simply having to print them out takes time, and time makes a real difference because of the volume of patients we see. If we can get rid of that, it would change the value proposition entirely.

Mr PAKULA — If you could just do them electronically?

Mr LAU — It would.

The CHAIR — Just an observation, if I may, on this point. I understand that as of this financial year Medicare requires Medicare benefits to be paid electronically and it has gone to a non-cash rebate system. So what is good for the goose is good for the gander, I would have thought. Anyway, there is an interesting point for our federal colleagues to take up.

Mr PAKULA — Keep making observations.

The CHAIR — Well, I am enjoying it!

Mr SCOTT — Really?

Ms HENNESSY — Would you prefer to check? You don't strike me as the type of man who lines up outside the Medicare office for hours on end.

Mr SCOTT — Let me just follow up on that issue, though, because it was quite an interesting piece of evidence, to be frank, and we are looking for improvement. Has there been communication from your hospital with the federal department relating to those sorts of issues?

Mr LAU — Not specifically from the hospital, but those communications are certainly there and I am aware of conversations that have occurred between the Department of Health and — —

Mr SCOTT — The Victorian Department of Health has taken up the issue with the federal department?

Mr LAU — The Victorian Department and DOHA, and certainly I am involved in some work with NEHTA looking at that issue.

Mr SCOTT — That acronym is?

Mr LAU — NEHTA is the National E-Health Transition Authority.

Mr O'BRIEN — Thank you for coming to give your evidence. That was an interesting example. Practical examples like that are always helpful for this inquiry, because whilst you have outlined that the goal is to go to the paperless office, our purpose is to find good examples and bad examples and lessons learnt, if you like. Just on that particular example about the description issue, my general question is: to what extent in the planning phase were you consulted about your needs or challenges or the particular requirements, and to what extent were you able to provide input into this? There was no business case formally prepared. In terms of the governance program or a rollout of IT, particularly if we are looking at a statewide system, to what extent might

your needs or particular requirements, such as the prescriptions or the high level of turnover of patients that you have in your practice, have made a difference in practical ways?

Mr LAU — Our hospital was involved in those various advisory groups and committees throughout the process as one hospital amongst many. I do not think we have particularly backward staff; I am sure they spoke up at the time. The difficulty that we all would have had was that until we had done it, we did not know a whole lot of stuff. You have talked about how this was an ambitious program of works, and it was. It was the first time it was done, and many of the issues that we found we did not know at the time. At some level they were lessons that we had to learn.

Mr O'BRIEN — What about in relationships particularly with the computer vendor as well as the HealthSMART department? Are there lessons learnt in relation to decisions about the type of IT to learn or the manner in which you train consultants to adopt this sort of technology?

Mr LAU — It is a bit hard to answer. We have learnt bits along the way. It is a bit hard to separate exactly what we have learnt and when.

Mr O'BRIEN — Sure. It is always helpful to go to some specific examples, like the Medicare one, and you have listed some others — the number of visiting medical staff et cetera and the different IT systems across your pathology. Could you take your time to go through some of those lessons?

Mr LAU — It is an interesting relationship that has been built up over time between the hospital, HealthSMART, which is a part of the Department of Health, and the vendor, which is Cerner. It is a three-way relationship, and I think at times that has been quite strained. There have been substantial improvements over the last 12 months or so. We have had difficulties at times. The inclusion of Cerner staff onto the state steering committee has helped considerably. That would probably be a specific example where I think there has been some real value.

Ms CLARK — I will add to that. As a specific example for us as an organisation, one of the things we have learnt is that we probably should have spent more time considering the individual clinicians' needs and experiences in terms of using a complex system — for example, as David has alluded to, the frustrations of how long it takes to log in on a system. If when you initially log in on a system it is going to take time and you have already got a very busy schedule, that is not a great start to your experience with using the system, so I think we should have spent more time considering the individual experience of using and probably wrapped more resources around ensuring that the base infrastructure was really sound, fast and very well supported. For example, if a clinician has a problem, they get an instant response from a help desk; obviously that requires a lot of additional resources.

In terms of the training, again we have sessional clinicians who are only here for part of the time, and we underestimated how much training they would need and reinforcement and ongoing support. That is a good lesson not just for this project but for other projects as well in the future. That is another example.

Mr O'BRIEN — Thank you, Ms Clark.

