

CORRECTED VERSION

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospitals performance data

Melbourne — 18 August 2009

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Dr G. Lane, consultant physician.

The CHAIR — I welcome Dr Garry Lane, a consultant physician at Western Health. All the evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the Legislative Council standing orders. Any comments made outside the precincts of this hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard, and you will be provided with the print version of the transcript in the next couple of days. I now ask you to make an opening statement, if you wish, then the committee will ask questions.

Dr LANE — Firstly, I would like to thank the committee for the invitation to give evidence to this inquiry. I would also like to clarify my position and interest in relation to this inquiry. Although I am an employee of Western Health, I have not made my submission to this inquiry as a nominated representative of Western Health, but because of my personal professional concerns that the highest achievable levels of patient safety in healthcare, and specifically in public hospitals, should be reached.

Following substantial clinical experience within the Victorian public hospital system, I wish to provide emphasis to several areas of hospital performance where I believe that changes are required to further improve the risks to patient safety, and the overall level of quality of health care in public hospitals.

I am not suggesting that further improvements in patient safety and quality of public hospital performance will be easy to make, nor that those currently working at a government departmental, academic, or health service administrative level are not doing their best to improve processes. However, the level of process change that is required to achieve further improvements in some of these areas is beyond the power of most individuals and will usually require additional resourcing. There also needs to be greater transparency and greater involvement in high-level quality improvement activity by representative, currently active clinicians who are frequently dealing with the practical problems on the wards, emergency departments, clinics and operating theatres of our public hospitals.

You will have had the opportunity to read my written submission to the committee from December. In addition to this, I would like to expand on several matters of concern which I raised. With regard to accessibility or ‘access’ to services within public hospitals, there are several aspects that require clarification.

Firstly, while accessibility to hospital services is an important dimension or ‘domain’ of the larger entity of ‘quality’, it is critical to place ‘access’ into its appropriate place within the broader context of quality. Indeed, it is important to appreciate all the domains of quality that exist in the context of healthcare occurring in the Victorian public hospital system. An Australian and Victorian version of these domains is displayed in the accompanying slides and appendix.

As important as it is, access remains just one aspect of quality, and arguably the disproportionate emphasis that DHS, politicians and the media have given to it often distracts public and political attention from problems existing within other domains of quality. This in turn often adversely affects patient safety.

As an example, this disproportionate emphasis is reflected by the existence of financial penalties imposed on health services for failure to meet key performance indicators related to access but not to other quality domains. It is further reflected by the Victorian government’s submission to this inquiry under its section on ‘Performance reporting and data’ on pages 66 to 68, in which ‘access’ has actually been split from ‘quality’. It describes how key performance indicators are used to report on what it sees as the ‘three broad measures’ in relation to the performance of health services: access, quality and financial.

Secondly, while the government has set a target for the major metropolitan hospitals to spend no more than 3 per cent of time on bypass, and time-based targets regarding access for patients attending emergency departments and awaiting elective surgery, there are no such targets for other important areas of access to medical care in public hospitals, such as the time taken for requested inpatient consultations and specialised investigations with other sub-specialities to occur for admitted patients. These latter interventions are also important factors that affect both the safety of patients and the efficiency with which they are managed.

Furthermore, there are no time-based targets regarding access for patients to the outpatient departments of public hospitals. This must include the time taken for patients from the community to be allocated an outpatient appointment after one is requested by their referring practitioner, a proportion of which are inordinately delayed, and the time for this allocated appointment to occur, again with a sizeable proportion having long delays.

Indeed despite all the recommendations contained in the extensive 2006 report of the Victorian Auditor-General, *Access to specialist medical outpatient care*, a copy of which has been provided, the quality of care provided in Victorian public hospital outpatient departments has seemingly had minimal improvements instituted and remains a major issue for the welfare of patients and obviously requires major additional resources.

