EDUCATION AND HEALTH
STANDING COMMITTEE

ONGOING HEARINGS: DEPARTMENT OF HEALTH HEARING 2

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 16 JULY 2013

SESSION TWO

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Mr N.W. Morton
Ms J.M. Freeman

Hearing commenced at 11.32 am

STOKES, PROFESSOR BRYANT
Acting Director General, Department of Health, examined:

SEBBES, MR BRADLEY
Executive Director, Fiona Stanley Hospital, examined:

RUSSELL–WEISZ, DR DAVID
Chief Executive, Fiona Stanley Hospital Commissioning, Department of Health, examined:

NUNIS, MR GILES
Executive Director, Information and Communications Technology, Fiona Stanley Hospital, Department of Health, examined:

SALVAGE, MR ROBERT WAYNE
Executive Director, Resource Strategy, Department of Health, examined:

The CHAIR: On behalf of the Education and Health Standing Committee I thank you for your appearance before us today. The purpose of this hearing is to assist the committee as it examines the delayed opening of Fiona Stanley Hospital. I thank Professor Stokes for his correspondence. The committee has resolved that the evidence relating to anticipated costs of the delayed opening will be taken in closed session, to take place in the second part of the hearing. At this stage I would like to introduce myself, Graham Jacobs. Other members of the committee are Rob Johnson on my left and Nathan Morton on my right; Rita Saffioti is on his left and Janine Freeman on her left.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during the evidence, it will assist Hansard if you could provide the full title for the record.

Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witnesses sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Do you have any questions in relation to being a within at today's hearing?

The Witnesses: No.

The CHAIR: You have done this before!

Prof. Stokes: Mr Chairman, may I just make a statement? I sent you a letter dated 21 June to correct a statement I made at our last meeting in which I said there were approximately 100 redeployees across Health. I went back and had that checked and the number is 56, so I apologise for that.

The CHAIR: We did receive that. Thank you very much for that correction.

Prof. Stokes: The second thing is that we only received your letter of request as of yesterday. It came to my office on 15 July, yesterday, at about 10.30 in the morning by email. Consequently, much of the issues that you are going to raise today we will need to take on notice in order to find the past history of some of those things to provide to you. As you are aware, many of us have not been in this position for long periods of time, so our own personal corporate history is not good, but we will find details for you later. The third thing I would like to thank you for is the ability to go in camera should there be issues associated with commercial sensitivity or issues that come before cabinet and are subject to cabinet confidentiality.

The CHAIR: Thank you, Professor Stokes. We understand that if you cannot provide those answers today that we can take them on notice and you can provide that for us, and I thank you for that.

May I just open with a generic statement in and around risk. I understand you might need to provide information to the committee on notice, but we were really asking about the reasoning for the analysis underpinning the decision to open Fiona Stanley Hospital on 1 April 2014 and the decision to include that date in the contract with Serco. Having said that, I wonder if you have some general comments to make about the selection of the date and some of the risks that the department identified in selecting that date.

Prof. Stokes: I ask Mr Bradley Sebbes to comment on that.

Mr Sebbes: The date of April 2014 was selected as a product of the work that needed to be done to get the hospital open. Back in 2007 when we put together the business case analysis for the project, part of that was to do up a detailed program of work to be done for the project. The major driving component of the work at that point in time was to get the design team and the builder in place and to get the hospital designed and constructed. That program took the work through to December 2013, which is still the current program. On top of that we had advice from consultants that said that on other similar projects—there were not a lot of similar projects at that point in time—there is a three to four month commissioning period for clinical services and then a short period of actually opening up the hospital. That program took us through from 24 March to 22 April as the opening of the hospital, and for years now they have been the program dates that we have been working to. It was based on the critical path through that, which was actually the construction program at that point in time. That is a fairly natural process, I think, to get to where we got to.

The CHAIR: Thank you for that. I suppose we could probably move on to the status of ICT projects, and since I had forgotten your name I might give you the privilege of asking the first question!

Ms R. SAFFIOTI: Thank you, Mr Chairman. I will just go through the information provided. There are 48 different computer programs, or ICT systems, that are currently being developed for the hospital. I will not go through each one in detail, but can you identify those systems which are causing the significant delays and who is actually responsible for developing those, in a broad sense?

Mr Nunis: Of the 48 systems, most are existing applications within Western Australian Health—I think we gave you a number in terms of that. Around 25 of the 48 are existing applications and the remaining 17 related to a range of existing applications that required further enhancements, so there are quite significant enhancements to meet Fiona Stanley requirements. The last six required new

procurement by going to the market place. If I may, those that related to new procurement included closed loop medication system, ICU clinical information system and electronic health record management system and also oncology system.

Ms J.M. FREEMAN: You have them numbered in correspondence, and so that they are clearly stated can you tell us the number that you are talking about, as that would assist us?

Mr Nunis: They are not numbered according to that. So closed loop relates to item 4 on the list. Number 10 is the intensive care clinical unit. Number 40 is the health records management and scanning e-forms, and 32 is the credentialling system. The last was the scheduling application that sits within 45, which is enabling services.

Ms R. SAFFIOTI: If we can go through them, number 4 is the closed loop medical management system, which is the robots?

Mr Nunis: Yes. That went to the market on 7 January 2013—I am sorry; it was approved to go to the market on 7 January. It went to the market on 5 February 2013. The tender closed on 1 March. We completed the evaluation on 4 March this year. The preferred supplier is about to be notified, so I cannot release that at this point in time.

Ms R. SAFFIOTI: Is that one of the causes of the delay?

