HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Mr SW Davies MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Mr K Holden (Principal Research Officer)

PUBLIC HEARING—EXAMINATION OF THE AUDITOR-GENERAL'S REPORT TO PARLIAMENT NO. 4: QUEENSLAND HEALTH EHEALTH PROGRAM

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 7 AUGUST 2013

Brisbane

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Committee met at 11.33 am

CHAIR: Good morning. I declare this public hearing of the Health and Community Services Committee open. My name is Trev Ruthenberg. I am the member for Kallangur and chair of the committee. Mrs Jo-Ann Miller MP is the member for Bundamba and deputy chair. Mrs Ros Bates MP, member for Mudgeeraba; Mr Steve Davies MP, member for Capalaba; Dr Alex Douglas MP, member for Gaven; Mr John Hathaway MP, member for Townsville; and Mr Dale Shuttleworth MP, member for Ferny Grove, make up the full committee.

This hearing is part of the committee's examination of the Auditor-General's report to parliament No. 4 for 2012-13 about the Queensland Health eHealth program. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearing at the discretion of the committee. We will hear from officials from the department of health. Witnesses are not required to give evidence under oath, but I remind them that intentionally misleading the committee is a serious offence. Mobile phones or other electronic devices should now be turned off or switched to silent. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to.

BROWN, Mr Ray, Chief Information Officer, Health Services Information Agency

CLEARY, Dr Michael, Deputy Director-General, Department of Health

CHAIR: Welcome. I invite you to make an opening statement.

Mr Brown: Thank you, Mr Chair. My name is Ray Brown and I am the Chief Information Officer within the Health Services Information Agency attached to the department of health. My role in eHealth is the principal supplier of the solutions that meet our business need. Dr Cleary's role is the senior responsible owner or the business owner for the eHealth agenda overall.

I thought I might give a very brief background in terms of eHealth and then get into some of the detail. The Queensland eHealth strategy was developed in 2006 with a stated vision to enable a patient-centric focus to healthcare delivery across a networked model of care. The eHealth vision remains consistent with a recent government *Blueprint for better healthcare in Queensland* and, in particular, supports the principal theme of health services focused on patients and people where the patients are at the centre of what we do. Collaboration and partnerships allow the healthcare system to be less complicated and more accessible to Queenslanders. Remote communities gain a wider range of new services delivered at call through a revised Telehealth network.

At the commencement of the eHealth program in 2007, Queensland Health had already established some strong foundations for sharing patient information including having a single wide area of communications network and e-mail service across the state; a consistent patient administration system in the form of HBCIS; Australia's first state-wide pathology service with a single shared information system providing online results to all hospitals; a client directory service which linked patient identities from different hospitals; 450 videoconference units to support Telehealth consultations; a clinical data repository which was an outcome of the national HealthConnect program; and departmental information systems at larger institutions in the areas of pharmacy, radiology, emergency departments and operating room management.

In 2007 the Queensland government provided funding of $396 million excluding depreciation to implement an eHealth program. As a result of this, the eHealth program was established within what was then Queensland Health to support clinicians across the Queensland public health system and to improve communications with private providers. This move towards electronic healthcare solutions for Queensland's public hospitals is being undertaken in a considered, staged approach to ensure a successful transition from paper based medical records to electronic patient records for clinicians supporting staff and, in particular, patients. The first phase of the eHealth agenda saw not

only the delivery of speciality clinical systems to meet an immediate need and growing demand but also the laying of foundations for the delivery of an integrated electronic medical record to support a more sustainable public health system for Queenslanders into the future.

When the Queensland Audit Office undertook the audit, it reviewed 15 project business cases under the eHealth body of work. Of these, 12 are now completed, one has been discontinued due to a change in business model post health reform and two are still progressing. What has been delivered over the last five or six years since the eHealth program commenced is substantial and has produced significant clinical and patient value. I will give a couple of examples.

In the area of radiology, the Queensland Radiology Information System allows diagnostic medical images that are taken in rural, remote or Indigenous healthcare facilities to be reported on by radiologists in major hospitals and by external private providers. These radiology reports are available online at all locations. The Queensland Radiology Information System is now available in 96 hospitals, with over 1.8 million validated radiology reports having been sent through that system. In addition, an Enterprise PACS, or a picture archiving communications system, which is the system that stores those images, is now available to 64 of those smaller hospitals. An external radiology reporting service or interface has also been developed to electronically enable the Queensland Radiology Information System to communicate with contracted external radiology service providers.