Thirdly, regarding a specific aspect of access, I wish to draw specific attention to the problems of inadequate availability of gastrointestinal endoscopy services within Victorian public hospitals. The Australian national bowel cancer screening program, which commenced in 2008, is a program which, as part of its planning design, had already deliberately limited the potential number of patients screened because of concerns about insufficient capability for follow-up — namely, colonoscopy — by only offering testing to people turning 50, 55 or 65 years of age between January 2008 and December 2010.

Not only is the Victorian public hospital system for colonoscopy inadequate in promptly servicing all these patients, it remains unable to provide a reliable service that can promptly diagnose colonic and gastric tumours in even patients at higher risk patients of cancer, namely those with iron deficiency anaemia in men and non-menstruating women. This reflects the need for increased access to public hospital gastroscopy as well as colonoscopy services.

Finally, in relation to access, in 2009 while most health services have already instituted repeated measures to become as efficient as possible, specifically rationalising their own resources and management processes to make significant improvements in many areas of quality, they have very limited further capability to improve access unless there is improved resourcing, including the prompt and equitable development of appropriate infrastructure.

With regard to quality of care, an important methodology in assessing the quality of health care is the use of ‘clinical indicators’. Although these have been defined in several ways, in 2003 Mainz — and the reference is given — said that:

Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritisation in the health care system. To ensure that reliable and valid clinical indicators are used, they must be designed, defined, and implemented with scientific rigour.

The Victorian DHS has chosen 11 clinical indicators to address patient safety. These were chosen from the sets of the Australian patient safety indicators and Queensland Health, which are listed in appendix 2. It is notable that several clinical indicators of patient safety contained within the list of Australian patient safety indicators have been omitted from the Victorian list.

These include those related to decubitus, or pressure ulcers; failure to rescue patients — that is, failure to prevent a clinically important deterioration, such as death or permanent disability from a complication of an underlying illness and failure to rescue those patients who have acute renal failure; deep venous thrombosis; pulmonary embolism; pneumonia; sepsis shock or cardiac arrest; gastrointestinal haemorrhage or acute ulcer; pneumothorax, or collapsed lung caused by medical care; post-operative respiratory failure; post-operative sepsis; post-operative abdominal wall wound dehiscence or breakdown, accidental puncture or laceration; transfusion reaction and birth trauma resulting in injury to the neonate. All these are major areas of risk to patient safety. One of the main factors which makes it difficult to reliably collect data to measure these clinical indicators is the absence of a reliable comprehensive ICT system.

The implementation of an appropriate ICT system is crucial to improving patient safety and most of the other domains of quality within the Victorian public health system. Not only would it provide safer and more efficient methodology for enabling specific direct patient interventions, such as drug prescribing and administration, ordering and review of pathology and radiology investigations and clinician administrative tasks, it would also allow for the creation of additional — as well as the continued and more reliable use of — current indicators, whether clinical or otherwise, and allow these to be used to monitor and improve the quality of health care.

HealthSMART is the system which was chosen by the Victorian government to fulfil this need. However, there are major concerns among active clinicians within the public hospital system regarding the ability of HealthSMART to meet their requirements, its reliability and, in particular, the capability and slow implementation of its clinical systems component.

In addition to this local clinician concern and recent concerns reported in the media about the capabilities of HealthSMART to deliver on what was initially promised in the UK as well as Victoria, further concerns were reported by the Victorian Auditor-General's report on Victoria's ICT change program in April 2008, a copy of which is provided. It included the following findings. On page 2:

The ICT implementation most at risk is clinical systems, the application with highest potential benefit.

On page 27:

Failure to implement clinical systems is a serious issue for DHS and the health sector in terms of delivering the expected outputs and benefits of the HealthSMART program.

On page 6:

The ability to plan and accommodate HealthSMART costs is dependent on the viability of individual health agencies. While some agencies have sufficient reserves to pay for their share of implementation expenses and ongoing costs, others have struggled.