Mr Nunis: Yes; in terms of a procurement—if I could pick up maybe the ICU clinical information system, it is a new application within Western Australian Health. They are currently a paper-based environment, so this looks toward managing the information through intensive care. Once that comes on board, the normal processing procedure is a requirement for design work and development work; we configure the system and then we test and deploy. That is typically the cycle. In most circumstances that takes, as a minimum, 12 months; it could take longer. It really relates to settling those requirements with the physicians.

Ms R. SAFFIOTI: Can we go through those six, which might be easier—otherwise we might be jumping around this morning?

The CHAIR: If I can jump in there: when did that process start on closed loop medication?

Ms R. SAFFIOTI: We are going back to number 4.

The CHAIR: When did you start work on that? You said there was a 12-month lead time. Mr Sebbes talked about designing and building a hospital and how long it takes to build and there is a regulation time. What about the IT, particularly in item 4? You envisaged that that would take 12 months.

Mr Nunis: It will take 12 months from the date on which the vendors are on site ready to do work. They are about to come on site, so when they come on site in July I expect they will be finished by July next year.

The CHAIR: So you have to have a built hospital to do that?

Mr Nunis: The hospital is built.

The CHAIR: Yes, but you cannot do any of that work before you have the walls and roof up, or anything like that?

Ms R. SAFFIOTI: The walls and roof will be up by January. Basically, you have 12 months from when the preferred tenderer is announced—hopefully in the next two or three weeks.

Mr Nunis: Yes.

Ms R. SAFFIOTI: Basically, it does not give you a lot of flexibility over when you hope they can deliver. You do not want them to experience any significant delays.

Mr Nunis: Part of good IT management is to manage scope and outcome, predominantly with this user group, the clinicians. We have had a lot of discussions with the ICU physicians in that regard

and trying to implement, in essence, the most vanilla product as possible, because once they seek to have amendments to the software which the product does not offer that slows the cycle down quite significantly. That I do not know until we start that journey.

Once we settle with software—it is functional enough—then we use the clinicians to come and advise us of their workflow and how ICU works and we configure the system to meet that particular ICU workflow and then we test and deploy.

Ms J.M. FREEMAN: Going back to the question asked by Dr Jacobs, if you knew that you physically had to have a built hospital and you knew that the construction phase came through to 1 April, why did you have an operating date on or around 1 April if you knew you had to add this on and have a physical structure? I am now completely confused.

Ms R. SAFFIOTI: No, the construction phase is December. The hospital will be handed over by Brookfield Multiplex in December this year. The hospital will be built by the end of this year.

[11.45 am]

Ms J.M. FREEMAN: But you could not get the ICT system in before this process that you have now got here?

Mr Nunis: No, I do not have a dependency on the hospital being built or the ICU being built; rather, I have more of a dependency on the clinicians telling us what they want the system to do.

Prof. Stokes: One of the issues of that is, of course, patient safety. Closed loop medication is supposed to significantly increase patient safety, reduce dosage of medications, and timely efforts, and so forth. One of the things of which we have to be absolutely sure is that the system will be 100 per cent safe. That is why the testing takes months to do.

Ms R. SAFFIOTI: The 12 months seems quite fine. You went out for tender in January. Why did you not go out previously; that is, why did it not happen last year?

Dr Russell-Weisz: When I came into the role and we reviewed all the ICT systems, when we started the review we looked at the core systems. One of the newer systems that was always flagged for Fiona Stanley was closed loop, but a decision about whether we were going to procure it at the time had not been made.

Ms R. SAFFIOTI: Sorry; when was this?

Dr Russell-Weisz: In November last year.

Ms R. SAFFIOTI: That is when you came on board?

Dr Russell-Weisz: Yes. When we saw the benefit of the system, we started that work straight away so we could go out to tender, as Giles said, on 7 January.

Ms R. SAFFIOTI: So no decision had been made to implement this system as of November last year?

Dr Russell-Weisz: No decision had been made. These are being procured through the lease facility and obviously we wanted to have surety of funding. I wanted to make sure the scope was right. Closed loop medication management has quite a wide scope, so you can have a number of packages. What we have done for the first to get ready for day one is the essential packages plus also the intensive care clinical information system, which is part of closed loop. Anything from there can be done after day one.

Ms R. SAFFIOTI: I remember seeing robots dispensing medication on television a couple of years ago. Are those robots part of the initial scope?

Dr Russell-Weisz: Yes.

The CHAIR: So what you are saying is that it was not in the original thought to have the closed loop system, but someone woke up in November to how good it was and said we have to have it.

Dr Russell-Weisz: No. It was always mooted that this is something that the new hospital should have, one because it was going to rely less on paper and more on electronic records. Closed loop is generally a new product for Western Australia. It has been used in other states. As I said, there is a wide variety of areas in which to use closed loop. It can be used in ICU, in oncology, you can have smart carts. So we had to do significant work to scope what we wanted up for day one.

The CHAIR: When Giles was saying that he generally accepted it could take 12 months to develop and get it running, the clock would not start until November or December last year and you already knew it would take 12 months so you were going to run over some of those time lines.

Dr Russell-Weisz: Yes. I cannot comment on what went on before November, but in November we knew that this was a critical system that we wanted for the hospital. Also, we had done a review of the all systems that were required, concentrating on, as Giles said, the new ones that would take time to implement.

The CHAIR: You said it was significant component of work. Of that component of work, what are we looking at in money terms for that number 4?

Ms R. SAFFIOTI: Would it be okay to ask for it as a percentage of the total ICT?

Prof. Stokes: We will have to take that on notice.

Ms J.M. FREEMAN: I am a bit confused; obviously I just do not get this IT stuff. If you are saying that you had determined that you wanted to do this closed loop medication when you came on board, as I understand it a large tender for closed loop medication management systems was put out and cancelled by Serco on 21 June 2013. There was the intention that Serco would run —

Mr Nunis: On 21 June this year?

