Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Wednesday, 21 February 2024 at 10.00am

(Day 007)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting_**
Mr Dan Fuller	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**

Also present:

Mr Lachlan Gyles SC with Ms Joanna Davidson for NSW Health

THE COMMISSIONER: Good morning.

MR GLOVER: Thank you, Commissioner. The first witness today is Ms Chiumento, she is via AVL and she is on the screen.

THE COMMISSIONER: Good morning, Ms Chiumento.

<JODI CHIUMENTO, affirmed: [10.01am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q Ms Chiumento, you can see and hear me okay?
A. I can, thank you.

Q. If at any stage something is unclear or the feed distorts, just let me know, okay?
A. Thank you.

Q. Can you tell us your current role within the Illawarra Shoalhaven LHD?
A. My role is the director of procurement and supply chain for ISLHD.

Q. Just in general terms what does that involve on a day-to-day basis?
A. I have oversight of my procurement and supply chain team in terms of we're broken down into three streams. We have category management or strategic sourcing, who are responsible for managing the sourcing and contract requirements for our district, in particular, working with the HealthShare category team and also working with local end users on their local agreements that they need; the supply chain team, who have oversight of the inventory management and our clinical products management support; and, lastly, the policy compliance team, who are responsible for the governance components of purchasing.

Q. How long have you been in your role?
A. Five years.

Q. How many people in your team?
A. Twenty-one at the moment.

Q. Thank you for outlining the streams. If we can just start with the strategic procurement or category management team, that was the first one you mentioned?

A. Yes.

Q. You gave a general description, but if you could just expand on that a little bit, what do they do on a day-to-day basis?
A. Their focus is making sure our contract compliance is where it needs to be in terms of purchasing from statewide contracts, when they are whole of government or whole of health.

The category side of things is we've obviously broken down the spend into categories so they're understanding where we're spending our money within the categories and who with, and then obviously they're also understanding whether we have local contractor service agreement needs and they'll work with our local people to put in place those relevant agreements as well.

Q. When you referred to "compliance" in that answer, do you mean compliance with the various statewide health, whole of health policies that apply to the procurement function; is that what you mean?
A. Yes, policies and also the contracts that are in place at the state level for us to purchase from.

Q. And implementing local contracts in addition to those; is that right?
A. Yes.

Q. The supply chain team? What do they do on a day-to-day basis?
A. The supply chain team are operational focused. Our inventory and logistics coordinator is supporting the management of sub-inventory work within our ward. So just, to expand on that broadly, the inventory that are held in the wards around medical consumables, the par levels associated with those, so the min/max levels, and our clinical supporter is supporting the district in terms of any clinical product decision-making that needs to occur as well as any other items such as product recalls, et cetera, that need to be done.

Q. And the policy and compliance team?
A. They're effectively educating and supporting our district for those that purchase on how to purchase correctly in line with policy requirements.

Q. Are there are a number of people across the district who can purchase items, or services?
A. I think we have approximately 500 people that can order via our procurement, yes.

Q. And there are a number of overarching policies and procedures that apply to the procurement functions; is that right?
A. Yes.

Q. You will be relieved to know that I don't propose to take you through them. Has the district developed its own manuals or guidelines to assist its staff in that process?
A. We have.

Q. Why has that been done?
A. There was a - from our perspective, there was a gap in terms of being able to operationalise the number of policies that were in place around procurement, and we wanted to I guess have what we would call a tool kit of resources available for end users to be able to access to support their understanding and capability in terms of being able to get what they needed when they needed it.

Q. When you say there was a gap in the ability to operationalise those policies, what do you mean by that?
A. The easiest example I can give is the procurement policy has a - it's a long extensive policy and there is a lot of requirements in that, and an example of a gap would be how does someone raise a purchase requisition? It's not outlined in that policy, that policy gives us the rules, so we felt that there was a need to create a purchasing manual, which my policy compliance manager did, and has distributed that across the district, in particular to those people that need that information for ordering, but that manual is also accessible for everyone else on the district, across the district, on our intranet page.

Q. So the idea is to take these detailed, complex, varied policies and distil them into some tools and processes that staff can follow on the ground; is that a fair summary?
A. Absolutely.

Q. Is one of the documents that has been prepared for that purpose a purchasing matrix?
A. Yes.

MR GLOVER: I will ask the operator to bring it up on screen. It is [MOH.0001.0447.0001]. It is exhibit B.023 at tab 146.

Q. Can you see that on your screen, Ms Chiumento?
A. I can.

Q. You see there it's a table with values in the left column and a series of descriptions across the top of various ways in which one can purchase; is that right?
A. Correct.

Q. And does this reflect the fact that the procurement policies that apply may require a different process, depending on the value of the good or service, firstly?
A. Yes.

Q. And the type of arrangement under which it is going to be procured, secondly; is that right?
A. Yes.

Q. And at the footer there, beneath the table, one can see a series of goods or services that are subject to their own special arrangements, like ICT, motor vehicles, mobile phones and travel, et cetera?
A. Yes.

Q. Are they subject to their own individual policies and processes?
A. Yes.

Q. Do you have a role in the ICT procurement function within your district or does that sit primarily with someone else?
A. Primarily that sits with someone else.

Q. Who's that?
A. SESLHD.

Q. Sorry?
A. Sorry, South Eastern Sydney LHD.

Q. And is that because the ICT function is managed together with South Eastern Sydney Local Health District for your LHD?
A. That is my understanding, yes.

Q. What I'm going to ask you to do in general terms is we'll just work through the table to get you to give a general description of the process that needs to be followed in each of these scenarios. If we just start with the under $3,000 value at the top, what is the general process that applies when a procurement of a good or service under $3,000 is to take place?
A. Would you like me to talk to each of the scenarios?

Q. Yes, please.
A. In terms of if there is a whole of government or whole of health contract in place, the purchase requisition can be raised via iProcurement or via - if it's a medical consumable in a ward, within DeliverEASE, it will be raised by the STARR app. But you would raise a requisition through iProcurement, that would go through to HealthShare NSW purchasing and that would be issued to the supplier and then the goods or services would be issued or provided.

Q. Just pausing there, for a consumable, it would be ordered through the DeliverEASE platform; is that right?
A. Medical consumables within the DeliverEASE system would be ordered via DeliverEASE. Anything not covered in that scope would be ordered via iProcurement.

Q. And DeliverEASE is part of the procurement reform program that has been under way within NSW Health; is that right?
A. Yes.

Q. And when did it arrive in your district?
A. We completed the rollout at our eight hospitals in December and so - I just can't remember the timing off the top of my head, but within the last 12 months.

Q. And it doesn't apply in theatres, as we understand it; is that right?
A. We have put principles in, in place in our theatres, in Wollongong, yes, and - yes, sorry. Yes, to answer that question. We have done that.

Q. So does the ordering through DeliverEASE sit separately from ordering done through iProcurement; is that right?
A. Would you like me to go through that process now?

Q. Yes, please.
A. Okay. So for medical consumables that sit within DeliverEASE, the assumption there is that the items are either held in Onelink warehouse and have a catalogue number or they are a direct purchase item with a catalogue number, so they will be on a contract. They will sit within DeliverEASE.

A person that needs to order under the DeliverEASE system will utilise the STARR application. They will input the information of the amount of items they need to purchase in the STARR application and then that will automatically flow through to iProcurement and be raised - a purchase requisition will be raised and subsequently a purchase order.

That - I guess, in summary, each ward has its own list of medical consumables, like a mini catalogue, and that will be attached to its cost centre. So there is no need for that to - sorry, not "no need", but that doesn't follow the delegation process like a purchase requisition raised in iProcurement would take.

Q. Thank you.
A. Would you like me to go through that as well?

Q. No, I think that's sufficient for present purposes. The next arrangement is a prequalification scheme. What's a prequalification scheme?
A. A prequalification scheme is where a panel arrangement has been set up for different services and there is a number of suppliers that will be available on those schemes to provide services for district, depending on what your need is. They have been prequalified, those suppliers, so the relevant due diligence has been done and a local - the local health districts are able to access those prequal schemes directly based on those values on the left with the relevant governance identified in that column.

Q. And again, that's just a purchase order raised through iProcurement to access those arrangements; is that right?
A. Correct. And depending on the value, as you can see there, is the due diligence that's required - the number of quotes or whether, based on the value, they should engage strategic sourcing to assist with their purchasing needs.

Q. We'll come back to engaging strategic sourcing shortly. The final arrangement is direct purchase. What does that mean?
A. Direct purchase means a purchase where no whole of government or whole of health contract is being used and no prequalification scheme is being used to purchase from.

Q. An example, if you're able to call one to mind?
A. We need to put in place a service agreement for grounds and gardens maintenance, as an example. So we would look at how much annual spend we've had with - for that particular category of spend over the last two to three years and depending on that value, we would determine what level of procurement sourcing need support was required.

We would - if it was less than $10,000, we would get a quote for that service to be undertaken and we would raise that purchase requisition based on that quote. If there was - if the value was greater than $30,000, we would request three different quotes from different service providers and do that market engagement piece to get the right level of service agreement in place.

Q. Thank you. In the $30,001 to $250,000 row, there's a requirement to contact strategic sourcing in each of those --
A. Yes.

Q. -- and the next level up?
A. Yes.

Q. What's the process that's being referred to there?
A. So the contact strategic sourcing is to - is basically to reach out to our category management or strategic sourcing team internally to support with any sourcing needs. So anything over 250, so any contract estimate over 250, we need to engage the HealthShare local tendering and contracts team.

For 30,001 to 250,000 my team can support facilitating the market engagement approach on that. So we are encouraging people who spend over 30,000, where they're not using a contract or prequal scheme, to engage our team so we can provide them with support in getting the outcomes they need.

Q. Are there processes in place within the LHD to ensure that the various processes summarised in this table are being followed?
A. Yes.

Q. How is that done?
A. We have a number of tools. Obviously the purchasing manual that was referred to earlier is one of those. From a strategic sourcing perspective, we have developed a sourcing and contracts framework, which aligns closely with the HealthShare NSW sourcing process flow but has been localised for our operational needs in terms of where we are putting contracts in place for the local end users.

Q. And are there various levels of approval that these orders go through?
A. Yes.

Q. And is that based on the relevant financial delegation within the LHD?
A. Yes.

Q. Where goods or services are procured off a whole of government or a whole of health contract, does the LHD have a role in engaging with and managing those suppliers?
A. Could you repeat that question for me, please?

Q. Yes. Where a good or service is procured within a whole of government or a whole of health contract, so the first scenario in the table --
A. Yes.

Q. -- how is that purchase managed locally? So it goes through the process, and is it left to the LHD to engage with and manage the supply to the extent necessary?
A. Yes.

Q. Is there a process within the LHD for that, as to how that should occur?
A. Generally, we have - within the strategic sourcing team, we have the category managers that provide support in a category space, but effectively, if the purchase order is raised up to $30,000, we won't see that. Over $30,000, we have a gatekeeper in place, and so our gatekeeper will pick up any requisitions greater than $30,000 to ensure that the appropriate governance and compliance has been applied to those purchase orders.

Q. And what about managing the delivery of the good or service in particular? So say an order is placed and it's only partially delivered; is that something that's left to be managed - and this is under a whole of government or whole of health contract - is that something that's left to be managed within the LHD or is that something you engage HealthShare with?
A. Predominantly, in my opinion, it's managed by the LHD and an area within our organisation that is not within my scope.

Q. Which area of the organisation would be engaged in that task?
A. So that would be the hotel services teams at each of the hospitals. They manage the receiving docks at each of the hospitals and they are responsible for receiving any deliveries.

Q. Are you aware of any escalation processes that are available to the LHD to engage HealthShare if there are concerns about performance under whole of government or whole of health contracts?
A. Yes.

Q. What is your understanding of those processes?
A. If we have issues with the contracts - in particular, suppliers - then my category management team, strategic sourcing team, will escalate those supplier issues through to the relevant HealthShare NSW category manager managing their relevant contracts.

If you are talking about receival of items at a delivery dock, there is an escalation process there for partial deliveries whereby the receiver at the dock, upon their check and recognising that there was a partial completion, can potentially raise a ticket and advise about the partial delivery.

Q. Do you have visibility at the LHD level over any KPIs that may be in whole of government or whole of health contracts?
A. No.

Q. Is that something that would assist in your day-to-day management of those arrangements within the district?
A. Yes, sorry, can I just confirm, are you talking in

relation to supplier?

Q. Yes, I am, yes.
A. Yes, that would assist.

Q. Why?
A. We would understand the key metrics that suppliers needed to meet to service our needs.

Q. When these whole of government or whole of health contracts are - prior to them being established, is there consultation with the LHD, with HealthShare?
A. Yes.

Q. What form does that take?
A. I have seen requests for members or end users within our local health district to nominate people to attend technical evaluation committees for upcoming tenders.

Q. Is that the extent of the consultation that you're aware of?
A. In - at my level, yes.

Q. Would you like to see any changes to that process?
A. Potentially, but I - no, I can't really comment on that, sorry. I don't have a view at this point in time.