Adequate funding of ICT infrastructure within health agencies is an ongoing challenge within the sector, as ICT competes for funds with general medical equipment, which is given priority due to its clinical 'patient facing' usage.

If the past patterns of ICT underinvestment continue, some agencies will not be able to keep their infrastructure up to date and are at risk of not fully benefiting from the investments made through the HealthSMART program.

On page 9:

DHS, in collaboration with implementing agencies, should review the benefits received from the implementation of the HealthSMART program. This review should focus on whether:

the applications and ICT infrastructure are operating as planned,

benefits are being realised,

ICT systems and infrastructure are providing the expected functionality, without any negative impacts.

With regard to resourcing, it should be noted that the WIES method for determining the level of payment to a health service for a patient's inpatient episode often fails to allow those patients who are unable to undertake usual activities of daily living, or ADLs, without the assistance of others. This is commonly relevant to elderly patients who are admitted to hospital with multiple health problems. Studies have shown that health costs were substantially higher for patients dependent in their ADLs on admission compared to patients independent in ADLs on admission. This failure to allow for lack of independence in ADLs means that health services have to provide the increased necessary services without reimbursement. Thank you.

The CHAIR — Thank you, Dr Lane. I would like to ask you firstly about something you mentioned on the first page of your written submission, where you stated:

The emphasis of the Victorian public hospital performance data on logistics at the expense of assessing whether investigations and treatment are appropriately provided, is diverting the focus of resources of hospitals from efforts that are more likely to affect patient outcomes ...

How would you see the collection and reporting of clinical data improving hospital outcomes? Is it in the sense of monitoring by DHS? Is it in the sense of tying it to financial incentives? Or is it to close a loop on clinical performance by doctors, self-assessing effectively? How do you see that data providing those improved outcomes?

Dr LANE — Until you know the outcomes exactly and precisely you are not going to know what areas are required for improvement. Although some outcomes can be collected through a paper-based system at the moment, without improvement in ICT, particularly a fully functioning electronic medical record, a lot of data will be lost in the system, and, therefore, a lot of outcome data will be lost.

Quality is sometimes difficult to measure, but the clinical indicator system — although it is not the be-all and end-all and only forms one part of the assessment of quality — is heavily dependent on either outcome data, which is arguably preferable, or process data. Without knowing precisely what the outcomes are, people are not in a rational position to suggest changes to processes which can improve the quality.

The CHAIR — So you see it largely as an internal tool for quality improvement?

Dr LANE — Internal to health services?

The CHAIR — Yes, internal to particular health services.

Dr LANE — No, not at all. I think health is so important that it cannot just be left up to individual health services to determine their own quality agenda. I think DHS has tried hard to make marked changes over the last five years or so in that regard, but the system is really struggling in the deficiency of not being able to capture all the relevant data as it is occurring because it is paper-based, predominantly.

The CHAIR — I guess I am making a distinction between data that is collected for the purposes of the *Your Hospitals* report — that macro data that you referred to in your introductory statements — and data that is used internally within a health service by clinicians to improve practices. They are very different datasets and presumably the material that is reported through the *Your Hospitals* report is not much use to you as a clinician?

Dr LANE — That is because the initial set of material, the stuff that is presented through the hospital report, is easy to collect. That is why it is being collected — because it is easy to collect. I am not saying that it is bad to collect, but I am saying it is very easy to collect. There is a whole array of clinical data which is much more difficult to collect while the system is paper based, and without that data we are struggling to judge what needs improvement and what does not need improvement.

We have to come back to qualitative sources of data such as adverse outcome committee inquiries within the individual health services and sentinel events as they are reported to DHS. They are largely qualitative. Most of those do not have a numerator and a denominator, or they certainly do not have a denominator.

The CHAIR — I accept that point. One of the issues that has been raised with us is the need to provide funding in order to collect that qualitative clinical data. How would you see that work? Is that something that needs to be built into WIES?