Ms J.M. FREEMAN: Yes. The document says that a large tender for closed loop medication management systems was cancelled by Serco on 21 June 2013 for this particular job. That is what our research papers show. Was the intention in the first instance for Serco to run it and for the Department of Health to take it over?

Mr Nunis: I will clarify that. Serco, acting on behalf of the state, went to the market for closed loop, ICU, oncology and some system integrations; so a package of solutions.

Ms R. SAFFIOTI: So this one is part of the Serco contract.

Mr Nunis: Yes. It went to the market on behalf of the state. It was presented to the state. It was presented to us in early June 2013. We are satisfied with it and have accepted some of the proposals put forward and also rejected some. Oncology was one that did not meet the requirement, which is one of the systems we have taken out of the solution. We are now in the midst of settling the contracts relevant to those and closed loop is one of them.

Ms R. SAFFIOTI: To clarify, closed loop is being handled by Serco. I will go through that question again. The information we got from the tender website was that no submissions were received and tenders declined on 21 June 2013. That information is from the Tenders WA website.

Mr Nunis: I have not seen that. But in terms of the package solutions, there was a second rejection, one related to system integration, because we did not have a compliant one and the first one was oncology.

Ms R. SAFFIOTI: Sorry, that is right. They are the two—the subset.

Prof. Stokes: It is not the total package.

The CHAIR: By way of information, there has been a power surge in the building. Hansard can still record, so if you are happy to carry on in the twilight, gentlemen, we will. There is an alternative venue —

Prof. Stokes: Mr Chairman, it is peaceful like this!

Ms R. SAFFIOTI: We should have some incense burning!

I want to go through the time frame again. Like I said, what interests me is that two years ago robots were shown on television dispensing medicine—robots that would be used at Fiona Stanley. But it was only in November that the final decision was made to go ahead with this significant advancement in dispensing medication. Back then you would have known this could cause some delays in the opening of the hospital.

Dr Russell-Weisz: Yes. It was not only this—there were enhancements to other systems that were required that Giles referred to that needed to be done over a period of months, which would challenge the opening date of the hospital. Certainly something as substantial as closed loop was probably the most challenging. What I can say is that when we looked at closed loop medication management in November–December, we took the view that it was a critical system for the hospital that we should proceed with. We proceeded pretty quickly because, as you can see, the tenders went out on 7 January.

Ms R. SAFFIOTI: Is there a cross-government steering committee that oversees the management of the project?

Prof. Stokes: A cabinet task force.

Ms R. SAFFIOTI: Was it informed back in November that this was a significant issue?

Dr Russell-Weisz: I cannot recall the actual dates of the task force's meetings.

Prof. Stokes: We would have to take that on notice and look up the task force minutes.

Ms R. SAFFIOTI: Okay, but from back in November–December, there was knowledge that there would be a delay in the hospital opening because of this system.

Dr Russell-Weisz: I should just clarify that. It was not because of the system; it was not just around the system. The new team that had been to put in to assist with the Fiona Stanley Hospital commissioning was in place in mid-November. Over the next two months, work was being done on not only ICT, but on clinical commissioning, on workforce—on a stream of things, because this is not just in relation to ICT. As Giles has said, there are links and you cannot do ICT in isolation from the clinicians. There were clear interdependencies across workforce, clinical commissioning and ICT that we needed to take into account. From a personal perspective I had to get my head around all the ICT systems, not just this one, from the ones we use in other hospitals, webPAS, our radiology system, and get an appraisal of where the whole project sat. That was not done in November because we only started at that time.

Ms R. SAFFIOTI: I want to clarify the role of Serco in this. I am slightly confused. Serco is looking after 28 facilities, one of them includes ICT, but as part of the entire ICT development for Fiona Stanley, is this one of those?

Mr Nunis: No, not one of the 28.

Ms R. SAFFIOTI: This is additional one to the 28.

Mr Nunis: Yes. It is procuring the systems on behalf of the state, which the state will own and run once they are deployed and on deck.

Ms R. SAFFIOTI: So this is not part of the Serco contract; rather, you are using it as a procurement vehicle because it is already established as a procurement vehicle for the rest of them?

Mr Nunis: In addition to that, Serco manages the IT infrastructure for Fiona Stanley Hospital, so there is benefit for it being involved because of compliance with the standards of information technology. It manages IT once the systems are on deck to ensure that it is in a workable state.

Ms R. SAFFIOTI: Is that an additional cost that you pay Serco over and above the contract you have for procurement?

Dr Russell-Weisz: It is within the cost of the current contract.

Ms J.M. FREEMAN: I have here that the Serco Group ICT procurement 2012–13 identifies computing storage and backup requirements. The tender date was 26 June and the value was $15.6 million. There were 18 hardware and end user computer packages with a tender date of 21 December 2012 to the value of $42 million. There were 17 software and services packages on 21 December to the value of $15 million and facilities management applications award processes are still underway. That was on 11 January 2013 and it was $30 million. That is four and you said there were more than four. There are 12, did you say?

Mr Nunis: It has 29 services that it delivers. One of them is ICT and all those relate to the ICT component of its service delivery.

Ms J.M. FREEMAN: That does not include the ICT for this closed loop medication management that it did for you separately in a procurement package from which you took this closed loop but left out others. Was that included in the initial contract with Serco?

Mr Sebbes: If you are going to the cost of the procurement, in the FM contract there is a lease facility in place and the total cost of that lease facility is included in the cost of the contract. So as long as this procurement keeps the total envelope of costs of all the procurements on behalf of the hospital, that lease is within the costs. At this point in time it is in that framework.