Film based radiology has now been eliminated from Queensland public hospitals totally. From the perspective of a patient being treated in a rural, remote or Indigenous facility, this means a much improved outcome in many cases. An example would be if a patient presented at the Thursday Island Hospital and required an X-ray to be taken. Prior to the new radiology system, that X-ray would have been in the form of a film and quite often the treating doctor may not have been able to interpret that film. Often that patient would have been airshipped to Cairns essentially hanging on to the film image. Now if that patient presents to Thursday Island Hospital, the image is taken electronically and is read by a radiologist in Townsville. The radiology report is then made available back to Thursday Island within a matter of hours. That report can also provide input or assistance to the treating physician in terms of what extra advice or input they may need. The result from all of that is there is a significant reduction in the number of transports or unnecessary transports because the treating clinician is getting expert advice from larger centres where expert radiologists can interpret those images and inform a treatment plan without having to move that patient around. That now happens at 96 hospitals right across Queensland and it has a huge impact in terms of reduction in unnecessary patient travel and the impact on patient and family life.

In relation to discharge summaries, the Enterprise Discharge Summary system enables information to be sourced from a number of existing Queensland Health specialist systems to create a legible and consistent electronic discharge summary supporting continuity of patient care when a patient is discharged from a Queensland public hospital. This is now available from 173 locations or facilities and is being sent to more than 5,000 general practitioners state-wide. There have been over 1.1 million of these summaries now electronically made available to GPs. This means that when any of us are discharged from a public hospital it is more likely that when you go and see your GP they will have your discharge summary already within their system. This really assists in terms of future care plans when you go back to your GP.

Another significant system that has been made available recently has been the Viewer, which is an application that allows access by treating clinicians to a clinical data repository. All clinicians in hospital and health services have access to this Viewer application, which provides a single view of patient details, admissions, discharges, procedures, pathology and radiology results, medication summaries, discharge summaries and emergency department information. This system is now available in 242 sites across the state with over one million records already having been viewed. What this means to any of us is that, if we are admitted to a Queensland Health facility and receive treatment, that treatment is then recorded and made available in the clinical data repository. Once you are discharged and some time later if you are in another location within Queensland, if you are discharged from the PA and then are admitted in Cairns, that information that was relevant to your treatment in the PA is now available to the treating physician in Cairns. Similarly, if you leave Cairns that information is then captured as another encounter within Queensland Health and that information is available should there be subsequent admissions or contact with Queensland Health. Again, in terms of ensuring that the treating physicians gets the best information available to treat you when you present, that CDR Viewer has been an incredible additional tool.

In the area of mental health, an integrated mental health information system has replaced and integrated the functionality of three previously existing and ageing systems. That mental health application is now available in 120 mental health facilities across Queensland. To date 3.7 million

electronically signed clinical notes are stored within that system. Again, in terms of the benefit to the patient that means that, wherever that patient may present, the relevant clinical information around that patient is available to that treating physician regardless of where they present in Queensland.

In the area of BreastScreen services, the BreastScreen Queensland digital initiative replaced film mammography with digital imaging at all fixed, satellite, relocatable and mobile sites. Technology upgrades at the 11 BreastScreen screening and assessment services and 22 satellite services have been completed. Already over one million images have been sent through that new system. A major benefit has been the reduction in technical recall rates. A technical recall occurs when a woman is asked to re-attend for the examination to be repeated because the initial screen is technically inadequate for reporting. Technical recalls have fallen from more than 3,000 per annum to less than 100 per annum as a result of the system going live.

In the area of anaesthetics, the automated anaesthetic record-keeping system enables improved consistency of data recording, clarity and access to perioperative patient information resulting in improved patient outcomes, clinical decision making and effectiveness. This is now available in 43 hospitals, with 1.5 million procedure records having been captured. Surveys have identified time savings of three minutes per procedure in compiling adverse event data, 35 minutes per case to compile Australian Council on Healthcare standards reports and 57 per cent of respondents, being medical anaesthetists, agreed that the system allowed for more timely decision making during operations.

With intensive care, a new ICU system has been implemented, which improves patient safety, reduces risk and the rate and severity of adverse patient events during ICU admissions. This new system is in place in six hospitals. A new project is being established to look at the metropolitan facilities with a view to replacing the existing ICU systems there.