Dr LANE — I know it sounds repetitive, but the only way I can see to collect all the necessary clinical data is to have a proper electronic medical record.

The CHAIR — I understand you need the IT platform but do you also need direct funding at the health service level? We have heard evidence this morning as to the effectively administrative burden of developing and maintaining records, and that is where my question is leading. It is an issue distinct from having an overall IT platform.

Dr LANE — From my experience, the amount of resources given to information technology within individual health services is woefully inadequate and not only at the health service I work at. Based on reports of colleagues at other health services, they are in much the same position. It leads to a lot of frustration and exasperation on the part of clinicians and administrative staff, with frequent breakdowns from just not having enough resources within the IT department for individual health services to keep it functioning smoothly.

The CHAIR — And in your experience at Western Health, does Western Health use HealthSMART?

Dr LANE — We use several components of HealthSMART. I do not propose to be an expert on all aspects of HealthSMART, but my understanding is we use the human relations aspect, the financial and logistics ordering aspects, and recently we have introduced the patient management iPM aspect. We have not yet implemented the clinical systems.

The CHAIR — And is the patient management aspect working satisfactorily from a clinician's point of view?

Dr LANE — I do not purport to be an expert on the exact status, but there have been reports of several difficulties with patient management or iPM, including some interfacing problems with other software, for example patients on operating lists being 'lost': if they have attended a pre-admissions clinic, for some quirky reason they drop off the waiting list. That is not through anyone's deliberate fault but for all intents and purposes it seems to be a fault of the software. There have been some problems with invoicing, and based on reports from just generally speaking to people, clerical administrative people particularly have had more than just a couple of problems with iPM.

Mr HALL — Thank you for your time with us this afternoon, Dr Lane. I gather from some of your comments today about the time taken for patients from the community to be allocated an outpatient appointment that you would therefore see the publication of waiting times as well as waiting lists to be an important thing that should be occurring?

Dr LANE — It could be one aspect. What really needs to be looked at is why it is happening. I am reticent about putting out a league table of waiting times for outpatients like I am reticent about having a league table for complications or issues with patient safety at hospitals, because it is usually presented as non-stratified data where it is done by people who do not have the full knowledge of the levels of risk of the individual patient and where data is all aggregated together and is not able to be analysed in a proper manner.

Mr HALL — I take the point that I think you made both in your submission and today that the quality of care is important. But is timeliness not part of quality as well?

Dr LANE — It is. If publication can somehow magically improve waiting times without doing anything else to the infrastructure of outpatients, that is fine, but I doubt that is going to happen.

Mr HALL — You spoke about the bowel cancer screening program by way of example and suggested there was insufficient capability for follow up. Are there waiting times for procedures like colonoscopies for example? Is that sort of information publicly available?

Dr LANE — So far as I know it is not publicly available. No.

Mr HALL — So there is no separation of procedures, for example, for such cases?

Dr LANE — I do not think so, but I could not swear to that.

Mr HALL — You spoke, as many others have, to this committee over the last two days about the need for improvements in the ICT system and the importance of getting fully electronic medical records happening across the whole system. In terms of the priorities that you see of the need to address deficiencies in the health system where would you rate an improvement to the ICT system?

Dr LANE — No. 1.

Mr HALL — No. 1?

Dr LANE — For a variety of reasons. It is actually much easier to find the data you want, whether it is clinical data as in entries into the patient's record by clinicians, results that have been done or that are planned to be done. By the way, it also forces doctors to write in the medical record. Sometimes it is very easy to have a problem of inadequate documentation within medical records, but if it is electronic, it is there for everyone to see. If you have not done it, then it is obvious.

It is also much easier in retrospect if people coming along to consult on patients can find out very quickly all the things that have happened in the recent past. With a written record which is often indecipherable, it is very difficult to be sure what happened two weeks ago if the patient has been in hospital for three weeks, four weeks or longer.

Mr HALL — And such a system should be extended across both the public system and the private system?