The CHAIR: I go back to the late opening of Fiona Stanley Hospital and the risks associated with the date that was set. Did the Department of Health have the ability and the consideration to delay the ICT systems' development in a risk framework to calculate that risk. As Brad said, obviously you can do the bricks and mortar stuff, and essentially there is a pretty structured ability, but there was also an ability, from what Giles says, to say that this system, whether it be closed loop medication or whatever, will take this long to develop. Until the doctors are using it will take 12 months at least. This is where I would like to come from: those delays in ICT were predictable from what Giles says, so why was the date set for 1 April if there was a possibility of running over that date and was that risk factored in; did you have a risk framework for this?

[12 noon]

Mr Sebbes: Yes. If I go back to the original business case, there was a risk register profile included in that business case. I will just quickly go to the highest five risks. The first one was building cost escalation increasing beyond the cost plan allowance. The second one was ICT does not fully enable reform of clinical service delivery—that was a reform rather than a time delay risk at that point in time, remembering this is 2007, so it is a long time ago—area of building growth due to clinical pressure, making it too big and unaffordable; budget risks and delay in environmental approvals, delaying the total project, were the five key risks. There were two others in the high-risk category that related to ICT. One was the ICT new core systems would not be ready for opening, which is the one I think we are going to. Medical equipment not able to operate with ICT systems. They were the key risks that were produced as part of the business case.

The CHAIR: So, who carries that risk? Do you take that risk? Does Serco takes that risk? Maybe this goes to closed session, but who takes on that risk?

Mr Sebbes: If I can go back to the time of the business case, at the time we wrote this business case the Serco contract was not under consideration. That was some time ago.

Ms J.M. FREEMAN: Is that business case publicly available?

Mr Sebbes: I do not think it is. It is part of our EERC and cabinet submission, so I am not sure.

Ms J.M. FREEMAN: But you can make that available to the committee, but we cannot—in camera.

Mr Sebbes: I think what we should do is refer to our minister first, if it is a cabinet document. We need to determine if it is a cabinet document and then —

The CHAIR: Maybe we should talk about that in the closed session.

Ms J.M. FREEMAN: That is fine. Can I just go back to what you were saying, Mr Sebbes. We have not met before. I apologise and it is a bit dark in here.

Mr Sebbes: I am struggling to read.

Ms J.M. FREEMAN: That is right. Out of that amount of money that I spoke about before in terms of Serco putting together tenders, I think I said—a large tender for closed loop medication. I do not know the amount. And you said they did a bundle of tenders, which includes the closed loop medication, and you took some of that, and yet from our figures it suggest that the department so far has spent approximately $3.2 million on ICT—Fiona Stanley Hospital ICT—since 2012. So, it seems a bit ad hoc. If you have used Serco to do your procurement for some things, why have you not just used them to do your tender procurement for all things when we go through some of our documents here, something like the number 7 clinical patient flow enterprise management system, you have got that—I think that went out to procurement. I am just picking up things. What I am getting the figure of is that sometimes you use Serco and sometimes you do not and it seems a bit ad hoc and without the clear management lines. Is there a reason for that?

Mr Sebbes: The original reason for that is that Serco are to procure everything that is required at Fiona Stanley Hospital, essentially. Some of the ICT being procured was not just for Fiona Stanley Hospital, it was for whole of Health and where it is for whole of Health, the health information network, and that the government procured their own, whereas specifically for Fiona Stanley Hospital as per the closed loop medication—it is the only hospital that has this. It will be the first hospital to get it. That is then in the Serco contract. So, it is a Fiona Stanley Hospital–specific thing.

Ms J.M. FREEMAN: Does that mean it will only be owned by Fiona Stanley Hospital and you will not be able to transfer that to other hospitals in terms of the intellectual property of that ICT because the problem we had with the car park, as you two might remember, at Sir Charles Gairdner Hospital, all the boom gates we could not go and use at other sites because we had this whole issue of intellectual property. So, are we going to fall into that same problem with intellectual property?

Mr Nunis: No. The licensing arrangement allows for the state to own it and for the state to further negotiate that licence to be extended to other WA Health sites.

Ms J.M. FREEMAN: Okay with no restrictions on that and no factor that you are going to have to pay extra costs to transfer that over to other areas?

Mr Nunis: Only in the negotiation with the vendor.

Mr R.F. JOHNSON: So there will be costs?

Mr Nunis: If you are going to extend it. So, if they have licensed Fiona Stanley Hospital only and normally the licensing arrangement for a site—say we want it to go to Sir Charles Gairdner Hospital—they will say it is an additional licence cost. That licence cost —

Prof. Stokes: That is very standard with all ICT applications.

The CHAIR: Can I ask you, Brad, you talked about Fiona Stanley Hospital, basically, ICT specifically for Fiona Stanley Hospital and then other ICT for other parts of Health, not just Fiona Stanley Hospital. So, what are we talking about here for the rest of the health system so far as the ICT that Department of Health is solely responsible for as distinct from Serco and Fiona Stanley Hospital?

Mr Nunis: Out of the 48, if you take out closed loop and ICU, the remaining are all done by the Department of Health.

Ms J.M. FREEMAN: Yet, there were more than that came in the Serco tender.

Mr Nunis: There were nine packages, but four packages related to closed loop only. So, automated medicine units. There were smart carts. There were the robots. They all form the closed loop package. So, system integration was another panel. Oncology was another package. There were nine packages in total.

Ms R. SAFFIOTI: Should we go through each of the packages or did you want to keep going on the closed loop?

The CHAIR: Just one more. Is it fair to say that by managing the procurement in-house the Department of Health has retained the risk arising from delays of rolling out systems. In other words, not being able to transfer the risk of delay to private partners through the use of financial incentives? It is, basically, you carry this for the delay?

Mr Nunis: I can answer that. In terms of the way the health information network are structured, there is a hybrid of different models.

The CHAIR: That makes it difficult, does it not?