In terms of intensivist support, this means that the intensivist in a location that use the new system is able to provide support or, in fact, assistance to other intensivists in other hospitals that use the same system, because that information is available online to them. So they can get access to it from their existing location without having to go to the ICU and provide input and advice in relation to the treatment of that patient. In addition, New South Wales has recently engaged the same vendor and is implementing this system throughout New South Wales.

In relation to emergency department information, the existing EDIS system follows the progression of a patient through the emergency department. That system is able to monitor patient progress and provide alerts and record treatment details. This is now live at 35 sites and is being extended to an additional 12 rural facilities by November of this year.

An integrated electronic medical record—the IEMR solution—is currently under configuration, initially delivering to nine public hospitals, those hospitals being Cairns, Townsville, Mackay, Royal Brisbane and Women's, the Royal Children's, the Princess Alexandra, Robina, Southport and Carrara. This system will be made available in four releases. Release 1 is the first phase of the rollout and will implement scanning functionality, but importantly the foundations of the system on which subsequent releases will be deployed. The foundations of this cover a lot of the integration of this system into other existing platforms in Queensland Health, including the patient administration system.

Release 2 is really where the clinical functionality starts to be significantly deployed. Release 2 will delivery clinical functionality such as orders entry, results reporting, alerts and adverse reactions and clinical documentation within that one environment. The reality is that today a doctor can go to a patient's bed within the PA Hospital, stand at the foot of the bed, pull out his iPhone and book an around-the-world trip but he cannot order an X-ray or a pathology test electronically; it is all done on paper. So this system will move into allowing those orders to be made electronically and to start to move towards having an electronic record or chart.

Releases 3 and 4 will deliver further clinical functionality, including structured clinical notes, medications management and scheduling. This system is being delivered as a fully hosted and managed service by the vendor—the vendor being Sonar. Sonar has established data centre facilities already in Brisbane. It is populated and connected back to the Queensland Health environment. Already they are hosting clinical applications for the Alfred hospital from Melbourne out of that Brisbane data centre. UnitingCare Health, which is also a significant Sonar customer, is also looking at moving its systems into that arrangement. These are just some examples that I thought would help give some understanding of some of the, I believe, excellent achievements that the e-health program has so far implemented across Queensland.

In his report to parliament, the Auditor-General made six recommendations, which the department responded to and were included in the report at appendix A. Will I go to each of those recommendations and provide an update in terms of where we are at with their implementation?

CHAIR: I think an update is appropriate, but if you could get to the point of them fairly quickly?

Mr Brown: Absolutely. The first recommendation was for the department to assess the full infrastructure upgrade costs necessary to effectively implement the IEMR at the nine selected hospitals and fund the implementation accordingly. The original funding proposed under e-health required each district, or HAHS as they are now known, to fund their own end-user devices. Access to end-user devices was reiterated as a key issue during the stakeholder consultations that were undertaken during 2010 in relation to the IEMR and there were approximately 4,700 staff consulted during that process and most of those were clinical staff. Originally, $4 million was allocated for devices and that has been aligned from the e-health funds to ensure sufficient density of devices.

Site audits have now been completed for each IEMR site, verifying the quantity and device type best suited for the clinical work spaces and these have been approved by the relevant HAHSs. However, other infrastructure upgrades, including cabling and wireless infrastructure and so on, have also been required to be installed to support these devices. Some funds have been reprioritised from within the available e-health funds and allocated for each infrastructure upgrades to the amount of around $25 million, particularly for the Royal Brisbane hospital, the Royal Children's, the PA and Robina hospitals. Capital works funding incorporated infrastructure upgrades for Cairns, Townsville and Mackay hospital redevelopments. So in summary, the status of this recommendation now is that the infrastructure deemed as necessary and sufficient for the IEMR is in place or will be in place for systems deployment and the department regards this recommendation as having been addressed and we will be seeking in the future to have it closed.

The second recommendation is in three parts. Part A relates to enhanced financial reporting to the e-health program board, which is to clearly and concisely provide information on the financial status of the program, including a breakdown of future expenditure projected to complete the program. The e-health program board, which Dr Cleary chairs, has been actively involved in the governance of the e-health program since its inception. Reports to the e-health program board have always been comprehensive but quite complex, which has made it a little difficult for board members to interpret easily. They have requested that the financial reports be more concise. This was also identified by the Queensland Audit Office. Improvements have been made to the e-health program financial reporting to the point where the financial reports are now much clearer and succinct and better able to be understood by board members. The current financial status of each project and the overall e-health program is reported monthly and tabled. In February 2013, the e-health program board noted that the financial board report is consistent with what the QAO was suggesting and the department also now regards this recommendation as having been addressed. Again, we will be seeking to have this one closed in the not-too-distant future.