Dr LANE — I think the system should be national. Honestly I do not see the point in every state having a different electronic medical record system. I know there are issues with privacy et cetera, but honestly, until there is a proper electronic national system with links between private, public and between states, we are going to go on with this system of duplication of results — as the previous speaker was addressing.

We are going to go on with sometimes unnecessary investigations. It would just make it so much easier if the data and the information that we need or that has been generated is readily available — and follow up of patients and continuity of care. People who come into the public hospital system go back to their family doctor with or without a discharge summary — it may or may not happen — but if everything was electronic and online, and if the family doctor had access to those records, there would be far greater continuity of care and flow of information.

Ms HARTLAND — Would you talk a bit more about the problems with HealthSMART? I am aware that this has long been an ongoing issue. Certainly when I worked at Western Region Health Centre the system was just being developed for the community health sector. But I understand from you and other people, it is quite a problem. Could you talk a little bit more about why it has not worked as well as it was hoped, because it seemed like a very logical thing to do?

Dr LANE — I am an infectious disease physician, and I have a passion for safety, but I am not a computer specialist. I honestly do not know why it has not delivered what it was supposed to be delivering. There are a lot of people trying to make it work. We have to give credit where it is due, a lot of effort is being put in trying to make it work.

The only system that I have had contact and hands-on experience with is the iPM, or patient management system, basically to find out where my patients are when I come in to do a ward round on a Saturday morning and there are no clerical staff around. For very basic systems, it works fine, and my needs are very basic. There are other more complex needs, and apparently there are shortcomings with it in that area, but I do not know why that is happening.

Ms HARTLAND — I know HealthSMART had real potential, and it looked promising, especially from the community health perspective; I know we were all quite excited about it because it was going to eliminate the problem with all those files that nobody could ever find. I was quite interested in hearing about your experience of it.

Dr LANE — We have not had any experience yet in the clinical systems, because it has not been implemented. If that works very well, it will make an enormous difference; if it works very badly, it will have a grossly negative impact. Let us hope it works in the clinical system.

Mr DAVIS — I want to thank you first of all for your submission. I think it is very helpful indeed and reinforces a point that has been made earlier in the day about the need not just for data that relates to the speed of progress through the system but also actual outcomes.

I am interested in the comments you make in your submission, drawing specific attention to the problem of inadequate availability of gastrointestinal endoscopy services within Victorian public hospitals. Can you tell us what the impact of that is on patients?

Dr LANE — The worst impact is that it usually applies only to either asymptomatic patients or people with chronic conditions rather than acute problems like acute gastrointestinal bleeding or sudden onset of vomiting blood or passing blood through the back passage. It is not an issue there. But people who have either an iron deficiency anaemia or who are suspected perhaps of having gastrointestinal malignancy may have a diagnosis delayed through not having a prompt colonoscopy.

Mr DAVIS — What period of time are you talking about — weeks or months?

Dr LANE — Or months.

Mr DAVIS — Three or six months? What sort of period is it?

Dr LANE — It is possible.

Mr DAVIS — And what sorts of numbers of patients are we talking about there?

Dr LANE — I can speak anecdotally; I do not know the total number of patients because that data is extremely hard to come by. And because we do not have any methodical way of collecting the data, we do not have a methodical way of retrospectively analysing when a particular patient became anaemic, when the colonoscopy was ordered — —

Mr DAVIS — This could be scores of patients across the system?

Dr LANE — Hypothetically, yes.

Mr DAVIS — How does this compare to other systems? Is this the situation in other places in the world, or are we facing a unique problem here?

Dr LANE — I cannot comment on that because I do not know.

Mr DAVIS — The outcome for a patient of a delay of three or six months could be quite serious indeed?

Dr LANE — It could. It could mean the difference of having a totally resectable or curable malignancy and not having one.

Mr DAVIS — Is it the case that the individual networks would have lists of patients waiting for those services, with a referral in from a GP or a specialist?