Ms HENNESSY — To continue with that theme, given the fact that we have a health system that is regulated at a number of tiers of government, we have devolved governance and obviously specialist hospitals and workforce issues that are specific to each hospital — you have taken us through them — are your VMOs working in the private system on other days?

Ms CLARK — Yes.

Ms HENNESSY — Right. If you were to redesign an ICT project that had to be rolled out across the state, what would you do differently, taking into account that it does have to be a complex system?

Ms CLARK — One of the things I would suggest would be rather than having a standardisation in terms of the system used, you would take an approach more of establishing standards that would ensure that systems had an ability to interface and be interoperable rather than defining which system each individual health service could choose. As long as there was an ability to share information appropriately and to have appropriate interfaces, I would suggest that would be a more appropriate approach.

Ms HENNESSY — Which kind of defeats one of the purposes of having a standardised system. We have got the devolved structure, and effectively what you are saying is a devolved ICT model that has the capacity to interface?

Ms CLARK — Not necessarily a devolved ICT model, but you would still have the same ability to interface. You would have the same standards so you could report and benchmark, and all those other things. What you would not have is the potential for economies of scale and purchasing systems, so I think that would certainly be lost in that scenario.

Ms HENNESSY — And the capacity for government, as opposed to the utility convenience at the local health service sector, to be able to maintain and influence the quality, nature or the cost of a system?

Mr LAU — I think there is an interface between those systems. Does the practice of medicine dictate the system you use, or the other way around?

Ms HENNESSY — Yes.

Mr LAU — To an extent both influence one another. As long as across the state your systems of medicine are reasonably similar, putting in a similar system is not too disruptive. We are here because we are the extreme example, and our system of medicine, because it is a subspecialised hospital, is more different from the others. That is not to say that for the Victorian public health care system as a whole that it is not reasonably similar; it is just that we live as an outlier and have a perspective about being that outlier.

Ms HENNESSY — Absolutely. I am sure your experience as an outlier is not just applicable to your ICT experiences as well.

Mr ANGUS — I want to go a little bit further down the track in terms of the post-implementation review that you mentioned in your submission which was conducted in December 2010, and then the follow-up review from Deloitte in April 2011 that the hospital commissioned. You have said in your submission that that provided a remediation plan as well as a clinical information systems vision and plan. Can you flesh out a little bit more about that in terms of what the purpose of all that was and give us an update in relation to that?

Ms CLARK — The initial post-implementation review that was undertaken was just so we could assess the success of the implementation to identify whether there were any issues that we needed to pick up and improve. That is fairly standard in terms of project methodology. Some of the issues that came out of that identified for me that we needed to get a more in-depth review and get an external organisation that had significant expertise in that area to come and provide some advice to us as an organisation in terms of ensuring that we had a safe and effective clinical system.

Mr ANGUS — So the report was then obviously received and then that, as you have said in your written submission, gave you a plan, and presumably you have followed that?

Ms CLARK — There were two parts to the review. One was a remediation plan which was related to what we could do to make the Cerner system work better for our organisation, so we implemented that, and David has already talked a little bit about that — for example, the larger screens and those sorts of things. In the second part of the plan Deloitte identified that a clinical system is just one aspect of a larger ICT electronic medical records strategy, so we did a piece of work looking at what we really needed to do at a strategic level for our health service and our cohort of patients, in addition to Cerner clinicals, to ensure that we could move towards an electronic medical record.

Mr ANGUS — And that has provided you with a way forward in more general terms?

Ms CLARK — Yes.

Mr PAKULA — We have not talked much about the patient experience, and it might be that it is miniscule — I do not know. We understand the teething issues, but in terms of where you are today and the change that the patient sees at that interface level, is this negative or positive? Do patients see any difference? How does it impact on the experience of the patients in the real world?

Ms CLARK — In terms of the actual experience, obviously the objective in any system like this is to ensure that we have a high-quality system of patient care. That is the overall objective. But in practical terms of what a patient may see on a day-to-day basis, a patient in one of our outpatient clinics may see a frustrated clinician trying to print out your script. That might be one example of what they may see.

Mr PAKULA — Rather than writing a script out with a pen and paper?

Ms CLARK — Yes.

Mr LAU — Because of the type of relatively low-risk medicine we practise, our safety data would indicate that there has been no overall change to patient safety one way or the other. It is neither more dangerous nor safer, but I am quite aware that that is different in the other hospitals. It is certainly no worse.