The second part of recommendation 2 relates to providing performance measurement data to the e-health program board in a clear concise format that demonstrates clearly the progress of each project, the tranche of work and the overall program against the relevant budget's baseline time line and subsequent impact of variations to plans. As mentioned previously, the e-health program board has been actively involved in the overall governance since its inception. Work is underway to continue improving a maturity of program reporting. Monthly reports to the e-health program board comprise an overall program road map, with time lines and RAG status, which is the red, amber, green status reporting; program performance reports to the clinical program and the IEMR program; exception reports, where applicable; briefing notes on e-health program risks and issues are tabled at each board; and the financial report. Quarterly reports to the e-health program board are also provided, which include benefits reports cards and a quarterly summary report. Again, the department regards this recommendation as having been addressed and we will be seeking also to have that one closed.

The final part of recommendation 2 relates to reporting more clearly on the outcome and benefits of e-health clinical and administrative systems demonstrating clearly their impact. Again, the program board has had significant involvement in this but QAO believes that the reporting on outcomes and benefits could have been clearer. E-health benefit report cards have been produced and presented to the e-health program board quarterly since June 2012. Quarterly progress reporting has also been commenced to the Department of the Premier and Cabinet and Queensland Treasury from April 2013. Work is ongoing with each project to ensure that outcomes

are aligned with benefits and that these benefits can be measured as appropriate. The department regards this recommendation as having been addressed and, again, we will be seeking to have this closed.

The third recommendation from the audit report recommended that Queensland Health take appropriate action to address the obsolescence of the patient administration system—HBCIS—within a time frame that will not adversely impact on hospitals. The department has commenced a patient administration system investment planning project to deliver an implementation approach architectural framework and business case to guide the selection and implementation of a new patient administration system for Queensland. The department is focused on implementing a solution that will provide a foundation for future innovation in health service delivery and enable greater collaboration between healthcare providers across the state whilst addressing the risk associated with the current system. The development of the implementation approach architecture framework and business case will be completed by January of 2014. The work will be structured to enable review, input and approval at multiple points.

The patient administration system implementation approach will also incorporate recommendations from recent reviews—the Deloittes report of my division, the Commission of Audit, the whole-of-government ICT audit, the right to private practice and the payroll inquiry—and it will also align with the Queensland government's strategic directions as articulated in the Queensland Health blueprint and the Queensland government ICT strategy 2013-17.

The HBCIS replacement activity is particularly complex, as HBCIS is more than just a patient administration system. It also includes a range of additional functionality associated with managing the registration and flow of patients. There are 165 separate HBCIS instances with local configuration to support the business processes of 202 business units across the state. There are over 80 clinical and business systems that share or integrate with HBCIS. The department will be recommending the appropriate approach to address the replacement of HBCIS following the completion of the investment planning project in early 2014.

The fourth recommendation from the QAO report recommended that Queensland Health progress a single sign-on project to increase efficiency of accessing multiple systems, particularly for the IEMR sites. Access to the desktop and clinical applications at the point of care is critical in the delivery of patient care. Clinicians' take-up of the IEMR solution may be impacted by the time it takes to get to the first clinical screen. Queensland Health has approved a project to implement a single sign-on solution to the nine IEMR sites as part of release 2, with the implementation schedule to commence in the second quarter of 2014 in line with the IEMR implementation time frames.

Key outcomes being sought through the introduction of the single sign-on solution are the reduction in the number of user names and passwords that need to be remembered and the removal of generic log-ins that increase security risks. The single sign-on solution implementation represents a cost-effective investment given the significant business benefits that it delivers, including improved speed of access to clinical information at the point of care and improved security. The current status of this initiative is that the project schedule has been aligned with the IEMR release to timings. The single sign-on business requirements, software requirements and solution architecture documents have been released for review. A procurement plan has been drafted and governance for the project is in place.