Mr Nunis: Yes. One is there is in-house development. So, that is on some of those systems developed in-house. Another one is to procure an external application. Our webPAS—patient administration system—is one of those procured externally, but the licences come on board and the risk of implementing remains with health. Then the third model is you outsource the whole thing. So, ICU is probably going to be that outcome where we put the risk on the vendor to deliver based on the set of requirements for Fiona Stanley Hospital.

Ms J.M. FREEMAN: When you talk about the vendor, is that like another—that will not be Serco; that will be another —

Mr Nunis: IBM or a technology company.

Ms R. SAFFIOTI: I was just thinking, because I was just trying to go through the six that were identified. So, with closed loop you basically knew in November, went out to tender in January, and the successful tender is being announced. It will take about 12 months to develop the system and to implement it and you hope there is no delays there.

Mr Nunis: I put a clause on the 12 months. We have not sat down and worked out the time frame of it, but, generally, it would be that because there are some interfaces with our existing system. So, closed loop, for example, is interfacing with iPharmacy. That is the drug request process. So, some of those other interfaces we need to undertake as well but in general software implementation it takes that time.

Ms J.M. FREEMAN: Can I just interject with a question? Given that this is quite timely talking about medication and it takes us off a bit about the costs, but given today's reports about misuse of drugs in hospitals, will this our process, be able to limit that? Is this a process that will give you greater surety around those sorts of things?

Prof. Stokes: It gives greater security about drug security and the ability of staff and others to obtain illegal drugs and also improves patients safety. The exact doses are given, the exact time, and so forth and so on. So, it will produce another layer. Already the drug system process in hospitals is very secure, despite the sadness that occurs every now and then because someone has access to a drug cupboard.

Ms J.M. FREEMAN: Or in the case of a woman who was in one of the country hospitals who was administered medication that she should not have had. Will this be able to address those sorts of issues?

Prof. Stokes: Theoretically it will, but that's one of the problems with that particular case and it is before the court at the moment and, therefore, what I am saying a confidential thing. But,

unfortunately, that drug does have a sulfur radical in it which very few people know about, and if you look up the literature about it, it does not talk about it.

The CHAIR: It does not talk about it, does it? I looked it up the next day and —

Prof. Stokes: Yes, exactly right.

Ms J.M. FREEMAN: Anyway, I made us digress.

Prof. Stokes: I am not sure whether this system would even pick that up, quite honestly.

Dr Russell-Weisz: I think generally where I have witnessed this working is if you take back 25 years when I was in intensive care, when you were doing—you wrote them in 20 years ago. Now you have written-based charts. This is a decision-making tool for clinicians, electronic and it stops people misinterpreting dosages or drugs. It still relies on the consultant, the registrar or the consultant making a call, because the consultant and the doctor should still have the ability to say, "No, I am going to prescribe this drug for this patient for this valid clinical reason," but it stops the errors happening through a paper-based system and it allows drug interactions to be shown. So, it is very much about medication safety.

Ms R. SAFFIOTI: So back to closed loop. There are two parts of it—the oncology application—what are you guys going to be doing with that now?

Mr Nunis: That was registered, so that is not going to be implemented in Fiona Stanley Hospital from day 1.

Ms J.M. FREEMAN: So it will still be paper?

Mr Nunis: It will still be paper until such time Health decides on what it wants to do with its oncology and information systems.

Prof. Stokes: The clinicians will decide that issue.

Ms J.M. FREEMAN: Why did you decide to reject oncology?

The CHAIR: What was the impediment there? What was the issue?

Mr Nunis: I was not part of the evaluation team, but in terms of the requirements, it just did not meet the requirement. There was only one vendor, I think, that submitted.

Ms R. SAFFIOTI: Okay, so the oncology application software is not happening from day 1 as part of this project at Fiona Stanley Hospital. So, that would have seen, just to clarify, the automated—what exactly was it? I ask the question.

Dr Russell-Weisz: Very similar to ICU, it was a clinical information system. So, similar to a medication management system but where the ICU system in the analysis—I also was not on the evaluation panel, but the analysis was done by will the clinicians and it was felt that it made the requirements. Oncology at the time did not. It does want mean that it will not go in day 30, day 60 or a few months down the track, but what we have tried to do, and have done, is lock down the scope of ICT systems to say you have got 48 systems going in, these are the time frames for these systems. There is no more core systems going in and this will make the date in October 2014, noting we also have—I think we talked about last time—smaller systems that clinicians will bring with them that we also need to put in as well.

Ms R. SAFFIOTI: So the other package that was rejected was systems integration. What impact does that have?

Mr Nunis: That in essence is one or many vendors who have the capability of doing interface work and again the requirements, for what reason I do not know, were not met in terms of the submissions that came forward.

Ms R. SAFFIOTI: So what impact will that have on how the hospital will operate?

Mr Nunis: Nothing at this point because once we have a discussion with the preferred vendors, then we will talk to them about system integration and they will bring those services as part of their risk.

Ms J.M. FREEMAN: Why, as the executive director of ICT, do you not know why it was rejected?

Mr Nunis: Because I started in health on 2 April this year.

Mr R.F. JOHNSON: That is not good enough!

The CHAIR: You should have been here earlier.

Prof. Stokes: I started on 18 April.

The CHAIR: You are not filling us with a lot of confidence!

Ms J.M. FREEMAN: Is that part of the delay? We have just not had the expertise in there that—we have taken on this grand idea of how we are going to run this hospital, but we just did not have the expertise that we needed to deliver?