Q. Do you ever have a circumstance within the LHD where a supplier might approach a clinician directly to promote a new product?
A. I haven't experienced that directly.

Q. Are you aware of that happening?
A. I am aware of that, yes.

Q. Is there a process that should be followed when something like that happens?
A. I can't comment on that. I'm not aware of a process.

Q. The purchasing manual that you have mentioned - we might just bring that up on the screen. It's [MOH.0001.0446.0001], it's exhibit B.023 at tab 145. You can see that on your screen, Ms Chiumento?
A. Yes.

Q. That's the document you were referring to earlier?
A. Yes.

Q. And just to take you to a couple of parts of it, can we turn to document ID page 4, please. There you will see a screenshot of within the iProcurement system. Do you have that about halfway down the page?
A. Yes.

Q. And then it has the heading "Raising a Free Text Requisition"; do you have that?
A. Yes.

Q. What is a free text requisition?
A. A free text requisition is a requisition that is not linked to a whole of government or whole of health contract or a prequalification system. So it is - it enables an end user to type in the text that they want in terms of their purchase.

Q. So does that mean that that's a function that's being used to purchase an item that is not within a catalogue, for example?
A. Yes.

Q. There have been some recent developments in the production of a master catalogue; is that right?
A. Yes.

Q. To your understanding, is part of the development in the master catalogue to reduce the need to enter free text requisitions?
A. Yes.

Q. Are there other benefits, from your view, to the implementation of the master catalogue?
A. Yes.

Q. What are they?
A. The master catalogue gives a local health district more access to a number of catalogued items that are available on contract and potentially available across other local health districts.

Q. Prior to the implementation of the master catalogue, did the LHD have its own catalogue of items that it would frequently order?
A. Yes.

Q. Are there any disadvantages, in your view, of the implementation of the master catalogue?
A. From our local perspective, we had available 4,000 items on our catalogue prior to the master catalogue - the single master catalogue. We now have access to upwards of 50,000 items, and from - in my view, the risk there is obviously if there's areas within our clinical teams that have aligned on what items must be bought within their space, having access to more items means that that clinical standardisation is at risk in terms of people can actually order outside of what might have been approved for their area.

Q. We might just break that down a little bit. So when you say there's been agreement on items that might be used, is there an example that comes to mind?
A. Yes. We have a wound care committee and that wound care committee approves the available wound care products that the district should be purchasing, and the intention there is that people utilise those wound care products specifically. Having access to a broader catalogue means that people can potentially purchase outside of that approved cohort of products.

Q. Is there an ability within the system to limit the category of products in that scenario to those that have been approved for use within the LHD?
A. Not at this stage.

Q. Is that an issue that has been raised?
A. Yes.

Q. With HealthShare?
A. Yes.

Q. Are you aware of any response to that issue being raised, from HealthShare?
A. I understand that in the design, a number of LHDs provided that feedback and were advised that that couldn't happen. I'm not sure of the reasons why.

Q. If we can go to document ID page 12 of that document, please. About two-thirds down the page, there's a heading "Creating a Standing Order"; do you see that?
A. Yes.

Q. What's a standing order?

A. I would define a standing order as a blanket order with a supplier, so it is generally a one-line purchase order for a value, let's call it $100,000, and from that, people can use that type of order to procure goods or services from that supplier.

Q. And then the next heading "Receipting a Purchase Order" --
A. Yes.

Q. -- this is the process that is to be followed once the order for a good has been made and it has been delivered and this is the process that's to be followed once delivery is received; correct?
A. Correct.

Q. Is this an important part of the process, from your perspective?
A. Yes.

Q. Why?
A. One, it confirms that we received the goods or services that we expected per the scope; and two, it enables the supplier to be paid.

Q. And where you haven't received the goods or services in accordance with the purchase order, what's the next step of the process?
A. Sorry, can you just ask me that question again?

Q. Yes. You said that one of the reasons why this process is important is to confirm that you've received the goods or services in accordance with the scope, I think was the word you used. But say that doesn't happen, say you haven't got everything you have ordered or the service wasn't delivered to the full extent, is there another process that then kicks in? What is to be done?
A. If it is an item that we are receiving locally - so the caveat there is that if we've purchased medical consumables from Onelink warehouse, they are automatically goods receipted, so we don't actually have to do that process, but for all other items, we would have to do the receipting, whether it was a good or a service, and I guess, if we received a partial order in any of those or there was an issue, we would escalate with the supplier, the person who identified that there was an issue would escalate with the supplier.

Q. Are those issues recorded centrally?
A. I'm not sure.

Q. Are you aware of something called the "switch savings policy"?
A. Yes.

Q. What is it?
A. My understanding is it's a strategy from HealthShare within their statewide contracts where they identify an opportunity to switch products to achieve savings for the local health district.

Q. Have you had any experience with that policy being deployed in your LHD?
A. Not direct experience.

Q. One of the other limbs which you have touched on in your evidence this morning of the procurement form is DeliverEASE?
A. Yes.

Q. From your perspective, can you just explain to us how that functions on the ground within your LHD?
A. Yes. DeliverEASE is a system - and I briefly talked earlier about the fact that by ward, it is almost a mini catalogue, it has the cost centre linked and it is focused on the medical consumables process from purchasing through to delivery.

It also establishes principles on a storeroom layout and how storerooms should be set up to manage those medical consumables on a day-to-day basis.

In terms of how does the stocking of those storerooms occur, the items that will sit in the DeliverEASE system are medical - as I said, medical consumables with a catalogue number that are held in Onelink warehouse on a statewide contract and also direct purchase items from a supplier that have a catalogue item on a contract with NSW Health as well.

What then happens is the person who's doing the ordering for those products will undertake their reviews, they will use the STARR application to reorder per the min/max levels that are written on the barcode labelling,

and from there, those purchase requisitions are raised and automatically generated into purchase orders through to the supplier, who then issues the stock to the local health district and delivers that to our docks.

Our stores team then obviously pick up that stock and distribute that through to the wards.

Q. Does it assist in identifying stock levels?
A. There's been a lot of - sorry, to answer your question, yes.

Q. How?

THE COMMISSIONER: When you say "does it", you mean does DeliverEASE?

MR GLOVER: Yes, I'm sorry, yes, "Does DeliverEASE".

THE COMMISSIONER: I will be the only person in the room that doesn't - this is an online platform, or software, or what is it?

THE WITNESS: Yes, it's an online platform.

THE COMMISSIONER: Q. It is an online platform, was that the "yes"?
A. Yes.

Q. And what is STARR?
A. It's the name of the application used to facilitate the process, the automated ordering process.

Q. Is there a difference between DeliverEASE and iProcurement? There obviously is, but what is the difference?
A. iProcurement is the enterprise planning system, Oracle, that we use, so that is how we purchase. How the STARR application works is that - it's a bit like a Woolworths online shopping catalogue. You would say, "I want X number of this, X number of that, X number of this." You hit your basket, "Yes, that's what I want to purchase", and that automatically goes through to link in to iProcurement and generate the purchase requisition and the purchase order.

It doesn't follow the delegation process in terms of

approvals for the value, whereas if you raise a purchase requisition directly in iProcurement, that purchase requisition will follow the financial delegation established in that system for approval.

Q. Sorry to ask you again, but DeliverEASE, what does it show you? How much stock you've got in your store?
A. Yes. So there is an algorithm that sits behind the system and it determines what your minimum and maximum levels are. But if there is inconsistency in that data or we haven't been doing cycle counts to ensure stock accuracy is where it needs to be, then that is when my team are engaged to assist with what we call in procurement "sub-inventory reviews", which is where we look at those minimum/maximum levels of all those medical consumables on that ward's, let's call it, catalogue, and we would make those adjustments manually in the background.

Q. Give me an example of a particular medical consumable that's within the DeliverEASE platform?
A. Bandages.

Q. Okay. So if you go on line to DeliverEASE, will that tell me - tell you - how many bandages you've got at any particular time?
A. We do have reporting that you can see what excess stock is, but no, there's no live - there is no live, up-to-date stock on hand number. It's - that element of the process is not automated.

Q. No doubt it does have a usefulness. What is the usefulness of DeliverEASE then?
A. For me, it is the improved visibility. We had no visibility before DeliverEASE. So now we --

Q. Sorry to interrupt: improved visibility of what?
A. Oh, of stock within the wards, so --

Q. Because it's telling you how much you've got?
A. It is - so the reporting will tell you, yes, how much you have, but it relies on a ward to be doing cycle counting. So if you're doing the cycle counting --

Q. Stop there. Sorry to interrupt. What's cycle counting?
A. Oh, a stocktake of the medical consumables in the ward.

Q. And that's manual?
A. That's manual.

Q. And that manual count then gets, what, fed in to DeliverEASE, does it?
A. Yes. We would input that into the system and then we would be able to look at - as well as the nurse unit managers on the wards, we can then look at the reporting components of DeliverEASE.

Q. Just stopping there, then, if you have to do a manual stocktake which you feed into DeliverEASE, what's DeliverEASE adding to this?
A. DeliverEASE adds the storeroom principles of how you lay out your storeroom.

Q. Sorry, the storeroom levels, yes?
A. The storeroom layout principles, as a starting point. So a nurse can go from one ward to the next and, in theory, see the same layout. So it reduces the time they have to spend looking for things because it's colour coded.

Q. It tells you where something is?
A. Yes.

Q. Precisely within a storeroom or wherever?
A. Yes.

Q. Okay, I suppose that's useful, yes.
A. And then the other - the other element, obviously, is that you can see where you have excess stock and you can see, based on the cycle counts - well, it's the improved stock accuracy because you're doing - the wards are doing cycle counts, in theory.

Q. Why is it called DeliverEASE? What's the "deliver" bit?
A. I can't answer that. Sorry, that would be a HealthShare question.

Q. I won't ask you what the "EASE" bit then is, either. All right. Thank you.

MR GLOVER: Q. Another part of the reform program is SmartChain; correct?
A. Yes.

Q. Has that arrived in your district yet?
A. No.

Q. What is it, to your --
A. I'm sorry, yes, it's on its way.

Q. What is it, to your understanding?
A. A SmartChain is the reform program that's looking at improving our system capability for procurement and supply chain. It has a number of initiatives that sit within that and one of those initiatives that we're heavily involved in is an initiative called "traceability", and traceability is a project focused on implantable and prosthetic devices within our theatres, with a view that when we implement that system, we will have product-patient tracking for those implantable and prosthetic devices.

Q. Just step me through that. Once it's implemented --

THE COMMISSIONER: What are you talking about now, traceability or SmartChain?

MR GLOVER: Traceability.

Q. Once traceability is implemented, what will be different to what is in place now?
A. What is in place now is - in my understanding, I haven't seen this with my own eyes, but is a very manual process to manage the surgeries and the implantables and prostheses within our theatres across our district.

What this system will give us is visibility of the product that we will have on a catalogue for our theatres and then we'll be able to track those products via that catalogue number through to the patient who's having the surgery.

Q. Let's just use a practical example. Say if I need my knee replaced in Wollongong Hospital?
A. Yes.

Q. And traceability is online?
A. Yes.

Q. How will it interact with my surgery?
A. My understanding is that via the medical record number

for the patient on that particular day - or for you, having your knee done - on that day, we would - my understanding is that it would be knee - catalogued knee item X will be associated with your surgery and that will then speak to the product billing records. That's my understanding at a high level.

Q. So if someone were to look at my medical record, it would show that I had that operation and this particular knee part was inserted into me on that day; is that the idea?
A. On that day, yes.

Q. And what's the benefit of that, in your view?
A. We currently, at Illawarra, don't have visibility on our implantables or prosthetic devices via a catalogue. So for me, the number 1 aspect is the visibility of what we actually have; and then, secondly, the link to the patient, which we also do manually now, will be in the system. So reducing, in my view, the patient risk associated with anything that may occur.

Q. When you say "visibility", what is it that you are speaking of?
A. So by each item having a catalogue number when you raise the purchase requisition for those items, you will use that catalogue number to raise that item. We don't have that ability right now because we use standing orders which, as I explained earlier, are just a blanket value in a purchase order for a supplier. And then the second component around visibility is obviously we know it's your knee that got done on that day.

Q. And just dealing with the visibility point to close it out, why is that an advantage at the district level?
A. So we can obviously have an understanding of what we're ordering; we can manage the financial impact of that catalogue of items; and we can also reduce patient risk in the long run.

Q. And as I understand your evidence, you don't have those benefits at the moment under the standing order system, if I can put it that way; is that right?
A. No, we don't see that level of detail.

Q. And --

THE COMMISSIONER: Sorry, there are parts I'm not following. Traceability, it's an online platform?

MR GLOVER: Yes.

THE COMMISSIONER: Q. How does having traceability reduce patient risk in the long run?
A. Say a patient had to have a surgery done again because something occurred, we would have those records - we have those records now, they're manual.