Mr PAKULA — I suppose it makes me wonder why. Anyway, I have said enough about the Ombudsman's report.

Mr ANGUS — Go on! Keep going.

The CHAIR — Deputy Chair, I do not think you have even started actually.

I would like to change step a little. I wish to go to the issue of your interface with the Department of Health in terms of the implementation. In your response you indicated that the steering committee met regularly with the department and that the HealthSMART service desk has been used to lodge issues as required. I specifically want to go to the issue around skills, competencies and capabilities. It is a core part of our inquiry to try to understand the capacity of the public sector to deliver major projects. Could you make some observations about the skills of the Department of Health staff who are assigned to implement the HealthSMART project and your experience in terms of that interface?

Ms CLARK — The relationship between us and the department was a very collaborative one. Certainly in terms of communications and interfaces I think that worked very well. As has already been identified, the added complexity of having the vendor, the department and the individual health service, plus the fact that there were four health services, added a level of complexity to the overall relationship and the relationship management.

In terms of capabilities each of the health services themselves were at different levels of capability and so what they expected from the department in terms of support was probably a little different. There was certainly a robust project management framework which was put in place by the department, so I think their capabilities in terms of project management were there. David, I do not know whether you have got anything else you want to add to that.

Mr LAU — As a project I think it was largely populated by IT people, and so it was incumbent on the health services to provide that clinical context. We were included in those various working groups but obviously the management of the relationship between the various hospitals and the vendor was through the Department of Health. Certainly we fed into that process and we believe we were listened to, but we were quite aware that the Department of Health necessarily had to juggle the perspectives of many important stakeholders.

The CHAIR — I intend to try to tease this out a little bit if I can because it is quite complex to discuss it. There are various layers. You have the vendor, who has clearly got the high-level technical expertise, and other parties involved in an implementation governance type of structure which in itself is quite complex and bureaucratic — and we have had quite a bit of evidence about that — and magnified the complexity of the relationships. I will set aside the issue of the project implementation processes and structure and come back to it later.

What I am interested in is not whether or not there was a good structure — somebody sat down with a whiteboard, drew all the lines and said, 'These are all the relationships' — what I am actually trying to drill into is: in practical terms were the Department of Health staff members skilled? They were part of this project and the people whom you had to rely on in your day-to-day dealings with implementation. Did they have sufficient capacity, or were they required to go off all the time to the technical people with the vendor to resolve issues? In other words, would it have been a lot simpler for you just to be dealing directly with the vendor rather than working through the implementation phase? It is about the technical capability of Department of Health staff.

Mr LAU — To be really honest, I do not particularly know. Obviously we have had one experience, and without having had the other I cannot really draw comparisons. I have to apologise also because I was not the specific project manager in this, so the technical aspects about how long individuals had to wait to get feedback is a little bit hard to answer. Both myself and Ann were involved more in the broader governance.

The CHAIR — I understand; that is fine. It is a difficult question to answer, I know, but notwithstanding how well designed a process may be for interfacing different stakeholders at an implementation phase, it does come down to the capacities of the individuals at the end of the day, and that is a significant part of this inquiry — to get a better handle on that. If you are not in a position to inform the committee, that is understandable. Thank you for endeavouring to.

Mr SCOTT — I would like to take up the issue of skills in a complex IT rollout, which the Chair was referring to on a different matter. Considering you have given evidence that you have a fairly simple IT system compared to what was expected of you as part of this project, did you have to bring in specialist skills in order to implement it? And was that done through the employment of ongoing staff or through the engagement of contractors?

Ms CLARK — Yes, we did. We have actually strengthened our in-house ICT support through the ongoing employment of staff, but for the project in particular we brought in project staff on a mixture of ongoing employment contracts who had specific expertise relating to the project. There is always going to be a requirement for a sustainable system on an ongoing application support basis but also on a project basis to undertake the implementation. So we did both.

Mr LAU — And our overall project manager is an employee of the hospital.

Mr SCOTT — Just to give me some sort of idea of the scale, what was a larger cost to the organisation in terms of the sort of hump of costs associated with the implementation of the project? Was it when the short-term staff or contractors were brought in, or was it the ongoing costs on a year-by-year basis in that year? You are not sure?

Ms CLARK — To be honest, I am not sure. I can certainly take that on notice and provide some relativities, if you would like me to. But I could not answer that off the top of my head. David, I do not know whether you could.