[12.15 pm]

Dr Russell-Weisz: If you look at the hospital from my perspective, it is a complex environment; it is a different environment. We have not built a tertiary quaternary hospital in this state for the last 50 or 60 years from scratch. The last one was in 1958—A-block at Charlie's. That was the chest hospital in those days. This is probably the most complex hospital in Australia, if not in most areas of Europe as well. It was complex. The ICT environment was complex, and I think there was a tremendous amount of work on all those facets of commissioning done up to date. But when we got to the stage of what was critically important for the new hospital, closed loop was one of them, but I do not really want to put everything on closed loop because it sounds as though all the issues revolve around closed loop; they did not. There were a number of other systems that Giles has mentioned that we needed to upgrade, and also we needed clinician interaction to make sure that we had enough testing and training time for the clinicians who were coming on board in what is a very new infrastructure environment.

Ms R. SAFFIOTI: Let us go to the second system. There were six new systems. We have done closed loop. Number 10 is the ICU system.

Mr Nunis: ICU is on a similar time frame.

Ms R. SAFFIOTI: It is a similar time frame, so you have gone out to tender.

Mr Nunis: Yes. That was part of the package that Serco went out with; that was one of the nine packages. That is going concurrently with closed loop.

Ms R. SAFFIOTI: So, again, you expect to announce that in the next two or three weeks with that time frame. Number 32 is the next one.

Ms J.M. FREEMAN: Is number 14, the patient flow–service monitoring analysis response tool, not a new system?

Mr Nunis: That is a new application, but it has been built in house. We did not go to the market to procure it; we have set our requirements and done the design and the development work within Health.

Ms J.M. FREEMAN: Out of the 48 systems you went through, 17 were existing ones and then you said that there were a few that were not. Number 14 is a new system as well.

Mr Nunis: It is a new system.

Ms J.M. FREEMAN: What is the time line for that?

Mr Nunis: That one is on target to be completed before the end of this calendar year.

Ms J.M. FREEMAN: Why did you not go out for that one?

The CHAIR: They did not; that was an in-house one.

Mr Nunis: It was an in-house developed one. It was something specific to Health.

Ms J.M. FREEMAN: To be used across all the hospitals or just Fiona Stanley?

Mr Nunis: It starts at Fiona Stanley. Once you set the footprint for Fiona Stanley, you should be able to roll out to the rest of Health as time goes on.

Ms J.M. FREEMAN: So Health will be the vendor, or will you still send that out? It will not have that intellectual property issue about vendors.

Mr Nunis: No. The state will own the intellectual property. It has its own software development house that has developed that.

Ms J.M. FREEMAN: If it owns the intellectual property on that, does that mean it can sell that to other states?

Mr Nunis: Under the State Trading Concerns Act, yes.

Ms R. SAFFIOTI: I will just go through the six new ones. We have done —

The CHAIR: Number 40, is it?

Ms R. SAFFIOTI: Yes, we went through them. Number 32 is eCredentialling.

Mr Nunis: This application is about credentialling clinicians prior to coming on board. Again, this is on its last legs of implementation. It is a smaller application. I do not think this will take anywhere near 12 months. It is quite a simple application, so it should come on board hopefully in the next month.

Ms R. SAFFIOTI: So that is not a big issue.

The CHAIR: So what does that do—just checks the doctor's bona fides?

Prof. Stokes: And also their scope of practice.

The CHAIR: It is a bit like the medical board registration.

Prof. Stokes: Yes, but also scope of practice. If you are a surgeon, these are the things you can do, but you cannot do other things.

The CHAIR: That is not a big body of work.

Prof. Stokes: No.

Ms J.M. FREEMAN: Does that mean they will have a swipe-on card to show whether they can go into certain parts of the hospital or anything like that?

Mr Nunis: We will link their credentialling capability with their profile, but it will not link to security necessarily.

Ms J.M. FREEMAN: But other workers, other than doctors and nurses, will have a swipe-on card that they have to go through.

Mr Nunis: All doctors and nurses will have a swipe-on card, yes.

Ms J.M. FREEMAN: Everyone in the hospital will have a swipe-on card.

Mr Nunis: Yes.

Ms J.M. FREEMAN: Does something like that mean that if you e-credential staff, they will not be able to go into certain parts; for example, nurses will not be able to —

Prof. Stokes: No. This is clinical practice, not area attendance.

Ms R. SAFFIOTI: Is number 40, the health records management and scanning and e-forms, one of the other ones?

The CHAIR: Yes, the neighbouring systems.

Ms R. SAFFIOTI: How is that system going?

Mr Nunis: Fiona Stanley is proposed to be a digital hospital as much as possible to get rid of the paper-based folders or files of health records. Part of the scanning requirement is essentially scanning existing records for patients and also for patients who come from non-digital hospitals when they transfer across. That is the reason for the scanning. The e-forms relate to recording their diagnosis and the like by clinicians, who put that into an electronic file. That is on a slightly different time frame, so that procurement commenced on 13 March this year when the tender was advertised. It closed on 12 April. The evaluation was completed on 17 May and we are currently in contract negotiations with the preferred supplier.

Ms R. SAFFIOTI: So, again, is 12 months the estimated time of system development?

Mr Nunis: In terms of scanning and putting in a basic electronic health record, I would anticipate that we should do that within less than 12 months. However, there are quite a number of forms in Health and to work through those hundreds of forms and get them down to a smaller number is a clinical dependency from my point of view. In essence, I would think it will probably be about 12 months in the end.

Ms R. SAFFIOTI: What are the other new ones? I have gone through four; there are another two.

Mr Nunis: The other one was scheduling. We were also looking towards Serco proposing to do scheduling for and on behalf of the state.

Ms J.M. FREEMAN: What number was that?

Mr Nunis: It actually is not in here. We moved that scheduling component into an existing system, webPAS, but it is a new function within webPAS. That basically allows for the scheduling of outpatients and also elective surgery scheduling.