Q. I see. So say they had a device implanted, whatever it is, knee, pacemaker, whatever, through this record system, through traceability, you know what particular part, let's call it a knee, because Mr Glover did, was used as the prosthesis on that particular patient, and if it wore out in quicker time than what the supplier said it would - say it wore out in three years instead of 10 - you've got a good record of that so you know there might be a particular problem with that particular prosthesis. Is that what you meant by "risk"?
A. Yes, and obviously we know that now through our manual process that our teams have in place, but this --

Q. This would digitise it?
A. -- I think is an improvement.

MR GLOVER: Q. What about recalls, product recalls; is that another advantage of this traceability system if that were to occur, you would be able to identify patients who had the implantable more readily than you do now?
A. I assume so, yes.

THE COMMISSIONER: Q. And SmartChain is just the name of the policy, is it?
A. The project. It is the name of the project, yes.

THE COMMISSIONER: But it's not anything more than that?

MR GLOVER: That's right.

Q. And there are other elements to it beyond traceability; is that right?
A. Yes.

Q. What are they, to your understanding?
A. I can't remember them off the top of my head, but the

ones I do remember are the data flow one, so looking at improving data flow through our systems, and the sourcing of contracts component, which is looking at automating the sourcing of contracts process now.

Q. And to your understanding, how will that component of SmartChain, when rolled out, automate sourcing in contracts?
A. I haven't seen that solution right now. I can only make an assumption from my previous experience.

MR GLOVER: Thank you, Ms Chiumento.

That's all I have, Commissioner.

THE COMMISSIONER: Just before you, Mr Gyles, let me --

Q. One of the things Mr Glover asked you was, he asked:

Do you have visibility at the LHD level over any KPIs that may be in whole of government or whole of health contracts??

And you said, "No, we don't." And then he asked you:

Is that something that would assist in your day-to-day management of those arrangements within the district?

And you asked:

... Are you talking in relation to supplier?

He said, "Yes". You said "Yes, that would assist". He asked you "Why?" You said:

We would understand the key metrics that suppliers needed to meet to service our needs.

Do you remember saying that?
A. Yes.

Q. Can you just explain to me why knowing the key metrics that suppliers need to meet would assist you?
A. Mmm. The first example that I can think of would be

if we had a supplier that was providing medical consumables, obviously, when they're supplying to NSW Health or directly to our hospitals - sorry, when they're supplying to Onelink warehouse or directly to us, they would have a delivery and full on time metric applied to their service delivery, and that means that they've supplied what we ordered, in full, and on time. So everything we had on our order to them, we have received.

Currently, I don't know what the delivery and full on time metrics are for any of our suppliers. And for suppliers that deliver directly to us, I think it would be important to know that because we could then be, through my category team - we could then be having some conversations with those strategic suppliers that we actually need to focus on to improve those metrics if they're not meeting them, as an example.

Unfortunately - well, not "unfortunately", that's not the right word - in terms of the Onelink warehouse service provision, we don't know if suppliers are meeting their delivery in full on time metric because Onelink warehouse will goods receipt any items leaving their warehouse for us to receive, so we - I don't actually know how suppliers are performing.

Q. Do you know why you are not provided with that information?
A. No.

Q. Have you asked for it?
A. Oh, I can't remember everything in the last five years. I know we've had - sorry.

Q. No, nor can I. Nobody can ask for that.
A. We've had - I know I've definitely been a part of conversations around the automated goods receipting out of Onelink warehouse, yes. But I don't - I can't give you a definitive answer, sorry.

Q. All right. And in general terms, what's the reason you've been given for not being told that information?
A. I don't recall the answer, to be honest.

Q. Then Mr Glover asked you:

When these whole of government or whole of

health contracts are - prior to them being established --

I guess that means "entered into" --

is there consultation with the LHD ...

You said, "Yes". Question:

What form does that take?

You said:

I have seen requests for members or end users within our local health district to nominate people to attend technical evaluation committees for upcoming tenders.

Mr Glover then asked:

Is that the extent of the consultation that you're aware of?

You said:

... at my level, yes.

Then he asked:

Would you like to see any changes to that process?

You said, "Potentially" but then you said:

... I can't really comment on that ...

"Potentially" indicates that you might like to see some changes to that process. Is there a change you'd like to see?
A. Nothing came to my mind, so I can't think of what that improvement would look like right at this minute, sorry.

Q. All right. We can follow that up with you later, after you've had time to reflect.
A. Sure.

THE COMMISSIONER: Did anything come out of that,

Mr Glover, firstly?

MR GLOVER: No, Commissioner.

THE COMMISSIONER: Mr Gyles, is there anything?

MR GYLES: Yes, thank you.

THE COMMISSIONER: Mr Gyles, acting for NSW Health, is going to ask you some questions.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Thank you, Ms Chiumento. Just dealing with this question about KPIs and having knowledge of that, am I right in thinking that if you've got a statewide contract for procurement of a consumable, that within your strategic sourcing team, there would be a category manager responsible for that contract; is that correct?
A. Yes.

Q. And as you would understand it, that person would have access up the chain, as it were, to a statewide purchasing group - that is, there would be a category manager at statewide level who would have responsibility for that statewide contract?
A. Yes.

Q. And so that would be a form of - sorry, a means of dialogue concerning KPIs, concerning performance on a statewide level, as to compliance with that contract?
A. Yes.

Q. And, for example, if that supplier was supplying to one LHD or one hospital in a way which wasn't consistent with the way other hospitals or LHDs were being dealt with by that statewide supplier, that would be a conversation that could be had at that level?
A. Yes.

Q. So there are some benefits, at least, having the statewide negotiating level, which is something that's accessible to you at an LHD level in respect of that product?
A. Yes.

Q. So you have a team which sits within your

responsibility at LHD level of about 20-odd people, most of whom are in the strategic sourcing and inventory management support business?
A. Yes.

Q. And below that, at the various hospitals that you have within your LHD, there are procurement people working within those hospitals?
A. Yes.

Q. Mr Glover took you through a table which had different levels of, in effect, authority at different monetary levels?
A. Yes.

Q. I think you told us that you at LHD procurement level had a gatekeeper role where there was a procurement of any contract going beyond $30,000?
A. Yes.

Q. And as you would understand, for contracts that are below $30,000, there would be a necessity for authority by use of a delegated, in effect, power, to authorise purchasing at LHD level?
A. Yes.

Q. And if one goes to the lowest level of that, what is encouraged is use of a PCard?
A. Yes.

Q. And that's for purchases --
A. For direct purchases, that was for direct purchases, yes.

Q. Yes, direct purchases for less than $3,000, that's a convenient means by which that would enable those purchases to be undertaken without unnecessary red tape?
A. Yes.

Q. And a person can obtain a PCard if they have authority up to the level of the PCard?
A. Yes. That goes through a process, yes, that finance and procurement sign off on, yes.

Q. Now, one of the issues - obviously we're in a stage of procurement reform which is being rolled out, in effect, as we speak?

A. Yes.

Q. And SmartChain is something that is on its way to your LHD, as you understand it?
A. Yes.

Q. And Mr Glover asked you some questions about what might be described as "inventory issues", and I think at the moment you said to him that there is a need to do manual stocktakes within the various storerooms which are attached to the wards at the hospitals that are around your LHD --
A. Yes.

Q. -- which house the consumables? One thing you can do at the moment through DeliverEASE and iProcurement is you can know what is being ordered; correct?
A. Yes.

Q. And is one of the initiatives that you understand will be delivered by the SmartChain technology or by a further development of DeliverEASE, that where there has been ordering of a product, when it gets to a certain level of product having been ordered, it will then produce an inquiry or recommendation which will go to a procurement team, which will suggest that there may be a need to reorder because of the level of ordering as compared to an inventory being taken of what is left in the warehouse; is that something you are aware of? You may not be?
A. I'm sorry, can you repeat that for me? I just need to think that through.

Q. Perhaps I'll approach it in this way: in terms of this particular issue where you have at the moment a need to manually - when I say "you", your procurement team at hospital level needs to do manual stocktakes. One way in which to automate that process would be if all consumables were barcoded in when they went into the warehouse, and then if a nurse, or whoever it was, was obtaining a consumable product from a warehouse, then barcoded that item out, that would enable you at - sorry, the procurement team at hospital level and you at LHD level to know what the level of stock was without a manual stocktake?
A. Yeah, absolutely.

Q. And that could also generate an automatic ordering, once stock got to a particular level?

A. Absolutely.

Q. And that would be the ideal world of procurement because you could run between the minimum and the maximum without human intervention, at least in terms of generating the purchase orders, et cetera?
A. Yes.

Q. Now, what I am wondering whether you are aware of is something different from that, which is not based upon a barcoding automated system but it's something different than what you've described, which is that one can use the ordering - that is, the number of orders that have been made of a particular product - to generate a communication to the procurement team to say, "Because you have now ordered X,000 sutures, you may need to reorder", and then the procurement team can then look at the issue and work out whether they need to. Is that something you are familiar with happening now?
A. I'm not, sorry, no. I'm not familiar with that.

Q. Would you agree that, short of the ultimate - the automatic ordering by way of a barcode system, that would be of some assistance to the procurement team, because it would be a way in which there may be a reminder to the procurement team that, because of that level of usage, that's something that they should be looking at?
A. Yes, and that's my experience in previous roles, yes.

Q. Thank you. Now, you've said that part of this procurement reform system which is being rolled out has seen an extension of the master catalogue to incorporate items that were not previously within the catalogue that was available to your procurement people?
A. Yes.

Q. I think you've said there are in the hundreds of people within your LHD that are able to order?
A. Yes.

Q. And now they have a greater range of products that are available when they go on to iProcurement and have a drop-down box?
A. Yes.

Q. So previously they had 4,000 items and they might now have 25,000 items there?

A. Yes.

Q. But if they were ordering the same items as they had always ordered, that wouldn't create a problem, would it?
A. Not in theory, no.

Q. So the same items are there; there are just additional items.
A. Yes.

Q. And your concern is that if they don't order the item that they have been ordering previously, which is part of an authorised contract, whether at state level or at local level, they may order a product which is not part of a contract that is either a local contract or a statewide contract which they are authorised to use in your LHD?
A. Could you just repeat that for me, please? Sorry.

Q. Okay. So your concern is that because there is now a greater range of products that are available, there may be products ordered which they are not authorised to order; is that your concern?
A. Those items in the catalogue would be on contract, so it's more that they might not be per clinical standardisation principles for our district, if they're in existence. So we might buy things that potentially a committee - I gave the example of the wound care committee. We might be buying things that the wound care committee hasn't endorsed, as an example.

Q. I see.
A. Which then creates some risk for us because there's an approved list, obviously.

Q. Where there are items that are purchased which have not been approved in that way, is that something that would come to the attention of the procurement team within the hospital, once that order came through?
A. If it was being ordered through iProcurement through the delegation, it would follow the approval process. So the relevant financial delegate would approve purchase orders. Is that what you're asking me?

Q. Yes, what I'm wondering is, if there had been an item that was purchased that hadn't been approved for use by the clinical group, that would come to someone's attention going beyond the person who had actually placed the order,

wouldn't it?
A. It wouldn't flag as a - it wouldn't flag as an exception, if that's what you are asking.

Q. But either at hospital level or at LHD level, you would have access to what was being ordered?
A. Yes.

THE COMMISSIONER: What does "access to" mean?

MR GYLES: Q. Access to information - that is, you have visibility as to what items are being ordered within the hospitals?
A. Yes.

Q. Through the iProcurement system?
A. Yes.

Q. And is that something that you are aware - are you aware, through that, of people actually ordering items that fall into this category, or is this more a risk rather than something you've actually seen?
A. We've actually asked the project team who have implemented the single master catalogue solution to provide us that information. So it's only been live for, I think, three to four weeks now, and we've actually asked that team to provide us that information so we can understand what that risk profile looks to us.

Q. I see. So you've identified a risk and then you are looking into whether or not that becomes an actuality?
A. Yes, yes, how it looks.

Q. And if it does become an actuality, one thing you could do is you could make sure that those who were actually ordering, it was made clear to them that there is a certain range of products that they should order, and even though there were other products that were available, that that wasn't part of their authority to order those products, would be one thing you could do?
A. Yes. That is one way we'd manage it, yes, absolutely.

Q. Alternatively, you could, as I think you have raised up the line, question whether or not you could actually disable the authority for those particular items, and that's something that hasn't been approved at a level higher than you are at this stage?

A. At this stage, no.

Q. So that may or may not be possible?
A. (Witness nods).

MR GYLES: I think those are all the questions I have, Commissioner. Thank you, Ms Chiumento.

THE WITNESS: Thank you.

THE COMMISSIONER: Anything arising out of that?

MR GLOVER: Yes, just one brief matter, Commissioner.

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Ms Chiumento, my learned friend asked you some questions about dialogue between the category manager within your LHD and an equivalent category manager within HealthShare around performance concerns; do you remember that?
A. Yeah.

Q. Are you aware of any policy - that is, a statewide policy - that requires the LHDs to monitor performance of suppliers under statewide contracts?
A. Not off the top of my head --

Q. I'm sorry, I didn't mean to cut you off. Continue
A. No, no, sorry, continue.

Q. What about whole of health contracts. Is the answer the same?
A. Yes.

Q. Are you aware of any policy that requires an LHD to report to HealthShare any concerns about supplier performance under a whole of government or whole of health contract?
A. Yes. In our NSW Health procurement policy, we would - based on how the model is currently set up, we would be reporting back to the relevant category manager any supplier performance issues, if we became aware of them, yes.