Recommendation 5 of the audit report recommended that Queensland Health develop measures for outcomes and benefits for the IEMR and future specialist clinical and administrative systems that are specific, measurable, attainable, realistic and timely; collect baseline information data to facilitate performance measure; and reporting in accordance with the Queensland Government Benefits Management Framework. The IEMR program benefits management plan details the SMART—or the specific, measureable, attainable, relevant, time-bound—measures that will be baselined and when and how that will occur. For release 1, an independent organisation, the NTF Group, has been engaged to analyse the workload impact on medical records, analyse when chart movements will decline across the facility and what the resourcing requirements per facility will be.

Completion of benefit profiles and measurements for at least one site has been undertaken for the scanning component of release 1. All five initial sites and scope for release 1 have commenced their baseline measurement activity, which will be completed by the end of September of this year. Post going live, there will be post implementation reviews. However, it is important that projects transition to benefit owners for ongoing monitoring and realisation. Each subsequent

release will have specific benefits realisation management plans and the primary benefits realisation ultimately rests with hospital and health services as they are identified as the primary benefit owners responsible for realisation and harvesting.

The final recommendation, recommendation 6, recommended that Queensland Health provide system enhancements incorporated into the IEMR to the EMR at the Gold Coast Hospital and Health Service to address current deficiencies and test the practicality of these changes by using hospital based testing prior to implementing the IEMR at other hospitals. On the IEMR, design decisions have been made available to the Gold Coast Hospital and Health Service EMR team for consideration and implementation as appropriate. Lessons learnt from the Gold Coast have been incorporated into the design of the IEMR.

The Gold Coast Hospital and Health Service has incorporated state-wide recommendations and lessons learnt from the IEMR release 1 into update activities for their solution. The Gold Coast Hospital and Health Service will transition to the IEMR as part of release 2 in 2014. Again, the department regards this recommendation as having been addressed and we will also be seeking to have it closed.

CHAIR: Thank you, Mr Brown. Dr Cleary, do you want to make a very quick statement?

Dr Cleary: No, I think Mr Brown has covered the recommendations and the general overview.

CHAIR: Thank you. I will start questions with Ms Bates.

Ms BATES: I have a question to you, Ray. Obviously HBCIS is one of the critical systems that we identified in that IT audit. It probably looks like another debacle with a replacement cost now of some $440 million. I also note that it is unfunded for tranche 3. I would like to know are you continuing on the original path of replacement of HBCIS and is that a bespoke model, or is going to go out to the market?

Mr Brown: We did have a draft business case prepared for this. Again, that approach has been totally reviewed in light of the recent reviews, reports, audits and documents that have been provided. All of those documents are being reviewed and a new approach is being documented as part of having those documents ready by January 2014. The intent is not to have this as an in-house application as it currently is. The intent will be to have it as a form of a managed service.

The difficulty around HBCIS is that there are many layers to the onion, and we have to start to unwind some of the functionality that has been incorporated into that system over many years—it has been in place for 22 years—and then really get things back to what that core patient administration system is. There is nothing that just replaces HBCIS or a service that does exactly what HBCIS does today. The planning activity around that is going to be significant, but the intent in terms of the ICT as a service model will be moving to that approach.

Ms BATES: Can I follow up on the Cerner system, particularly the one down on the Gold Coast? I am well used to Cerner, having run a UnitingCare hospital in the past. My concern about Cerner on the coast is that when the Wesley was down on the Gold Coast all of the administration staff in all of the public and private hospitals all used that HBCIS system and were not au fait with the Cerner system. Has the educational component for staff to be trained in that system been included in the budget? I am hoping it is less clunky than it was when it took 15 screens to admit a patient.

Mr Brown: I might start and Dr Cleary might have a few comments as well. The new Cerner environment is totally different to what it was and is much more streamlined in terms of access to information and to screens. We have learned significantly from New South Wales and from Victoria. New South Wales now has Cerner deployed at 140-plus locations around New South Wales. We spent a lot of time learning what they have done and about some of their implementation approaches—the good and the bad. We did significant consultation within Queensland Health. As I mentioned before, over 4½ thousand people were involved in those consultations to provide input into that system.

In terms of the overall solution for this, the biggest component is going to be around change and adoption. It is actually more complex and probably higher investment than the actual technology itself. Absolutely, the HBCIS replacement, as an example, has a significant change and adoption component to that and a significant component that will relate to business process change to support a new system. How that integrates then with the Cerner system is a key part of that implementation strategy.