Ms J.M. FREEMAN: WebPAS has not had fantastic success itself, has it? WebPAS has been questioned by the Auditor General over periods of time. Is that right or am I making it up?

Mr Nunis: I cannot comment on the finances part of it, but part of its implementation has been very good.

Ms J.M. FREEMAN: It was the finances, was it? Okay.

Ms R. SAFFIOTI: So webPAS is on schedule.

Dr Russell-Weisz: Yes, and it is already deployed at Fremantle.

The CHAIR: What does webPAS scheduling mean?

Mr Nunis: It relates to scheduling, booking and making appointments for outpatients and it also has an elective surgery capability.

The CHAIR: That is not in this list.

Mr Nunis: It is within webPAS. It is a new function within Health.

Dr Russell-Weisz: We have had other outpatient systems that you can schedule. This is an overarching scheduling system, so you can see that you are not double booking patients for theatre and outpatients at the same time. It is actually an overarching system. WebPAS had the functionality to provide it, so we went for webPAS because we had the system in place.

Ms R. SAFFIOTI: Of the 48, we are focused on the new systems. Are any of the remaining ones experiencing significant delays and causing risk in relation to the deferral of the opening date?

Mr Nunis: Every application always has the element of risk attached to it. In terms of us meeting the timetable that has now been set for October, we are very much on target for that. We are looking towards all 48 applications being ready and available in July 2014. There are a couple of reasons for July 2014. First, there is an extensive training program required of the clinical staff coming on board; that is quite a large number of people. Secondly, you would normally book patients and line them up for 1 October, so you would do that obviously before October when they all start rolling in. Thirdly, it gives us the opportunity to do testing of the applications during those last months to make sure that they pass the clinical safety test.

Ms R. SAFFIOTI: What certainty is there with the October date? Given that you have just gone to the market and you are just about to start system development of one of the key systems, are you currently running any risk analyses of a 50 per cent chance of starting in October? We have an issue with Serco now, because we said definitely 1 April 2014, and there is going to be a significant delay and it will cause significant cost. Do you have a percentage or a risk profile of a 50 per cent chance of opening in October and how does that impact on the new negotiations with Serco?

Dr Russell-Weisz: I would say we are much higher than that. As Giles has said, we are aiming to get all these systems in for July next year. Then that allows some teaching and training. It also gives you some contingency if you hit a problem in that time. This is not every system coming on for July next year. If we can sort out a system now, which we are, we bank the system, it is done, it is away and we train people on it. They are already trained on some systems, because out of the 48 there are quite a few legacy systems that are just coming over. I am very confident that we will meet the October 2014 deadline, because we have built in some time to train the staff. This is not just about getting an ICT system and saying that we have got it; we actually need the time to train staff on it and that allows us to do that. Barring any major glitch with any major system, we are on track.

The CHAIR: With that training, obviously on 1 October, you are not going to have a 100 per cent occupancy rate on day one, and you have to train your doctors and the clinical staff to use all this stuff, so there might have to be a staged thing. How are you going to do that?

Dr Russell-Weisz: I will comment on this first and then I might ask Giles to comment on it. We have done a number of things first of all. Firstly, we have set up the test lab at Fiona Stanley. We are setting up a mock patient area with all the ICT systems on it. But to get away from the ICT systems, we have put a considerable amount of effort into workforce recruitment. We have got the senior clinical executive already appointed. Since the last meeting here, seven out of the eight co-director appointments—that is the clinical nursing and allied health appointments—have been done and they are on board. We are doing a raft of other heads of specialty advertisements at the moment and interviews. We have already done the first tranche; appointments are ready to be made. We are not delaying the tier 2 and tier 3 staff on board. They will then recruit the nurses, allied health and doctors to come on board. We will then set up a process for training those staff on the systems that are already banked and online. But we expect by mid-August to have a very robust test lab at the site, so when clinicians come on board—some of the senior ones have already seen this—they see these systems live and how they will work. I might ask Giles to comment on how the test lab will work.

Mr Nunis: It is difficult to implement technology in an existing site with existing practices. We are implementing technology at a new site with new practices and new people. It adds a lot to that complexity. We have engaged a lot of people to look at the clinical work flow and prescribing all those, and we are working with the clinicians and getting those work flows established. That will be the baseline for two things: one is for testing and the other is for training. As soon as we start to bank these systems—I do not think ICU will do that in the next few months, but let us assume that it will—there is no reason why we could not commence some of that training as soon as possible, recognising the fact that it might be 12 months out and we will have to do them again, but mainly because I think it is quite a significant change to introduce.

Ms J.M. FREEMAN: How long will you have staff employed at that hospital before you start having patients?

Dr Russell-Weisz: We will have the co-directors employed, but not full time. There is a doctor and a service co-director of four divisions. They will be employed in differing amounts because they have clinical work at the moment. But they will be the leaders of their division. Some will come on at 0.5 of their time and some will come on at 0.1 FTE or one session. With the heads of specialty, it really depends on which specialty. If it is imaging—imaging is critical to the hospital—I would expect to bring those staff on board early and have a good component of their time. I am really making no excuse about getting the staff I need on board very early on because they have to not just live and breathe the ICT systems, but walk the hospital and see whether the flows work and whether there are any things that we have not seen. If you look at any of the evidence about commissioning any hospital, there are things that you will discover up until day one and even after day one. Everything that is driving us is patient safety. We want to be absolutely sure that things work. We want these senior clinical staff on board because they will then help us recruit the next tier of clinical staff and then all the clinical staff to different wards.

[12.30 pm]

We now have a ward structure. We know what is going into each individual ward. Even at the moment we are making slight amendments to the infrastructure when we see that things may not work as well as they were originally planned to work. This is an intricate process but we need clinical staff on board early, and that is why we are doing all these appointments.