Q. How do you do that if you don't have visibility of KPIs of those suppliers?

A. We would just raise the concern with the relevant category manager and flag the issue with them, in theory.

Q. And it may or may not be actually a performance concern, depending on the nature of the KPI; is that right?
A. Correct.

Q. Taking the example of where there's been a failure to deliver a medical consumable under a whole of health contract - that's the example that I'm going to ask you some questions about - where there's been a failure to deliver, that is something that might be dealt with at a lower level in the system - that is, by someone in the stores team, is that right, by raising it with the supplier?
A. Yes.

Q. And it may or may not be escalated from there; is that right?
A. Yes.

Q. And to the extent it's escalated, it might be dealt with at a management level; is that right?
A. Management at HealthShare, you mean?

Q. No, within the LHD - so the category manager level within your team?
A. If it was a medical consumable, it would be a contracted item, it would come to the dock team. The escalation or process would be notification to HealthShare.

Q. From your category management team; is that right?
A. No, no, from the stores team that received the items at the dock.

Q. They go straight to HealthShare, do they?
A. There's a process, yes.

Q. What is that process?
A. I'm - I couldn't tell you. I haven't experienced that directly myself. I just am aware that there is a process.

Q. And is that each time something is not delivered?
A. In theory that process should be followed each time, yes. I'm not aware or sure of how often that is followed in our local health district.

Q. Is that something that sits with another team, as you mentioned earlier in your evidence; is that right?
A. Yes.

MR GLOVER: Thank you, Commissioner.

MR GYLES: Could I just ask a question arising from that, if that's okay?

THE COMMISSIONER: Yes.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Ms Chiumento, I think you've said that if - dealing with a situation where a supplier is not supplying within the - a purchase order is not being met within the specified time - that is, the goods haven't arrived - you understand that's something that can go directly from the hospital, those who are receiving the goods or not receiving the goods, perhaps, in this case, straight to HealthShare?
A. The escalation process can, yes.

Q. Is it the case that you have initiated a regular monthly meeting between your procurement team and the procurement teams within the hospitals making up the LHD?
A. My team have meetings with different teams within the hospitals. Is it - are you thinking of a team specifically?

Q. Well, sorry, that's okay. That's fine. So is it part of your - as you understand your procurement team, is one of the things that they do, meet with and seek information from the individual hospitals about any procurement issues?
A. Yes.

Q. And one of the things they're interested to know at your level is whether or not there are suppliers who are not - who are recalcitrant in providing goods regularly, on time and providing the right sort of goods and in the right quantity; agreed?
A. Yes, yes.

Q. And so if there was a supplier who was not doing that, irrespective of what their KPIs under the contract might be, the simple fact of failing to deliver either on time or the correct goods or in the right quantity, that's

something that you would expect would come to the attention of your team?
A. Yes. We've encouraged - we've encouraged people to do that, yes.

Q. So the lack of understanding of the particular KPI is not going to stop you raising that basic issue or, sorry, seeking information about that basic issue and then passing that up the chain to HealthShare?
A. No.

Q. And it may be that there are also communications which can occur between the hospital and the supplier or at your level and the supplier as well?
A. Yes.

MR GYLES: Thank you, Mr Commissioner.

THE COMMISSIONER: Thank you, Ms Chiumento, very much for your time. We're very grateful. You are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR GLOVER: Commissioner, the next witness is also by AVL. I'm told we just need a few moments to disable this connection and re-establish the fresh one.

THE COMMISSIONER: I will stay here.

MR GLOVER: Mr Fuller is going to take the next witness.

MR FULLER: Commissioner, I call Maria Kokkinakos. That's K-O-K-K-I-N-A-K-O-S.

THE COMMISSIONER: Can you hear us, Ms Kokkinakos?

THE WITNESS: Yes, I can, Commissioner, thank you.

<MARIA KOKKINAKOS, affirmed: [12.15pm]

<EXAMINATION BY MR FULLER:

MR FULLER: Q. Ms Kokkinakos, can you see and hear me okay?
A. I can't see you, but I can hear you. I can see the Commissioner.

Q. I think you might be able to see me shortly.
A. Yes, I can see you now, thank you.

Q. What is your position?
A. I'm director of strategic health sourcing for the Sydney Local Health District.

Q. Can you just describe what your role involves?
A. I have a team of people that oversee implementation of whole of government, whole of health contracts, we do local tenders, we oversee clinical product decisions and recalls, we oversee the h-trak service, DeliverEASE, and I have a transaction processing team that assists with gatekeeping, raising requisitions and matching invoices and processing them for getting ready for payment.

Q. I'll take you through some of those functions more specifically shortly, but just at a general level, how long have you been in your current position?
A. Six years.

Q. Who do you report to?
A. I report to the director of workforce and corporate operations, or to the CE via the director of corporate and workforce operations.

Q. Your title is director of strategic health sourcing. What does "strategic health sourcing" mean?
A. Strategic sourcing of health products. So it's really looking at a more - a strategic or whole of system way of how do we best provide services from a procurement point of view to the front line to ensure that it's patient focused and best value.

Q. Are you the most senior person in Sydney Local Health District with specific responsibility for procurement?
A. Yes.

Q. Do you have any role in IT procurement?
A. Our department processes all requisitions, and so the procurement of IT products, hardware and software, does come through our department, but we work with our ICT department to ensure - they're part of the gatekeeping process to ensure that the products are on contract and they are part of our bulk purchase arrangement. So we've standardised it across the district and it funnels through, we pick it up through gatekeeping and funnel it through to ICT to check before it's ordered.

Q. Are there clinicians as part of your team?
A. I have two nurses - three now, sorry. Three nurses, yeah.

Q. What is their role?
A. The clinical product manager oversees what clinical products, when we have new contracts, what would be best to use. He liaises with our clinical nurse consultants across the district who have expertise in the various areas to look at optimising those contracts, getting better value for money, and they have to provide their expertise into saying whether we will switch or change a product.

He also oversees what goes on the deliveries catalogue, so our way of controlling how we order things - everything has to be managed at his level. No-one can add anything else to the inventory list, if you like.

He oversees recalls. Product recalls is a central point. He liaises with the district director of medical services and clinical governance for that, and we have a contract implementations specialist nurse who also is responsible for implementing those clinical consumable contracts. We now have a DeliverEASE coordinator who'll oversee the maintenance and ensure that the delivery system is maintained because it's still - it's really a behaviour change to the way we manage imprest.

THE COMMISSIONER: I'm just wondering, I can hear you perfectly well, Ms Kokkinakos, but there's - it is not your fault, but there are transcript people here, and you might just be talking a little bit quickly.

THE WITNESS: I'm sorry.

THE COMMISSIONER: They're keeping up so far, but just

bear in mind that there are people taking down what you are saying, thanks.

THE WITNESS: Thank you.

MR FULLER: Q. Ms Kokkinakos, I will come in a bit more detail to some of those roles that you have just described. Can I just ask that you be shown a document, it's exhibit B.023 tab 152. The document number is [MOH.0001.0420.0001]. It should just come up on the screen for you shortly. It's B.023, tab 152. It's [MOH.0001.0420.0001].

Ms Kokkinakos, do you see that document?
A. Yes, I do.

Q. Do you recognise that?
A. Yes, I do.

Q. That's your position description; is that right?
A. That's correct.

Q. Thank you. Can you just describe, at a general level if you can, where your team sits in the overall procurement process that someone might go through to order a product within Sydney Local Health District?
A. I - certainly. I break up what we do and our involvement into three areas. There's tactical ordering, tactical skills required for procurement, how you order something through iProcurement; there's operational, you understand a little bit about the contracts and oversee a budget or a department; and there's the strategic side of procurement where you would need - you want tenders done, contracts or there's more complex procurement using the various prequalification schemes. So we provide services and support to those three - those three areas of skill base, if you like, because we focus our training on what people need to do.

Q. Just starting with tactical ordering, what does that involve? Can I just ask you to just slow down slightly, please, if you can?
A. Sorry. When someone joins the organisation, and they need to order something, they will request access to Oracle for iProcurement. That access request comes to our department and that's how we know that there are new people in the organisation or who need access, and we use that

opportunity to guide them to training that's available online but also provide one-on-one training so they understand the ins and outs and where they go for information, how they order things and where to go if they have questions. So that's the straightforward side.

If they need to use DeliverEASE then we would refer them to - when they need access to be able to order through DeliverEASE, we will refer them to our DeliverEASE coordinator.

Q. So is this someone new, starting in the district, who has the authority to order a particular type of product, they will come to your team to be set up to do that, effectively; is that right?
A. Yes. And we would check that they have - ordering is not - if the department manager signs the approval to give them access, we'll give them access. But if they are to have approval to spend, like a financial delegation, we would be checking that, yeah.

Q. Do you have any role in setting financial delegations?
A. No. We work off the financial delegations manual, for the district.

Q. Who is responsible for that, do you know?
A. Well, the board approves it, and a number of - it sits with the senior executive and a number of services contribute to that, so we do, workforce do for workforce delegations, and finance do, and audit. So there's a number of departments. But it's a whole of district document that's approved by the board.

Q. How does your team contribute to that document?
A. Recently we're updating it and we look at making sure there is consistency across departments and delegations and the types of things that are ordered based on what is required.

With some things that have been more automated, there's less need for a delegation, and there are some areas where we see that the average requisition may be higher and therefore that manager may need a higher delegation. But we could put it up as a recommendation but it is the senior executive who will decide.

Q. Will people from time to time within facilities

approach you with concerns about the size or otherwise of their financial delegations?
A. Not me personally, no.

Q. Do you know if that's something that happens within your team?
A. I've heard of people coming from other districts where they did have a delegation and were surprised that they didn't when they reached our district. So we explain it to them how it works. Because we have systems in place like GPALs, which are a type of standing - no, blanket order, we often - we don't need the delegation in those areas where, in other places, they would need a delegation to order on a daily basis. We use GPALs to pre-approve spending.

Q. I might come back to that issue if I can. Just sticking at the overarching level, the second stream, if I can put it that way, of your team's work that you described was operational, can you just elaborate on that a bit more?
A. So operational skills would be more understanding if you receive a requisition within your delegation to approve or you are required to oversee your budget and need to understand what is compliant, what is not compliant, how we use the stationery portal to order. It's that sort of first level of management where they need to have a broader awareness of how procurement works and perhaps have some knowledge around the fact that there are contracts in place.

At that operational level all of those people would know someone in my department that they would ring if they had a question. But we also do - once we find out someone has come into a management role, we actually reach out to them and provide one-on-one training.

Q. So your team's operational function is really assisting people on the ground who are --
A. Giving advice.

Q. -- involved in doing the day-to-day ordering?
A. Advice, training, gatekeeping, compliance, yes.

Q. The third limb or stream of what you described had to do with prequalification. Can you just elaborate on that, please?
A. The more strategic area is understanding what we have

as whole of government contracts, whole of health contracts, and prequalification schemes under the New South Wales Government, and knowing how those modules within those, how they work. And so this is sort of done at a higher management level and our procurement academy that is run by the ministry that we're involved in really focuses on explaining how those things work, and even to the extent of doing tenders, understanding conflict of interest and probity, it's that sort of more - higher level of understanding of how the whole framework works.

Q. And what, on a day-to-day basis, does that part of the team actually do?
A. Usually, people ring us seeking advice or support. They want to undertake a procurement, they want to start a lease or they're coming to the end of life of a lease and not sure what the options are going forward, or implementing new contracts where we're reaching out to clinicians and saying, "There's a new contract", do a bit of scenario modelling and say, "These are the ways to optimise this contract. If we move to this, we will save this much, if we move to this product, we won't", so it's that level. Does that help?

Q. Yes, thank you. And what's the relationship between your team and HealthShare?
A. We have a very - I want to say close working relationship in that our clinical product managers are often talking with their equivalents in HealthShare. I'm often speaking with the category managers or above and so are the contract implementation team about various contracts, whether we're escalating or whether we're implementing new contracts. And if we do have questions, for example, if there's equipment that we need to buy, we will always check with HealthShare that it's under a particular standing offer arrangement and that the pricing is correct. So it's a close relationship in that respect.

Q. I think one of the functions that you mentioned at the beginning that your team performs is contract management; is that right?
A. Not specifically contract management. Contract implementation is really the main role.

Q. Can you just explain what you mean by "contract implementation"?

A. Because most of the contracts we work off now are whole of health or whole of government contracts, if it's a new whole of health contract, I have a contract implementation team that will develop an implementation plan. So once HealthShare have executed that contract and they provide an initial introduction to the contract, provided it's complete, all vendors have signed and the tracker is available, our team will sit down and do a plan for implementation, which involves identifying the stakeholders, identifying risks with the contract, looking at ways of optimising.

Then they go and meet with the relevant clinicians or corporate people to implement the contract and report monthly on the track - well, we track it all monthly to see how they're going with implementation.