Dr LANE — It depends on different services. Some services have what they call open-access endoscopy and other services do not. Open access means that a GP can refer the patient for an endoscopy without them having seen the specialist beforehand and the specialist endoscopist is doing just a procedure without really assessing whether the procedure is absolutely necessary or whether it is safe to do the procedure or not. That is open-access endoscopy. Some health services have it; some do not. I know that some health services do have lists of colonoscopies with waiting times. Again, the data is purely manually collected. Things can get overlooked on a manually collected database, and that can be dangerous if you overlook someone who has potentially a gastrointestinal malignancy.

Mr DAVIS — Again it is a reinforcement of the need for proper electronic systems.

Dr LANE — Yes.

Mr DAVIS — If I step back to your example of HealthSMART and its implementation and the fact that a number of cases have been lost, as it were, in the transfer from one system to the other or in the movement of data from one system to another, what sorts of numbers are we talking about? Is this anecdotal or —

Dr LANE — This is sort of corridor conversation stuff. I do not have access to that data in my health service, so I cannot give you the exact number of patients that that has happened to.

Mr DAVIS — But, again, it would be potentially quite serious if a patient's details were lost between the two IT systems and their treatment or their management were delayed.

Dr LANE — Depending on the underlying diagnosis. If they have a serious underlying diagnosis and treatment is delayed, then that obviously is very serious.

Mr DAVIS — Very serious indeed. I wanted to talk to you about another point relating to gastrointestinal endoscopy. Does your college have an opinion on this? I know you are here in a personal capacity.

Dr LANE — I do not know. The previous speaker would have been the perfect person to answer your question.

Mr DAVIS — Yes, but he came before you.

Dr LANE — I honestly do not know. It is not my sub-speciality and I do not know what the college guidelines are for waiting times for colonoscopy/gastroscopy. I can find out for you, but I do not know.

Mr DAVIS — We may follow that up separately. Thank you.

Mr TEE — In terms of the evidence you have given to the committee in relation to HealthSMART, am I correct in saying that as head of the infectious diseases unit your need for data is limited and is being met by HealthSMART? Am I right in saying —

Dr LANE — No. My personal need for data, being an individual clinician who walks around a ward on a Saturday morning trying to find out which ward my patient is in or which one came in overnight, is being met by the IPM component of HealthSMART, or the patient management system. However, that is a very minimal need and it seems to do that quite well, but so could the previous system.

Mr TEE — So the concerns that you have in relation to HealthSMART relate to other physicians in the hospital, not so much yourself?

Dr LANE — Yes. That is in regard to IPM. My other future concern is that when the clinical system is implemented, it be implemented in a way that gives us a high degree of functionality, a high degree of providing us with what we need.

Mr TEE — I suppose I just want to understand the link between your giving evidence on your own behalf and not necessarily on behalf of Western Health or other professions.

Ms HARTLAND — He was very clear about that.

Mr TEE — No, I understand that. I just want to see the link between your evidence in terms of HealthSMART and then potentially the views you are expressing in terms of Western Health and its experience of HealthSMART.

It seems to me that if you are representing yourself, you are saying in terms of your access to or information around HealthSMART, it works for you, your needs are limited, IPM will cover them. If you are giving evidence representing a broader range of people or indeed Western Health, your comments then extend beyond yourself in terms of HealthSMART?

Dr LANE — Perhaps the only other thing that I can comment on from personal experience is the number of times that they have had to, after hours usually, close down HealthSMART or close down some of the computer systems to make repairs to HealthSMART, which is happening relatively frequently.

Mr TEE — You are turning up as an individual on it, and that is great, but I want to get a sense then in terms of the veracity of evidence, whether it is in terms of HealthSMART but also indeed in terms of the colonoscopy and the access that has been available for that. Is that something that you are directly involved in?