Ms J.M. FREEMAN: You almost have a disconnect because you have all these clinical staff and the staff you directly employ and have control over and you are able to bring them on as a 0.1 full-time equivalent or whatever to get the hospital running, but there is a disconnect because you have a contractor who will suddenly pop into place. Will they bring it on gradually or will they start staff gradually? When will Serco employ its staff so that they know all the systems and processes? Will the Serco staff start two weeks before the hospital takes its first patient or will it be three or four weeks? Obviously they will be paid in that time.

Dr Russell-Weisz: Obviously Serco has some staff on board already on all the work they have been doing, but since the decision was made to delay the commissioning, as we stated last time, they have to mitigate the cost to the state, and that is what they are doing at the moment. We are in negotiations as we speak. They have already delayed a certain number of staff coming on board. What we are working through now is a re-profiling of what that pre-operational transition period would be and when we need staff for specific buildings. As you would know, the phasing was not envisaged, but we chose to phase because of patient safety. You want them to look after the site, whether or not you have patients, but you would not expect them to bring on staff to do the linen services, and that is what we are working through at the moment.

The CHAIR: Russ, how do you phase in your emergency department? What do you do there? Do you say that on 1 October you will take all the ambulances or do you just take a few of them? How do you do that?

Dr Russell-Weisz: The phased commissioning is actually four stages of hard commissioning. We are not phasing in the emergency department. Phase 1 is the rehab, and that is a hard commissioning. We will move over a period of between 24 and 48 hours. That is what we are working through at the moment. State rehab involves moving 140 beds and moving one group of patients to another.

Prof. Stokes: It is at that point that we have to make sure that all the communications systems are working, radiology is working and the lights are working and those sorts of things. That will be a very important test bed because the acuteness there is not quite so great as it is with other areas.

Dr Russell-Weisz: Certain services on the site will be provided by the state and certain services will be provided by Serco. We will be able to test how the hospital is working. Phase 2 is the back-of-house phase. There will be a medical ward, a surgical ward and some ICU. Again, I make no excuse for wanting the back of the hospital flows to be tested before we open our ED. When the emergency department opens, it will not be a phased opening; it will open overnight and it will be fully open. All the medical surgical wards will be fully open a few days or a week before that, so we will be able to take the emergency department load.

Prof. Stokes: There will be some elective surgery before there is an emergency service, because that is essential.

Dr Russell-Weisz: Phase 4 is what I call the super quaternary services like burns, cardiothoracics, when you need everything working. Basically, at phase 3 we would expect to have 90 per cent of the hospital open. Phase 3 is the emergency, medical and surgical departments. Phase 4 is the small but very critical low-volume but high-acuity services.

The CHAIR: I would like to ask one more question and maybe we should move then to a closed session. Going back to the ICT infrastructure, obviously a significant body of work has been done, particularly in some areas. It has been reported in the media that Treasury has been responsible for delaying making money available for the procurement of the ICT infrastructure. Is that true; and, if it is true, what were the reasons Treasury gave for delaying the payment, and have you got over those problems?

Dr Russell-Weisz: No, there has been no delay in the ICT procurement in relation to Fiona Stanley Hospital. Under the leasing facility, there has been no delay in that respect.

Mr Salvage: There was a very clear decision through the 2012–13 budget process to allocate $150 million over two and a bit years, with $60 million in 2012–13 and $60 million in 2013–14. It is very clear that that funding was allocated predominantly for the commissioning of Fiona Stanley Hospital, plus also the service delivery through the Albany Regional Hospital.

The CHAIR: Can you give us a breakdown of that $150 million? How much went to Fiona Stanley and how much went to Albany?

Mr Salvage: We could give you that information on notice, but the decision of government was very clear that that funding to Health—$60 million last year and $60 million this year—is tied to the commissioning work of Fiona Stanley Hospital and Albany Regional Hospital. The significance of Albany is that it is part of the testing of the systems that were eventually going to Fiona Stanley Hospital.

Ms J.M. FREEMAN: Was it enough?

The CHAIR: You said "tied" to the commissioning; was there any push back from Treasury saying, "This process of commissioning is out to here," and Treasury is concerned about the spending of the money?

Mr Salvage: They were clear that they wanted that money that came to the Department of Health deployed to the priority projects, which were Fiona Stanley and Albany Regional Hospital.

Ms R. SAFFIOTI: Can I ask one last question before we go into closed session? We talk about Serco and the mitigation of costs. Is one of the clear issues that because 28 services have been contracted out and Serco is, in a sense, the head contractor and is subcontracting to other companies—I think linen is the example where Serco had a contract with a linen producer and that linen producer probably built factories, or whatever linen producers do, so it is a flow-on effect in is sense, is it not? The mitigation will be the issue that you have subcontractors that are operating on a 1 April start date, or a bit before that, and Serco is in the middle of it and there is Health at this end. As part of these mitigation discussions, or discussions with Serco, to determine what penalty the state government has to pay, one of the reasons is that, in a sense, there are many other players

involved who have been making decisions on capital and operating investment on the 1 April start date.

Dr Russell-Weisz: In general terms—we can probably take this in closed session—there is a cost mitigation pass through to the subcontractors. Serco has to mitigate and so do their subcontractors.

The CHAIR: May be the member can ask more about that in a few minutes.

Ms R. SAFFIOTI: Okay.

Ms J.M. FREEMAN: Just getting back to the ICT and the amount you got from Treasury, was that enough?

Mr Salvage: It has been enough this year. I do not know what the final figure was for last year, but we certainly spent what was in the budget.

Ms R. SAFFIOTI: You might need some more for 2014–15, given the delayed opening.

Mr Salvage: 2014–15 is another year and we do not actually have any provision for ICT funding in 2014–15.

[The committee took evidence in closed session]