Q. Who is it within your team who performs that role?
A. There's a number of people. The manager of contracts and compliance, the manager of contract implementation, our contract implementation specialist, the clinical product manager - well, sort of - the contract implementation clinical specialist reports to both clinical product manager and the contract implementation manager. So there's four or five people who do that. Plus the analyst, sorry, the senior procurement analyst, yes.

MR FULLER: Commissioner, I note the time. I wonder if that's a convenient point to break. I'm happy to keep going.

THE COMMISSIONER: Are you going to be a while?

MR FULLER: I will be half an hour.

THE COMMISSIONER: All right. Yes, we will have a break, then, until 11.50.

MR FULLER: Thank you.

THE COMMISSIONER: Thank you.

MR FULLER: Sorry, Commissioner, would that be 11.45?

THE COMMISSIONER: No, 11.50.

MR FULLER: I'm sorry.

THE COMMISSIONER: All right, we will adjourn until then.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, please go ahead. You can still hear us, Ms Kokkinakos?

THE WITNESS: Yes, I can, thank you, Commissioner.

THE COMMISSIONER: Thank you.

MR FULLER: Q. Ms Kokkinakos, we were talking about contract implementation. Can I just go back a step. I take it that if I'm working at a facility in Sydney Local Health District and I want to purchase an item, there has to be a contract in place before that purchase can go through; is that right?
A. No. Actually, there are many items for which there is no contract.

Q. What is the process if there's no contract in place when I want to purchase an item?
A. Similar to what was shown before, we work off the ministry's procurement policy, which has the thresholds that says first you will look to see if it's on a contract, whether whole of government or whole of state, then you'll look to see whether it's on a prequalification scheme.

If it's none of those and you are trying to direct purchase, that depends on the value of the product, whether we need to go to tender and how many quotes are required.

Q. Will it always be the case that those situations come to your team?
A. They most often come to our team, particularly at the higher level, but we have gatekeepers. So if someone got quotes and was trying to put it through, we would pick it up. If it was above $3,000, we would pick it up in gatekeeping.

Q. Let's start with the whole of government, whole of NSW Health contracts. Did you say earlier that most of the products that are purchased within the district are on these types of contracts?
A. Yes, our most frequently used items are, yes.

Q. I assume that the district is not a party to these contracts; it's HealthShare, State of New South Wales, something like that; is that right?
A. We're a customer of, yeah, the contract. So we don't sign an agreement with those suppliers, either the ministry has or the whole government - well, NSW Procurement has.

Q. So how do you use those contracts from the perspective of your district?
A. It really depends what they are. If they're medical consumables, we can contact the company; if the product's on contract, do a bit of forecasting if we're going to have to change the product. It may go into Onelink warehouse or we may still have to buy it directly.

So we will liaise - we would find out initially how it's purchased and then set up our purchasing arrangements with them. There's no - nothing else, no agreement needed for things like medical consumables. Similarly with the prostheses, those companies are all on the panel to buy from, so we just purchase from them.

But sometimes corporate contracts, for example, where there is a panel, you may need to sight a customer agreement to engage a particular company from the panel to buy from them. That's a customer agreement developed through HealthShare, if it's a whole of health contract, but there could be whole of government ones, as well, where we would enter into an arrangement with them.

Q. Let's go through some of those examples. Just taking a step back, the contract, the statewide or whole of NSW Health, whole of government contract, is just a framework, the actual implementation happens at the district level; is that --
A. Yes.

Q. Is that right?
A. Yes.

Q. Taking medical consumables as an example, is that done through the DeliverEASE system?
A. It depends on the consumables. If they form part of the imprest, which is the items that are used on wards and clinics on a daily basis, if there's a change, if there's a new contract and we are looking to change for better value to a different product, that's where the clinical

product manager will talk to the relevant clinical nurse consultant and see which is the best product and then a decision will be made across the district or across that facility, depending on the specialty, and it will be put on DeliverEASE.

Q. Can you just explain, how does DeliverEASE operate in your district?
A. We're still rolling it out. We have a couple more facilities. But Royal Prince Alfred Hospital, Balmain Hospital and Concord hospital are up and running with DeliverEASE. So it uses the STARR app, the application, and whoever is going to place the orders or do the cycle count, the stocktaking, will take the app to the storeroom on the ward and count what's in those areas that need to be ordered.

There's a QR code on the basket where the item is stored and that tells the STARR app what product that is, and it'll also tell you what your min and max, minimum and maximum levels are. The person then counts how much is there. Once that is entered into the STARR app, it can order - we can say, "Do you want to order to your max", and you press the button and you order it.

Q. DeliverEASE, is it mostly focused on the stock management level; is that right?
A. At wards. At wards, yes. It's not for stock anywhere else, yes..

Q. So in terms of the actual ordering of stock, how does DeliverEASE interact with that process?
A. Well, DeliverEASE is the whole system and the app is what we use, is the tool within the system. So the app then will send it. It's an auto-receipted order, so it will go through to Oracle and it's ordered and received. There's no other approval process needed. The approval for items on DeliverEASE happens at the control stage of what we allow to be on the DeliverEASE catalogue.

THE COMMISSIONER: Q. So if you've got - if someone goes into the storeroom looking for bandages and finds the basket with bandages and there's four of a particular bandage there, and your minimum is four and your maximum is 50, using the app, you do the QR code and you can then order up to the maximum of 40?
A. Yes. It will also tell me if I've already ordered it

and it's on back order or there's nil stock, and if it's not available it will also tell me if there is a substitute.

Q. So you might go, "Well, there's only four there, I want to order up to 40", but you look at the app and it says there's 40 on the way?
A. Mmm-hmm, it is to stop people over-ordering, yes.

MR FULLER: Q. You mentioned Oracle. Is that the same as the iProcurement system that you mentioned earlier?
A. Yes, Oracle - yes, Oracle is the enterprise platform for all of iProcurement and general ledger and finance, yes.

Q. Am I right in thinking that the STARR app allows you to effectively automate the process between order the stock, press a button in the STARR app and it goes automatically through the iProcurement system without having to do anything else; is that right?
A. Without having to upload it separately, which is what we were doing with the previous scanning system, yes.

Q. Is this currently used for all medical consumables in those hospitals you identified?
A. In the wards and in the clinics, yes. Sorry. I should clarify. If there's something that's not used very often, maybe once or twice a year, we won't put it on the app. We will order that through iProcurement as normal, and that would then need approval.

Q. Is it someone in your team who determines what goes on the app?
A. Yes. The clinical product manager.

Q. And so that's done at the district level, not at the higher level?
A. Yes, we have oversight at the whole district level, yes. District level, sorry, yes.

Q. And it's a clinician, in effect, who makes that decision?
A. It's a nurse. It's a nurse, yes.

Q. Do they do that in consultation with clinicians on individual wards, for example?
A. Yes. They know what's on contract, they know the

contracts very well, and then they talk to the relevant clinicians, particularly those with expertise for those products, to determine which provide the best value for us, and then - so the decision is made in consultation with the relevant experts on the ground.

Q. Is there a different catalogue for different wards or is it the same catalogue across the district?
A. It's based on the same foundational catalogue and there may be specific items on - in wards and clinics that are for them, added on to it. But they work off a common base, if that makes sense.

Q. What is the source of the foundational catalogue?
A. It would be items that are on the master catalogue or products that we are using. They may not be on any contract but we are using them and we have a catalogue number. We need to have a catalogue number to be able to order them, which is called a - which is a HIMF, is what it's called, a health inventory master file, number, and when we have that we can order directly, and that circumvents free text as well.

Q. What is the master catalogue?
A. The master catalogue is the group of consumables or inventory list, if you like, it's mainly the medical consumables. That is maintained by HealthShare and up until recently each district had its own version of a catalogue. But it is mainly medical consumables; it's not stationery or computers or anything like that.

Q. So there is a master catalogue maintained by HealthShare?
A. By HealthShare.

Q. And then at the district level you use that master catalogue to develop your own catalogue --
A. Yes.

Q. -- that feeds into the DeliverEASE system; is that right?
A. Yes, DeliverEASE, items on the DeliverEASE catalogue would be coming off the master catalogue or our local catalogue, yeah.

Q. If I'm a person in a Sydney Local Health District facility looking at DeliverEASE, can I only see the items

that are on the district's catalogue?
A. I think if you've logged in from a particular ward, I believe you can only see what you can order for your ward.

Q. So there is, to your knowledge, some sort of filtering mechanism, depending on how you are identified logging in to the system?
A. Yes. I'm speaking from the end of knowing what the dashboard looks like. There's a KPI dashboard for DeliverEASE and we can drill down to specific wards and see their ordering patterns, their stock holdings. So the fact that we can drill down to that ward tells me that it is defined by ward, down to that level.

Q. I think you mentioned there are some items that are not on - from the master catalogue in DeliverEASE. How does that work?
A. They might still be on the master catalogue but they may not be on DeliverEASE for that automatic ordering because we don't use them enough. So they can still pull them off the master catalogue or if it's a direct purchase from someone and it's not on a catalogue, they would order them through iProcurement and it would go up the financial delegation pathway for approval.

Q. So there is a gatekeeping function, in effect, that stops some items getting into the catalogues that are visible within the wards; is that right?
A. Yes. Yes.

Q. When did the DeliverEASE system start rolling out at those hospitals you mentioned earlier?
A. We started with the Royal Prince Alfred Hospital around August 2022, and Concord was done last year, and Balmain was done over Christmas, and now we're at Canterbury and about to start dental as well.

Q. Do you know the time frame for rolling out the system across the rest of the district?
A. We hope to be finished by May, in our district, yes.

Q. Have you observed benefits as a result of the DeliverEASE system being rolled out?
A. Yes, I have. Some of that are benefits reported to us by HealthShare, who've done a lot of the counting behind the scenes, but on the ground, we've had a lot of positive

feedback from nurses on the wards saying how much it's just streamlined everything and everything's organised, everything's in its place, it's easier to order, you have visibility of something on back order, the substitutes are there, you're not ringing up having to chase up substitutes if there's a nil stock issue. So, you know, the glitches with the system are still teething issues. On the ground, it's very effective, yeah.

Q. Can you just identify what the teething issues are that you're aware of at the moment?
A. At the moment, it's more around - there are some glitches that we're picking up with the dashboard, where some of the data is not following through properly, and we're working closely with HealthShare to fix those. So where we can see certain things in the dashboard, we say, "Well, it doesn't make sense, it can't say that this is not a problem and then on this dashboard it says it is a problem." So those sort of obvious things we are working closely with HealthShare to fix.

And the other, I guess, concern that we've had is when the system goes down, like most technology, how quickly are people notified and how quickly or how much of a priority is it for eHealth to restore its functionality, because ordering is down at certain times of the day and you have to have your orders in by certain times of the day in order to get deliveries. So that - service continuity of the system is very important.

Q. Have you experienced or are you aware of issues arising out of that service continuity glitch?
A. Yes. Not so much this year, but last year there were times when the system would - we would be notified by people scanning that nothing was going through, and it would be four hours before we'd get an acknowledgment from eHealth that it was a whole of system issue, that it's not just us, and that means you've lost your whole day's ordering if you're out for four hours.

The other, I guess, thing that sometimes happens is you think you have ordered - you think you've gone through, and nothing's come up, nothing's been delivered the following day or the day after. But now I believe there's ways they can go in and see if it's gone through. I'm not exactly sure about that, but that was something else that had come up where the system tells you the app is working,

but it's not going through to Oracle for some reason, yeah.

Q. Those are what you have described as glitches or teething problems?
A. Mmm.

Q. Just thinking about the design of the system at a broader level, are there any disadvantages with the system or improvements that you think could be made to make things easier?
A. I know there's a push to try and automate the whole counting piece, as was mentioned earlier, and I - my background in stocktaking and inventory management tells me you will always need the human factor somewhere to reconcile your data.

So you can scan - you can come up with systems to scan out. I'm not sure how successful they'd be on a ward. On a busy ward you go in and grab what you need. You're not going to be scanning it out. So you can have a system where the door will have a scanning sensor that will count the product leaving, but my experience is there will always be inconsistencies in reconciling the data. So at some point you still need to do some sort of stocktake, manual stocktake.

Q. Is it your view that it would still be beneficial to have a greater level of automation with the stock checking, even accepting that there needs to be some human involvement in the process?
A. I think there needs to be a balance. I think if people think the whole thing is automated, they will stop looking at it, and I think you need to look at it, keep looking at it.

Q. Do you think the balance is struck correctly now?
A. I think it's close. I think it's close, yeah.

Q. Is there any mechanism for tracking, for example, delivery progress or performance against KPIs, for example, in the contracts that are used for DeliverEASE?
A. The only KPIs in relation to DeliverEASE that we are aware of is actually at the front line at our level. So the management and operations dashboard for DeliverEASE have KPIs and it's how we should be performing or measuring against those KPIs. The contracts that those products come from are medical consumable contracts which are head

agreements under HealthShare. I'm not familiar with the KPIs in those because, at the end of the day, we're not the contract managers, HealthShare is, and so I think, again, what's our role in managing those contracts, versus reporting or escalating if there are issues to HealthShare as the contract manager.

Q. So just at a general level when your district is involved in implementing whole of government or whole of health contracts, you don't have visibility of either what are the KPIs or the performance against the KPIs under those contracts; is that right?
A. Yes, that's right.