Ms BATES: I also noticed the comments about getting rid of multiple log-ins—

Mr Brown: Absolutely!

Ms BATES:—and Queensland Health obviously did not partake of IDES. So you probably saved yourself a lot of money there in the past. This may sound an unusual question, and I have asked it before. Has anybody checked to see if the Tahitian prince's log-ins are now cancelled?

Mr Brown: I think that was checked pretty quickly.

Dr Cleary: Just to comment from the board's perspective on the arrangements at the Gold Coast—and we were particularly focused on making sure that a technical solution was delivered for the Gold Coast but also one that is practical. After a period of consultation with them, we agreed the best way forward was for them to continue with their current system but then to deploy the new system when the release 2 package is available, because that is more complementary to the system that they currently have. If they were to go with the release 1 they would lose some functionality that they current have.

In terms of the staging of that, we have worked quite closely with them and they are now aligned to the rollout of this whole package across the state. The training and development is built into that and it was really pleasing to be able to have them as part of the consultation with the 4½ thousand people in Queensland Health who have looked at the modules over recent times. The other thing to comment on is that, although they have a system which is a little bit less sophisticated than the one that will roll out mid next year, we are working with them on transition arrangements and they have a working group that is in place that makes sure that the operational arrangements using the current system are such that the system operates to its maximum capacity, and that includes training and support for staff. One of the areas that I am aware of is that the group that are oversighting that identified that there was a need to employ additional devices because in some ward areas it was very important to have terminals in patient rooms, especially the high intensity areas. I think in the last few months—it might be over the last six months—the Gold Coast has deployed something like an extra 50 terminals to those types of areas outside its usual rollout. So they have really been focusing on making sure that the service delivery end is looked after as part of the transition for the new system when it comes out next year.

Mr SHUTTLEWORTH: I have a couple of questions, and they are largely around recommendation 3. I have some concerns about what was mentioned this morning in Mr Brown's response to that recommendation. Primarily, because you had indicated that the business case is currently underway and is likely to be completed in January 2014 and yet the contract expires in 2015, clearly there is not enough time to implement even a very simple system. I used to sell enterprise software, so I understand the length of time in terms of process, redesign and all of those things that need to be undertaken. My questions are what mitigation of risks have we developed around the end of contract period and are we going to continue to get some form of support on the HBCIS system until such time as we are able to change over to the new system? Secondly—and it flows into that—what measures are being undertaken to ensure that the same risk factor, which I guess ensured that we were to have a 20,000 per cent blow-out in our health payroll system because we had to get to a drop-dead date—what are we doing to ensure that those same drop-dead pressures are not pushing the departmental staff to a point of feeling they need to change over when clearly no-one is ready for the changeover, because the dates just are not lining up? This is a 20,000 per cent blow-out. Obviously we are talking somewhere in the vicinity of $80 billion. I do not think the state can afford it.

Mr Brown: I absolutely agree with you. We have taken a number of risk mitigation strategies already in relation to the HBCIS environment. The vendor indicated that during 2015 they will stop providing direct vendor support. That means, as you probably are aware, not a lot of work is actually going to be done on the existing code base for that application and the version that you have at that point in time will probably pretty much stay the version that you have.

One of the issues for us was actually the hardware infrastructure. So over the last 12 to 18 months we have gradually replaced the server infrastructure on which all of our software runs. So we now have a solid hardware base in place to support HBCIS through to probably around 2019 and 2020. There are a couple of organisations that do provide external support for that software environment, and we are talking with the current vendor and we will talk to those organisations as well to get a level of support for the software on that platform through to that 2019 and 2020 period. It really does become a problem beyond that date because we move into a scenario where hardware replacement will need to be undertaken with a version of operating system that the software probably will not run on. The crunch date is really around 2019 or 2020. Kicking off now, getting some support arrangements in place, we are still confident that we can actually achieve that in that time frame.

Mr SHUTTLEWORTH: That time frame is a little better, but are we approaching it to replicate 'business as usual', or are we actually undertaking some significant review of the department to ensure that 165 business units and 80 integrated programs is not the norm going forward? Are we trying to declutter or unravel to make it a far simpler system in an ongoing sense, which obviously has significant benefits in terms of maintenance costs, support costs and then, ultimately, replacement costs in some years down the track?