Dr LANE — At Western Health I have had actual cases where this has happened, and I have had conversations with several of my colleagues from other health services where it has also happened, and the basic reason it has happened is there is not enough ready availability for colonoscopies or gastroscopies. And if you are asking me how often does it happen, I cannot tell you, and I do not think anyone could really tell you because the data is not being collected.

Mr TEE — I suppose I am just trying to get a handle on the capacity in which you are making those observations. You appear as an individual who deals with infectious diseases talking about colonoscopy and talking about the impact on HealthSMART in terms of other professionals or indeed Western Health, and I want to get a handle on how far your evidence goes.

Dr LANE — I have been on the adverse outcomes committee at Western Health for several years, and I have seen cases that are related to this and other cases that have happened because of a delay time for things happening on an outpatient basis, and most of these colonoscopies are done on an outpatient basis.

The CHAIR — Ms Hartland had a follow-up question.

Ms HARTLAND — I suppose this is a bit more of a comment than a question in some ways. We have had two witnesses today and while, yes, they are giving evidence from their personal experience, these are people who work in the area, and I think one of the problems, Mr Tee, is that — —

Mr TEE — It is a question to me?

Ms HARTLAND — It is a comment or a question — I do not care what we call it — but the issue is that the data is not being collected, so we cannot actually tell how often this is happening. I think that is what the physicians are saying: that if you did have good data, they would be able to answer the question, but because DHS or the hospitals or whoever is not collecting that data — —

Mr DAVIS — It is anecdotal.

Ms HARTLAND — — that is very difficult.

Mr TEE — It might be a matter for the report.

Ms HARTLAND — Yes, I think so.

Mr VINEY — I want to clarify, in relation to the clinical elements of the IT thing, your evidence to this committee is really about what your expectations might be for that system, is that correct? You have set a set of parameters as to how you think it should work.

Dr LANE — All I know about the clinical system that is proposed is, in broad terms, it is composed of an electronic prescribing and administrative system for medications, an electronic medical record and an electronic ordering-investigation-and-result-access system. And I should say that a lot of this is to be done at the bedside, so with mobile electronics. This has been discussed with some of the other senior clinicians or heads of units at the health service I work in, saying, 'What do you think about this?', and when we have asked for precise details as to what it can do, there have been no answers forthcoming. I might be wrong in this but I get the distinct impression that the capability of the system has been decided on, it is fixed and there is very little opportunity to modify that, which to me is a little bit disturbing because the senior clinicians that I associate with have not had any input into it.

Mr VINEY — But you just said that you have been asked to make some input.

Dr LANE — We were asked to talk about this system from a business case point of view as to whether or not Western Health was going to take it on, and I said, 'How can we make a decision about a business case — whether we take it on or not — when we do not know what it has got?'

Mr VINEY — But you just outlined what you understood will happen.

Dr LANE — Those are three or four broad domains, but you need much finer detail as to what the capabilities of each of those domains are before you can make a decision as to whether or not it is going to deliver what you want it to deliver, and those things are readily available. HealthSMART in the UK — —

Mr VINEY — I am just not sure. What process do you think should be put in place to identify that then? If you have been asked the processes, the sort of things that will be included in the system — —

Dr LANE — We have not been asked the sort of processes that will be included in the system precisely but in general terms. Okay, we have an electronic prescribing and administration system. What exactly can it do? The answer: 'We are not telling you', or 'We do not know'. We have got electronic medical records. What exactly can it do? 'We cannot tell you'.

Mr VINEY — So your proposition to the committee is that each clinician or doctor working in the hospital system needs to be consulted about the detail of the system?

Dr LANE — Not at all. I am not saying that every clinician needs to be consulted, but from my conversations with other multiple clinicians, none of them have been consulted.

Mr VINEY — Do you know what processes have been gone through to try and identify those specifications?

Dr LANE — No.

The CHAIR — Thank you, Dr Lane. The committee appreciates your evidence and your written submission to the committee. We will have a draft transcript to you within the next couple of days for any corrections that you wish to make. Thank you for your time today.

Witness withdrew.