Q. Do you think it would assist in any way the role of your team to have more visibility of either the KPIs or performance against them?
A. It depends on the contract and it depends what our role is meant to be in relation to - if we're going to be monitoring and measuring the KPIs, then we're effectively managing that contract, and that is very resource intensive. Our role as users of the contract, and when there are issues we escalate them, is HealthShare's role, and I think that's how we work together.

Q. From your perspective, is that an effective system or do you think there are any areas for improvement in that balance that you've just described at the moment?
A. I think there are always areas for improvement. Sometimes, negotiations are made on contracts or terms are agreed that we're not aware of until the contract is released and that can be problematic, whereas we have a lot of clinician participation in the tenders. They're all part of the technical evaluation committees. There's no-one from the districts that's involved in the negotiation with the suppliers of the terms and conditions, and we don't necessarily see that until after the contract is signed.

Q. So just to break that down, firstly, there is clinician involvement --
A. Yes.

Q. -- from the district level in the tender process?
A. In the tender evaluation of clinical products, yes.

Q. And so there will be district input at a clinical

level into, for example, choosing the suppliers who are successful, that are successful in a tender --
A. Yes.

Q. -- or form part of a panel; is that right?
A. Yes.

Q. And is that the same for the prequalification kind of process that you described earlier?
A. No. Prequalification schemes are whole of government schemes managed by NSW Procurement and there isn't - there's a basic due diligence done, but the schemes contain thousands of vendors and they've all agreed to the government's terms and conditions, but there's nothing there that is a pricing schedule or anything like that. They've just been pre-approved suppliers, yeah.

Q. Do you think there's any value in having district involvement in the prequalification process or is that too high a level, do you think, for the district to be involved in?
A. Well, the schemes that we use - yeah, I'm not sure how much benefit there is. I am aware of contracts where they are whole of government but they are not prequal schemes, and they have not been done in a way that assists health and creates risks for health. So that's probably my bigger area of concern.

Q. Can you just elaborate on that concern a bit more?
A. The waste contract is a whole of government contract and that includes clinical waste and it's not - it's managed by a different agency, not by health, and there have been a lot of problems with that contract in relation to clinical waste, which puts hospitals at risk, and it's very hard to manage that contract and escalate because I don't know that there is understanding of just how serious it is at a hospital level.

Q. Do you have any views about how that issue might be addressed or improvements that could be made?
A. It was escalated to HealthShare, who agreed because they had also received the same complaints from a number of districts, and there was a view, there was a legal - there was legal advice that we could terminate for convenience, however, at the New South Wales state procurement level, that was not supported and they were just told that they needed to improve. But we're still having issues.

Q. That's prequalification. We've spoken about tenders. Then the other --
A. Sorry, that was whole of government contract. That wasn't the prequal, yeah

Q. Sorry, yes. Where you thought it might be helpful to have more clinical involvement from the district level was in the negotiation of particular terms of the whole of government or whole of New South Wales health agreements; is that right?
A. Not clinical involvements in terms and conditions but an awareness at our procurement level, at the district, of what sorts of terms and conditions were being negotiated. So the clinical role is fine, we do have that clinical participation. But the negotiating happens outside of the technical evaluation committee. That's done by HealthShare. And that's where I believe procurement in the districts need some visibility because we're closer to the ground of what - what some - the impact of some of those decisions could be.

Q. Are you able to give an example of where - an issue that has arisen because, in your view, you haven't had the level of involvement in or awareness of terms and conditions?
A. The recent enteral feeds contract is a contract that provides enteral feeds for hospital patients but also for patients at home that rely on feeds, and there was a - in the recent contract, it was negotiated that there would be a delivery fee, and there never was before, but that delivery fee would be waived if you purchased in bulk, so a pallet, for example. Which the hospitals can do, but the patients at home cannot. So it disadvantages the people at home who rely on these feeds.

Q. Just coming back to DeliverEASE for a moment. Do you know whether there is any plan to expand that system or implement a similar kind of system in relation to other types of goods and services that are procured within the district?
A. I was told that there was a consideration of extending it to pharmacy, and in discussions with our pharmacy director, it was not deemed suitable due to certain restrictions and regulations around medications that it probably wouldn't work the same way.

Q. Do you think there would be any value in rolling out a similar kind of system for other types of goods and services that are regularly ordered - for example, things like stationery?
A. Not necessarily, because these items are pre-approved, the volume - there's scope, I guess, for people ordering more than what they need, whereas on a ward, you generally will order what you need on a day-to-day basis for clinical use. I think if you opened it perhaps more broadly, people would be ordering other things for their own personal use that is probably not what - not able to be controlled because, as I said, it's pre-approved.

Q. The Commission has heard some evidence from someone within your district that DeliverEASE has not, at least yet, significantly reduced the amount of time that clinicians have to spend engaging with the process of ordering medical consumables. Do you have any comment about that?
A. Clinicians are not involved in ordering anything from DeliverEASE. It's done by either dock staff or clinical support officers. So there's no clinician involvement in ordering through DeliverEASE. So if they're ordering things that are not in DeliverEASE and they need approval to do so, that process hasn't changed, but we've put more and more direct purchase items into the DeliverEASE app, which means that normally where we would have to raise a separate order for direct purchases, if they are items that we deem imprest items, we've put them on to DeliverEASE. So if they were involved in ordering those direct purchase items, then they've saved a lot of time by using the DeliverEASE system.

Q. We've talked about DeliverEASE, which is one process for at least facilitating ordering. Can you just describe at a general level the other processes within the district that are used for ordering goods and services?
A. So there is iProcurement for single or one-off items that are not used commonly, and there's also GPALs, which are like a blanket agreement, it's a budgeting tool that is used to pre-approve expenditure for certain vendors for particular products, and that's approved every financial year based on what's required.

Q. Those are the two other main systems that you're aware of; is that right?
A. (Witness nods).

Q. We've heard some evidence about a system called search and request anything, or SARA. Are you aware of that?
A. SARA. Yes, everybody uses SARA. If you want to request holidays or annual leave, you have to use SARA, yes.

Q. How is that used in a procurement process?
A. At this stage it's only used for ICT software and hardware. It's not used for procurement. We have no real oversight of it except where we have been put as a gatekeeper by HealthShare. So we don't manage the system. But if we're a gatekeeper in reviewing an ICT request, that's when we will receive a notification through SARA.

Q. So if someone within your district puts in a request for an IT product through SARA, who does that go to?
A. It would go to the manager, the financial delegate for the product, and I can't remember the order, but at some point it goes to ICT to see whether it's the required - whether it's compliant, and then it would come to us, if it's compliant, to order, and we check the financial delegation and whether it's on a trust fund or something, and the order is placed.

Q. So you would be, effectively, the third step in the process?
A. Yeah, I can't remember which order but we're one of those steps, yeah.

Q. Do you know whether there is any system for keeping people who lodge a request through SARA updated about the progress of that request?
A. The SARA system does. It tells you where your request is up to, who it's waiting on.

Q. And so, to your knowledge, that would give you the capacity to contact whoever it is?
A. It would - it gives you the name. If it's with your manager awaiting approval, it will actually say your manager and I think it might even say their employee number. If it's with a gatekeeper, it will tell you where it is.

Q. Do you know whether people at the facility level within the district are given any training in how to use

SARA?
A. SARA is very intuitive and it's run by - I believe it's eHealth, to be honest, because when it started, the information came from eHealth to everybody. There is training for it. If you go on to the site, I think there are links to take you to training, but there's also training on the - I think HealthShare SharePoint, that describes how it is used. But it is a question and answer system, that sort of says, "What do you want to do today", and it's at that sort of level of "Do you want to buy something?"

If you want to - if you need a quote, so if you're buying software and you need a quote, you still have to go to your department - to the ICT department to get a quote.

Q. And that's not something that you would have any direct involvement - you wouldn't have any involvement in that unless the ICT team came to you; is that right?
A. Our ICT department have the pricing of everything that's on contract for them under the ICT scheme - well, under the ICT contracts, and they know what's on the scheme. So they do that gatekeeping for compliance.

Q. And if the software wasn't on contract, then that's a matter that the ICT team would manage; is that right?
A. They would get back to the person and say, you know, "It's rejected. This is not the product that we're using in the district."

Q. And what if it was a product that that person thought they needed for their job? How would that then work?
A. I imagine they would be talking to someone in their ICT department about why they need it, put up a request, and they'd probably have to go to a high level for approval. Because --

Q. That's not a --
A. Well, it depends if there is a contract for that item. If there is a contract and they want to buy something else, that's problematic. If they want to buy something for which there is no contract, that's probably a bit more straightforward, but it always has to go through our ICT department because they're very aware of cybersecurity, they need to do a cybersecurity assessment, and they also need to see how it fits in with our standard operating environment, so there's a number checks and balances and

due diligence that the ICT department will do, which is why they are a central gatekeeper in all our ICT purchases.

Q. You've described the SARA system as being very intuitive. Do you think people could have different views about that or do you think it's just obvious?
A. It depends what exposure people have to systems. . If I compare it to Oracle or to Stafflink or to other systems that we use, it's probably the most intuitive system we have in health.

Q. If someone needed assistance with using the SARA system, who would they go to?
A. I believe there's the statewide service desk phone number on the bottom of the page - of every page, the 1300 number. You would ring that number.

Q. We've also heard some evidence about an S1 form.
A. Mmm-hmm.

Q. Are you aware of that?
A. Yes. That's our - it's our manual requisition form, so it's actually an ordering book with carbon duplicates underneath, and it replicates what an iProcurement requisition would look like in the system. But it's manual, as in that it's written, and we still use it particularly for requests that need to go to finance because the funding is coming from a trust fund.

So if it comes from a trust fund, that requisition has to be checked by finance to ensure there are sufficient funds in the trust fund, and if it's above a certain threshold, it might have to go to the chief executive, who will want to have all the quotes, all the background information, the brief requesting the product, all of that goes together as one bundle, so that's why that tends to still be done on an S1 requisition.

Once that's approved, that comes to my team who will actually put it in the system, put the order in the system, the requisition.

Q. Is that the only situation that you're aware of where the S1 form would still be supposed to be used?
A. There's a couple of areas where it still needs to be used. We had looked at, last year, trying to do away with them, and that's when we realised there are still some

processes that required the manual form, but we're still in a - in a stage of transition where we're trying to get more and more people to order directly from iProcurement and not use the S1 form, but we have both.

Q. Just on the first scenario that you gave about the number 2 trust fund, if items are being bought with funds from that trust fund, do they have to go through state contracts or prequalification schemes or not?
A. Yes. Yeah, they still have to comply, yeah, with the - all our policies, yes.

Q. You mentioned trying to, as I understand it, get people to transition away from using the S1 form to the iProcurement system. Can you just describe how you've gone about doing that?
A. We started with what I thought was a soft launch, where my team, when they were receiving the S1 forms, they would contact the requester and say, "We're moving away from these forms. Can you please raise them in iProcurement? Contact us if you need training and here are the HETI training modules that you can use."

So we did it that way and there was a bit of a backlash where some people said, "No, but my manager wants to sign it", and we said, "But you can do that in iProcurement". So clearly that's part of our training push at the moment for people to understand you can still approve them in the system, you don't have to physically sign.

But then there's - I can't remember - I think three or four areas where we still have to use the S1. So we still encourage people, where we look at a requisition and we know they could have done it online, we do write back to them and say, "Please put this online in future. We can help you with that." But for the others, we still process them, because it is part of the approval process.

Q. When did that soft launch happen?
A. At the beginning of last year, I think.

Q. Are you still engaging with that training and knowledge building process?
A. We're talking with the stakeholders about what the exceptions are and how we manage those exceptions because we don't want people to feel that it's an inconsistent

process. We want them to understand that, "This is when you use an S1 form, continue to use an S1 form", and that depends on delegations and the cost value of the requisition, "And this is when we want you to use iProcurement." That hasn't been straightforward to explain to people, yet.

Q. Is your team planning to engage in any sort of formal training for everyone within the district who might need to use the system?
A. There is formal training available through the HETI modules, through the statewide training. We do have someone who does train people in how to use iProcurement, but we would launch it as a bit of a roadshow of how everything - you know, put a lot of comms, communication, together about how we will support people to change over, yes.

Q. And is that something that's in train or being thought about?
A. It's a big project. It's not, at the moment, in train because we're doing another piece of work around GPALs, but it's still on the "working at it slowly" project.

Q. Let's then just talk about GPALs quickly. What does that stand for?
A. GPALs stands for global purchasing agreement local.

Q. That's a bit of a paradoxical title. Can you just elaborate on what that system actually does?
A. It's a budget management tool where, if you buy regularly certain items from a supplier over the course of a financial year, you determine how much you need to spend, based on historical spend, or demand coming forward and what's on contract, whether that supplier is still on contract, and you apply for approval for that sum of money. So if you estimate it to be 100,000 or 200,000, you put forward the vendor's name, the particular account codes you will order from - so it's quite specific to what you order - and you put it up for approval ahead of the financial year. And then we will raise a purchase order number that you can use every time you need to order from that vendor.