Mr LAU — A project will cost more in the short term, but your running costs obviously build up over time. It depends upon the time frame. Certainly the maintenance of what we have has now been transitioned from a project footing to a business-as-usual standing.

Mr SCOTT — Is there an ongoing evolutionary development of the systems within the hospital? That was the evidence we received from Austin Health. Or is it a fairly stable system that does not require great change at this juncture?

Ms CLARK — I think for us the HealthSMART proportion is something that we will leave as is, but as part of our ongoing electronic medical records strategy we will be doing a significant amount of work in terms of other systems and reporting. Yes, it is an ongoing journey. It has just started for us.

Mr MORRIS — I am interested in your response. I have no page number, but under '4. Steps to align system management with public interest', you talk about the commitment to the development of an electronic medical records system using HIMSS. Could you perhaps expand a little on exactly what the application is? The other question I have is that from a reference under '5. Lessons Learnt' to using that model for the implementation of an EMR, I am assuming that the EMR was a separate part of the process in terms of HealthSMART that the eye and ear did not go to?

Mr LAU — What was within scope for HealthSMART was specifically pathology, radiology, medication prescribing and discharge summary, and some ancillary services attached to providing those things. An EMR is a comprehensive digital hospital. It includes much, much more than that.

HIMSS is an acronym. It is a not-for-profit society that began in the United States. There is an Asia-Pacific section of it now, and it is really a society that is trying to synthesise the knowledge that health facilities are

learning through their progressive implementation of electronic medical records across the world. It has built a standard adoption model, which is slightly differentiated depending upon which part of the globe you are in, which suggests the broad aspects of an electronic medical record that need to exist to get to various levels and the order in which you do it. It is really about what makes sense, what is affordable and where do you get the benefits.

There are elements within HealthSMART that meet that, which are things like pathology and radiology, which you would put in fairly early on. But things like medications exist at the other end of the scale, so the challenge for all the health services involved in that is filling in the gaps. For our hospital specifically, we use medical photography in a similar way to the way most hospitals use radiology services. It is just that because the eye is transparent, you can actually look into it with a camera rather than having to use all sorts of other bits and pieces. That is, for instance, a piece of technology that we would put in next. Clinical notes functionality — clinical documentation — is something that we would also be looking at, because that allows us to start to synthesise what is happening to our patients at a population level.

Mr MORRIS — Just to make sure I fully understand the response, information provided to us by the Department of Health on the whole HealthSMART project talked about its various aspects — financial, patient administration, clinical, rostering and payroll — and it identified yourselves as having been involved in the clinical part of that but in nothing else. Is it that the supplementary aspects offered by HealthSMART are not suitable, given the specialised requirement for the eye and ear, or is it simply your desire to go in a slightly different direction? Or are the supplementary aspects that you are talking about not covered by the standard model?

Ms CLARK — No, the supplementary aspects that we are talking about to complete the electronic medical record pathway are just not included in the current scope of HealthSMART. They are outside that.

Mr MORRIS — Thank you for that.

The CHAIR — We will have one final question from Mr O'Brien.

Mr O'BRIEN — The Ombudsman's report mentions that yours is the only hospital that has fully evaluated the performance of the project, but not all parts of the system were operational. It ties on a bit to Mr Morris's question. Do you have any comments to make about the other HealthSMART applications, including the patient management system and the financial management system? I do not necessarily want to recapture too much of the material, but given it is a model that would have perhaps been built up from the clinical utility, which was the best benefit that could have been obtained out of this system but is yet to really come online, I would be interested in your comments.

Ms CLARK — I think with the other components of the HealthSMART suite — the financials and the patient management — it was about where we are at in terms of our need to replace systems. We already have a patient management system, which is fit for purpose and has actually been customised for our use. We do not really need that, so we have not participated in any other aspects of the HealthSMART program.

Mr O'BRIEN — Is it your intention?

Ms CLARK — Not at this stage, no.

The CHAIR — Thank you very much for your attendance today, Ms Clark and Mr Lau. It has been informative and another perspective, particularly as it is a view from somebody who has actually had hands-on experience, certainly ahead of the implementation phase, compared to some others. Thank you very much. You will receive a transcript in about 15 days. If you could return it to the secretariat, it will then be posted on the website. This closes the hearing.

Ms CLARK — Thanks very much for your time.

Witnesses withdrew.