Dr Cleary: For the committee's information, I was involved in the user group that selected HBCIS some many years ago. HBCIS is a system, as you would probably be aware, which comes as a package. It is an 'everything you want' package. At the time, 22 years ago, it was able to deliver the complete requirements of a hospital. Clearly, that has changed and now there are best of breed systems in all of those areas. So the operating environment has changed, but migrating from a package that is all encompassing to one where you want to have best of breed systems is obviously complicated. I think also in accordance with government policy, the approach is going to be completely different. So rather than an in-house solution with in-house support, it will be managed very much like the IEMR product, which is outsourced and hosted. So with Cerner, I would imagine, we would have a similar sort of a model where there will be a web based product which is hosted off site from Queensland Health, but that is going to take some time to construct. As you have indicated, it is an area where the realignment of the various modules is going to need to be undertaken with some diligence to make sure that the transition progresses smoothly. There has been quite an amount of work done on that already. The pathway is fairly clearly identified. It is now really the business model that would be required to support that pathway that would need further consideration.

Mrs MILLER: Just a quick question. Are there any officers or any consultants who worked on the Health payroll working on this particular project?

Mr Brown: The HBCIS project?

Mrs MILLER: The eHealth project.

Mr Brown: The eHealth project? I do not believe so.

Dr Cleary: Perhaps if we could take that on notice. I would be happy to say I am not aware of anybody who would be in that—

Mrs MILLER: The HBCIS project. And if you are going to take that on notice, I want to know what level they are, please.

CHAIR: Take that on notice?

Dr Cleary: Take that on notice.

CHAIR: Thank you.

Dr Cleary: Thank you.

CHAIR: Dr Douglas?

Dr DOUGLAS: I only have one question. I am presuming by what you are saying that it does integrate into the national eHealth strategy? I just took that as a given.

Mr Brown: Yes.

Dr DOUGLAS: And you are somehow integrating in some panel arrangement? Are you on that national thing or are you —

Mr Brown: Yes, I am involved in the national agenda through the National Health CIO Forum. You are correct, the solution will integrate with the national agenda, so very shortly discharge summaries—assuming you have a personally controlled electronic health record—will be sent to that record and stored within it and similarly will be able to be accessed by Queensland health clinicians through a viewer application. You will actually see that within—

Dr DOUGLAS: But the other southern hospitals will be able to integrate with their—

Mr Brown: Yes, you will.

Dr DOUGLAS: So portability is factored in, but also in a more back framework we will be able to get that broader information. I live on the Gold Coast; it is fairly critical.

Mr Brown: Yes, you will.

CHAIR: Dr Cleary, and then I will take one more question and we will need to shut the thing down.

Dr Cleary: I was just going to comment that Ray's involvement with the technical side of the House is through the committees he mentioned. Through my division within the Department of Health we integrated into the business side of things at a national level from data elements through to the clinical side, and I sit on the Hospitals Principal Committee, which is the national committee that oversights a range of the business areas. I think it is for us a very exciting time. The viewer is what we use internally to view patient records, and in time it will also allow us to view records of patients held in the national system. It has been a fantastic product. We have won some awards with that that are national awards. But most interesting to me, we used it when we evacuated Bundaberg Hospital recently following the floods up there, and one of the reasons that that went so very well from the Health perspective was because the clinicians in Brisbane who were receiving these patients could see the records of the patients in Bundaberg before the patients left the ground. They were already planning the care for those people before they arrived in Brisbane. So it is just, in my mind, a really good example of how those types of systems are going to provide, if you like, somewhat unexpected benefits, but benefits nonetheless. So thank you.

CHAIR: Thank you. I will take one more question, Mrs Bates.

Ms BATES: Just another quick one to you, Ray. I noticed the other day or last week that the gateway policy was introduced. Are you still having the peer review group meetings with all the IT CIOs as another check and balance?

Mr Brown: Yes, we are. The CIO group meets regularly. The peer review process will change a little bit shortly through having a council of DGs and a range of other processes, but that principle about a peer review process persists right through, yes, it does, and we do participate in it, absolutely.

CHAIR: Dr Cleary, Mr Brown, thank you for attending. We may have just a couple of other questions for clarification, given that fairly lengthy statement you made. What we will do as a committee is just assess those questions, and we may come back to you in a week or two with some questions on notice for you to send back to us.

Thank you to everybody. The time allocated for this hearing about the Auditor-General's report on Queensland Health's eHealth program has expired. I thank both of you, and I declare this hearing closed.

Committee adjourned at 12.19 pm