Q. Just tracking through that process, you've said "you" a few times, is that someone in an individual hospital, for example?

A. A requester, yes.

Q. So, for example, if someone - can you give an example of how this system might be used in practice?
A. In our theatres, for example, a lot of the high-cost items that need to be ordered regularly - so it could be the prostheses - we would have a GPAL order number with one of the big suppliers and every time we need to order, we would send through a request, we would typically - we can use h-trak as a pro forma for that and send through a request to order the items without having to have any other approval because the budget for that has been pre-approved.

Q. And this is a system that sits alongside DeliverEASE, so it wouldn't be used for items within DeliverEASE; is that right?
A. That's right. GPALs actually are a functionality of Oracle, they sit within Oracle, but they work differently to DeliverEASE, yes.

Q. So it interacts with the iProcurement system, is that right, or is it something distinct?
A. Yes, it - it's already a purchase order, so it sort of skips the requisition stage and goes straight to order.

Q. And that's based on a pre-approval up to a certain amount of money for a specific type of product; is that right?
A. Yes. Certain account codes, yeah, that you can order. Yeah.

Q. Can I just ask that you be shown a document quickly. It's exhibit B.023 tab 154, which is doc ID [MOH.0001.0413.0001].

I'll just ask for that to be blown up a bit for you. I'm not sure if you can read any part of that, Ms Kokkinakos, but --
A. Yes, I can, thank you, yes.

Q. -- do you recognise this document?
A. I can't say that I do recognise it. I'm familiar with something else we've come up with, but this could be local to facility.

Q. Can I ask you this: are you familiar with an Excel

spreadsheet that is used as part of the GPAL approval process?
A. Yes, yes.

Q. Might it be the case that this is a tab within that or a worksheet within that Excel spreadsheet?
A. Yes, yes.

Q. Do you recognise it as that or not?
A. It's certainly saying how to - it's telling you how to fill out that template and I'm aware of that Excel template, yeah, it comes from finance, yeah.

Q. Let's just scroll down to the last page. Is this the template that --
A. Yes. Yes, that looks right.

Q. Can you just explain for us at a high level what is it that you have to do with this template?
A. So this is where you write all the details that we're going to need to raise your GPAL order, but it also has all the information finance needs and all the information the financial approver, the executive, need to approve, so we need to know what cost centre, which - that is who will be paying, ordering and paying for the product, so the cost centre number and the cost centre description, which are in Oracle; who the company and vendor are; what their ABN is, because that's how we cross-check that it's the right vendor; what are the account codes, which are the group of items you're going to be ordering from this vendor and what that description is on the account codes, again, that's a check; what the approval you received for the previous year was and how much you had spent as at 1 May. So every month we send out what's called a trigger report to everyone that owns a GPAL and it says, "This is how much money you've spent, this is how much you have left".

So that's where they would take that figure for expensed as at 1 May, and then what the projected expenditure was for the end of last financial year. Do they have an existing blanket order or GPAL for that or is this going to be a new one for the next year, and how much money are you requesting for the next year and what's the variance from the previous year? Is it higher or lower? And then a big section to justify if you are making changes.

Q. Who is it who would normally submit this GPAL request?
A. Theatres use them a lot. A lot of the big departments that do a lot of purchasing of the same items over and over again - could be some engineering, could be radiology. It's not wards, it's other types of departments, yeah - ICT.

Q. In theory or in principle at least is it possible to use the GPAL system for any type of product that you might order regularly, or is it limited to certain types of products?
A. You can use it for anything, but you wouldn't use it for medical consumables that you would get from DeliverEASE or from the warehouse, yeah. It has to come directly from supplier, and it's not part of that everyday catalogue.

Q. And could you - you could use it for services as well?
A. Yes, you could - for pest control, for example, yeah.

Q. So anything that's on an existing contract, whether it be statewide or local - other than --
A. Yes, yes.

Q. -- things that are ordered through the DeliverEASE process?
A. Yes.

Q. Are there any other systems in the district for streamlining approval processes?
A. Not that I can think of at the moment.

Q. We've heard evidence, for example, that a nurse unit manager might only have the financial authority for procurement up to $50; is that something that sounds right to you, or do you not have knowledge of those sorts of levels?
A. I don't have knowledge at that level, I deal more with the higher delegations, but I do know that the systems have been set up so that there's no need at that local level for delegations, so that's why DeliverEASE is there, that's why GPALs are there. So these things are pre-approved so that people can get on with their clinical roles. If you have a delegation, chances are you'll be approving a lot of things, so you'll be spending a lot of time doing that process.

Q. Do you think any improvements can be made in that

regard, other than DeliverEASE and the GPAL pre-approval kinds of systems?
A. I think it depends what we're trying to control and how often things are ordered. I think for the things that you use every day, I think there are, for the most part, good systems in place to pre-approve or expedite approvals. I think there will always be people who would like a greater delegation and greater autonomy. I just think in an organisation this size, the way we track what people order and what they're requesting, I wouldn't make too many changes. I have three people who do gatekeeping and we can see the sorts of things people like to order that they maybe should not be ordering.

Q. In your experience, is it common for multiple layers of approval to be required for procurement within your district?
A. Depending on the level of expenditure, but sometimes it also depends if something has to go to a separate gatekeeper, and if someone holds the budget for something that is not their direct reporting line, which is more of an Oracle issue.

So in some of the clinical areas, people may report to someone outside their direct report in Oracle, so my team then has to move that product, that requisition, away from the direct approver to somebody else to approve and then bring it back. So that's a manual process, which looks like there's a lot of approvers, but what we're doing is just moving it around to make sure the right person sees the request.

Q. Do you see the potential for delays as a result of that process? Is that something that you've seen?
A. Where I've had people say that it takes a long time and they'll send me a snapshot and say, "Why do so many people have to look at it", invariably, it's often someone who's on leave and has given - delegated their approval to someone else, so in the system that looks like it's going through two people, but if you look at how long it stays with certain people to approve, it's not my department that sits on it; it will generally be a manager who may be on leave and hasn't delegated their access to anyone or - so there can be times where things will stay longer than they should, but I can't say that that means that person should have a delegation, just because of that.

Q. Again, do you see any opportunities for improvement in relation to that issue?
A. If we could improve some of the functionality in Oracle so we can - things could be moved around more quickly, that would help. Yeah, the putting in a vacation rule is something that most people forget has to be done and then things get stuck. So the system, improvements that could be made in Oracle that help that side of things, keep things moving, definitely.

Q. Do you think that the number of different approval - sorry, different procurement processes and pathways within the district might be confusing for people on the ground who have to engage with those processes?
A. If the person is completely new to health, probably, but it really - health is a people business, so you're always talking to people. So that's how people will find out, "How do I order this? How do I get this? Who needs to approve this?" That happens.

My team on the ground, we know there are 1600 people who have iProcurement access. We know every single one of them. My team will know every single one of those people and they can ring our people directly for service. If they have to ring a service desk and raise a ticket, or whatever, I know it puts people off, so we really try and go out of our way to make sure they can ring one of our team if they have a problem or they're stuck or they're not sure about doing something.

So my view in most positions, not just procurement, is there's always someone in health you can talk to - always.

Q. Is this a fair summary of your view, that you think it's an issue of education rather than streamlining, further streamlining, of the processes themselves?
A. There's opportunities for both. There's opportunities to streamline, definitely, but some of them are system issues that we can't change. How do we work within that system, I believe is really important, and I think just having someone to help you do something is really important.

Q. And can you just identify those system issues that you think could be streamlined?
A. Oh, the way the vacation rules are set up in Oracle for example. Being able, in Oracle, to move the approvers

for certain things out of that direct hierarchy, so being able to move that around automatically rather than us having to do it manually, would also help, which could be if you're linking a cost centre, that the person doesn't normally sit in, and if that other cost centre has to approve, we have to move it to the approver of that cost centre. That's a manual function.

Q. So it's really streamlining things within the iProcurement system; is that right?
A. Mmm, yes.

Q. Just two more things finally. You have mentioned a couple of times "h-trak". Can you just describe what that is?
A. H-trak is a software system that tracks and monitors use of items. For us, it's our high-cost prostheses and consumables that are used in our procedural areas. We have 12 areas around Sydney Local Health District. So they track the patient, because they talk to the clinical systems; they track what procedure the surgeon is doing; the implantable, so from a TGA requirement, we have to be able to track patients that have anything implanted in them, and h-trak enables that; it tracks expiry; tracks products - it does a lot of things, and increases our billing because we can identify all patients to be billed.

Q. Do you have any awareness of the SmartChain project?
A. Yes, I do, yes.

Q. What does that involve from your perspective?
A. SmartChain has a number of modules and it's really about improving data flow end-to-end in procurement, using Oracle. So all the systems that are being built within the SmartChain project are being built in Oracle, is my understanding, and data flow, sourcing contracts, procure to pay, master data management are all sort of projects sitting within SmartChain.

Q. Have any of the modules been rolled out in your district yet?
A. Well, originally I thought DeliverEASE was one of the SmartChain ones and now it has taken a life on its own, so I tend to think we have done that, and we're now embarking on sourcing and contract which is another module that two of my staff are involved in.

Q. Are you aware of a module called "Traceability"?
A. Yes.

Q. Has that been rolled out?
A. No, because we have h-trak.

Q. You have answered my next question. It's similar in its functionality to the h-trak system you already have; is that your understanding?
A. It's being developed to replicate what h-trak does, yes.

Q. Finally, what's your experience when - if and when - you have to escalate procurement issues to HealthShare?
A. As with most contracts, we aim to resolve issues directly with the supplier first off. If we continue to have ongoing issues, we will reach out to someone in HealthShare who oversees that contract and say, "These are the problems we're having." If other districts are having the same problems then HealthShare will take more of an active role in talking to the suppliers and helping to manage the issue. Otherwise, they are a bit hands off in saying, "Well, it's only with your district, so try and deal with it and see how you go."

Q. Do you think there is any room for improvement there?
A. Sometimes I think there is. There needs to be more ownership, because we're not the contract manager, so we can't influence things in that way that the contract manager can, that being HealthShare. It depends what it is. Some contracts are managed really well, some of them sort of stumble along.

Q. Do you have a particular example that you have in mind about one that could be perhaps managed better?
A. There was one that was released last year, which is a relatively small contract on dental consumables, where one of the companies went bankrupt and ceased trading and they were on the contract, and when we found out we asked HealthShare, who were not aware of it, and the person managing that contract said, you know, "Don't worry about it." We felt they needed to tell everybody else in the state what had happened and they needed to also tell us what alternatives were going to be available, since this supplier was no longer trading, and there was a view of, "It's okay, don't worry about it", and so that was a bit frustrating. There were also a number of price

discrepancies, things that hadn't been followed through from a pricing point of view with that contract that were incorrect, and we ended up overpaying and having to try to get credits because the information provided to us from HealthShare about that contract was incorrect.

Q. I take it that that sort of scenario you have described involves a cost to the LHD?
A. Yes, not - cost in terms of product, in terms of overpaying, and a lot of time chasing up. The cost of change is significant, and if you're chasing up problems it just blows out your time.

Q. Is it common that the LHD still incurs not insignificant costs in administering statewide contracts?
A. Administering the contracts from an implementation point of view and a compliance point of view is resource intensive because it's complex, because you are dealing with people at the pointy end and different things have to be done in different ways to get the best outcome or optimise that contract. So if it is a corporate contract versus a prostheses contract versus a consumables contract, we have a different way of implementing them and monitoring those contracts. It is intensive but that's where the value is, in being able to make it as easy as possible to implement, easy as possible for clinicians to use and get the value for money that we want as well.

MR FULLER: Thank you, Commissioner.

THE COMMISSIONER: Is there anything, Mr Gyles?

MR GYLES: Yes, a couple of questions. That's something of a master class of LHD procurement, obviously this witness is pretty expert in the area, so I might just ask a couple of broader questions, in case it is of any assistance to you, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Ms Kokkinakos, one of the things that the Commissioner is looking into is, perhaps at a slightly more macro level, whether or not the health system in its current form is delivering efficiencies in the provision of health care and health outcomes to the people of New South Wales. Your role in the system is at LHD level, and can we take it, or can you comment on whether at your level,

within your LHD, your procurement team is, on a day-to-day basis, attempting to drive efficiencies in the acquisition of goods and services within your LHD?
A. Yes, definitely.

Q. And you would appreciate that there is a balance between a centralised system and local decision-making within the health system?
A. Yes.

Q. And do you find, on a day-to-day basis, that it is a benefit for your LHD in procuring goods and services to enable these health outcomes to be obtained, to be able to leverage off the statewide contracts and some of the pricing that's available through that?
A. Generally, yes.

Q. There is also a governance aspect that sits across, for example, HealthShare and the statewide bodies, which then provides a framework in which the LHDs engage in their decision-making, and that's again a balancing exercise between those two important things, which is the ability of the LHD to be able to act in some respects and make its own decisions about things, but within the greater governance structure. Now, do you find that that balance is a fair balance and do you find that the system provides a good balance in that respect?
A. To some degree. My view is that standardisation is appropriate, but that's different to centralisation. The needs on the front line are changing so frequently and I think that that partnership role with the central agencies is critical. It is no longer just a consultation piece. We actively need to partner if we want to standardise and still have room for innovation and still have room for local - you know, we will always have patients that need a customised prosthesis that might be 3D printed. We will always have people with certain allergies that no medication that is on contract is suitable and we have to buy something else. As long as we can still tailor it to the patient when needed, the standardisation piece is important. How much that needs to be centralised depends what strength of partnership there is there with the local health districts on the front line.

Q. Partnerships between the local health districts and bodies like HealthShare and eHealth; is that what you're talking about?

A. The shared service - yes, yes.

Q. So the stronger those relationships, the more likely you can have a coordinated and better response; is that the position?
A. Yes, yes.

Q. And to the extent that it was suggested, if it was suggested, that procurement within your team is too driven by price as compared to what might be described as value, what would you say to that?
A. I would say they are wrong because value is all-encompassing. It's a bit - it's like that saying, you know, "Price is what you pay, value is what you get", and so our view is, if it is not fit for purpose, I don't care what the price is; it's not value.

THE COMMISSIONER: I'm happy enough to get the answer, but I don't recall Mr Fuller putting that proposition in those terms. But it doesn't matter much.

MR GYLES: Perhaps it is floating around in there. Sorry, I was talking about one of the previous witnesses who seemed to be - that seemed to be at least one of the possible comments that were being made. I don't have any further questions.

THE COMMISSIONER: I'm not sure whether that's quite right, but it doesn't matter. Is that all?

MR GYLES: Yes, that's all.

THE COMMISSIONER: Thank you, Mr Gyles. Nothing arose out of that, or did it?

MR FULLER: No, thank you, Commissioner.

THE COMMISSIONER: All right. Thank you very much, Ms Kokkinakos for your time. It is greatly appreciated. You are free to leave us now, thank you.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. 2 o'clock, then, with Dr Anderson, is it, at 2?

MR MUSTON: Yes.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock. Thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner. The next witness is Dr Teresa Anderson. She's in the witness box.

<TERESA MAREE ANDERSON, sworn: [2.00pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Would you state your full name, please?
A. Dr Teresa Maree Anderson.

Q. You are currently the chief executive of the Sydney Local Health District?
A. Yes.

Q. And you've been in that role since January 2011?
A. Yes.

Q. Prior to that, you've had a long career in NSW Health, if I can put it that way?
A. Yes.

Q. Various roles in various districts?
A. Yes.

Q. You made a statement to assist the Commission on 31 January 2024; is that right?
A. Yes.

Q. It is exhibit B.004 [MOH.0001.0258.0001]. Do you have a copy of your statement there in the witness box with you?
A. I do.

Q. The statement that you've prepared is primarily focused on the issues around procurement in your district; is that right?
A. Yes, it is.

Q. I'm going to ask you some questions based on your statement, so I'll refer you to some paragraphs and ask you some questions about them. If anything is unclear at any stage, just let me know, okay?
A. Thank you.

Q. If we can start at paragraph 6 --
A. Yes.

Q. -- there you refer to your membership of NSW Health committees, but in particular, the NSW Health procurement reform steering committee and the NSW Health pharmaceutical reform steering committee. Do you see that?
A. Yes.

Q. Starting with the procurement reform steering committee, what's the function of that committee?
A. That committee is a NSW Health committee and it is overseeing the NSW Health reform of procurement.

Q. You joined that committee in about August 2020?
A. I did.

Q. Is it still active?
A. It is.

Q. When you say the NSW Health procurement reform, what do you mean by that?
A. So it was identified in '19/20 that we needed to reform our procurement --

Q. 1920?

THE COMMISSIONER: Q. 1920 or 2020?
A. Oh, 2019 and 2020 financial year. Sorry.

Q. It probably was in 1920 as well.
A. It probably was.

THE COMMISSIONER: They were probably recommending value based health care and other things we have heard too back then.

MR GLOVER: Q. Sorry, we cut you off? You recognised in 2019?
A. That there were improvements we could make in procurement. We had been working on procurement prior to

that and how we could streamline it to provide better value for our patients and also for our staff. But in 2019/2020 financial year, we determined that we needed to take some further steps, and so the procurement reform committee has representation from the ministry, from the pillars, like HealthShare and eHealth and NSW Health Pathology, and also from local health districts.

Q. In that answer you referred to "we". Who is the "we" that you're referring to?
A. "We" is NSW Health. Although we have local health districts, we are all part of the New South Wales health system and we work together to provide services to the people of New South Wales.

Q. And was that committee stood up in that 2019/2020 period or was it existing prior to then?
A. It was in August 2020.

Q. That it was established?
A. Yes.

Q. The pharmaceutical reform steering committee - what's the function of that committee?
A. So that committee is looking particularly at how we manage medicines and - as a state, and one of the working groups from the procurement reform committee is around medication management and we have established as part of that procurement reform committee a specific working group to look at how we can do better with the procurement and management of medicines, and from that, we've established the statewide medicines formulary, so one formulary for the whole state.

Q. We'll come back to the formulary in a moment.

Would you just turn ahead to paragraph 12 for me.

THE COMMISSIONER: Q. How often do those committees meet, Dr Anderson?
A. They meet on a monthly basis.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. Are there minutes taken?
A. Yes, there are.

Q. In this paragraph, you give what might be described as a summary of the work that is being undertaken. Do we understand that the summary in this paragraph refers to the work that flows from the committees to which you have referred earlier?
A. Yes.

Q. When you say in the first sentence of paragraph 12, "Significant work has been undertaken through this reform", what work are you referring to?
A. The work refers to a number of areas. So one is on strengthening the management of contracts as a state and state-based contracts, so that has included embedding additional contract management staff within the local health districts to assist in the implementation of statewide contracts to get the best value out of those contracts.

Q. So those staff - when you say "embedded" - are they permanent staff within the districts or are they temporary staff?
A. We had temporary funding from NSW Health for those staff. In our district we made them permanent because we have seen a very good return on investment for those staff in the implementation of those contracts.

Q. In an earlier answer I think you said they're there to assist with contract implementation. Did I hear you correctly?
A. That's correct.

Q. Does that differ from contract management?
A. So contract management - most of our contracts are either whole of government contracts or whole of health contracts. There are very few that are just with the districts. And we've been working through a process to implement those statewide contracts and there is a lot of implementation that's required, change management that's required, at a local health district level.

Q. When you say "implement the contracts at a local level", what work is required to implement those whole of government or whole of health contracts at a local level?
A. So it's not just a matter of switching on the contract in terms of procurement. There are changes that are often required at a ward level and also in our information systems. So, you know, with DeliverEASE, for example, we

need to change the barcoding within every storeroom within our hospitals. Just at one hospital, like RPA, we would have, you know, 69 different wards and therefore many, many storerooms.

Q. How are those whole of health or whole of government contracts managed as distinct from implemented?
A. They're managed - depending if they're contracts that sit with HealthShare or with eHealth or with the government, they're managed at that level.

Q. So under those contracts, your LHD can acquire goods or services; correct?
A. Yes.

Q. And those goods or services are delivered directly to your LHD under those contracts; is that right?
A. Yes.

Q. And if you have performance concerns about the supplier, are you aware of any process that's available to your LHD to deal with those concerns?
A. There's a range of processes. On a day-to-day basis that might be done at the dock level or at the ward level, if a supply - a good doesn't turn up, and that would be escalated to HealthShare through the normal process.

If it's a recurring problem, it would get escalated to our procurement - our local Sydney Local Health District procurement team; and if it's an ongoing issue, I would be escalating that to my colleague within HealthShare.

Q. In paragraph 12, in the second sentence, you say that the work - that work being referred to in the first sentence - is delivering financial savings. Do you see that?
A. Yes.

Q. What sort of financial savings did you have in mind?
A. So if I look at contract implementation, for example, the three additional staff that we have employed to assist with the specific contracts that we are tracking with HealthShare and as part of the procurement reform, we have made significant savings. We anticipated the savings would be around - I can't remember exactly, but around 600,000. We have, on those particular contracts, actually made savings closer to 1.2 million.

Q. Savings in respect of what?
A. The purchase of goods under those contracts.

Q. So the purchase price of goods under that contract; is that what you mean?
A. That's right, yes, savings.

THE COMMISSIONER: Q. Those figures that you just nominated - 600,000, 1.2 - where have you sourced those figures from?
A. They're tracked through the dashboards that we have. So part of the reform is giving greater visibility and so we track those particular contracts and our performance and savings against them and that's standard across the state.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. Jump ahead to paragraph 21, please, in particular, paragraph 21(a).
A. Yes.

Q. I should have done this at the start, but I understand there are a couple of minor corrections you wish to make in your statement; is that right?
A. Yes.

Q. One of them is in this paragraph, 21(a), the figure on the third line from the bottom, 200,000, should be 250; is that right?
A. That's correct, my apologies.

Q. No need to apologise. There's a very similar or the same correction in paragraph 67 on the last line?
A. Yes, that's correct.

Q. 200,000 should be 250,000? And in paragraph 121, the second line, last word, "central", should be "enteral", E-N-T-E-R-A-L; is that right?
A. That's correct.

Q. And they're the only changes that you wish to make; is that right?
A. Yes.

Q. Back to paragraph 21(a), there you refer to the "Major Procurement Assets and Imaging Steering Committee". That's

a committee that's established within your local health district; is that right?
A. Yes.

Q. Established during your tenure?
A. Yes.

Q. Why?
A. We collectively felt, the executive and the board, that we needed greater oversight in relation to asset management, procurement and imaging and also increased engagement of our clinicians in that decision-making, so it's a strategic committee of the district. It is co-chaired by myself and one of our clinical directors, and the composition is made up of not only executive and procurement staff, capital infrastructure staff, but also clinicians.

Q. I might just bring up on the screen to your right, Dr Anderson, the terms of reference, it's [MOH.0001.0414.0001]. It's exhibit B.023 at tab 151. There you can see a long list of members?
A. Yes.

Q. And is that membership designed, as you have mentioned in an earlier answer, to have a wide range of representation; is that right?
A. Yes.

Q. And its objectives are succinctly stated in a sentence, but what is the intended function of this committee, to you?
A. It is to assist the chief executive and the board in prioritisation, implementation - as it says, implementation, management and coordination of our assets. So that's our physical assets and our equipment, our imaging and other procurement and contracts, so for over $250,000.

In all health services, we have a finite budget that we have to manage, and we need to prioritise what we spend that budget on.

Q. What sort of advice or assistance are you in your role of chief executive getting from this steering committee?
A. The committee helps to oversee our annual planning of our assets, so the asset management plan and strategic

asset management plan that we submit to NSW Health on an annual basis, and that includes an assessment of our physical assets, buildings, but also major equipment.

It also helps to oversee business cases for over $250,000 and there is oversight around major contracts that have been established, the whole of government and whole of health and their implementation within Sydney Local Health District.

Q. And when you say it considers business cases, how does it do that?
A. So it reviews business cases that our clinicians, departments, submit to the district.

Q. Is there a practical example you can call to mind to illustrate its work in this area?
A. Yes. So when we're buying a CT scanner, which would be in the millions of dollars, a business case is developed. That business case is developed with assistance from our finance team and business units and then that is submitted to the district for approval.

Q. And part of the approval process is its consideration by this committee; is that right?
A. That is right, mmm-hmm.

Q. And part of the work of this committee is to assist you in making decisions about prioritisation, given your budget limits?
A. Correct.

Q. Is that right?
A. Yes.

Q. If you go down to paragraph 21(c), please?
A. Yes.

Q. That's a different steering committee, this is a contract implementation steering committee, and you have given a general overview of its role there. One of the aspects of its role that you refer to is to support value based health outcomes. Do you see that?
A. Yes.

Q. What does that mean to you?
A. So this is really about making sure that we get value

out of the contracts, not just in terms of savings, financial savings, but improved outcomes for our patients and the experience of our staff, helping to streamline the processes for our staff.

Q. And how do you measure that?
A. In a number of ways. One is the feedback that we get from our staff. So with the implementation of DeliverEASE, we undertook with HealthShare surveys of staff, also had working groups to get feedback from our frontline staff.

Q. And in an earlier answer you said that it's not just about financial savings; is that right?
A. That's correct.

Q. If you just jump ahead to paragraph 121 of your statement, please, just have a read of that paragraph to yourself and let me know when you have done that.
A. Yes, thank you.

Q. What's the issue that you're raising there?
A. The issue here is that we have patients who require enteral feeding, so colloquially, tube feeding, and that commences usually on a ward, in an inpatient area, and the contract covers that.

The previous contract was very much about the provision of enteral feeds on the ward which didn't include a delivery fee for when the patients went home. When the contract was negotiated, I think because the local health districts weren't actively involved, what they didn't realise was that our patients, when they got home, buy those feeds off the company, they don't buy it through us but they buy it off the company, under that contract. So if you buy over a certified amount, so a pallet, then the delivery fee is waived, but you can imagine a patient at home does not need a pallet of enteral feeds, so patients are being charged a delivery fee, and that is problematic for our patients, because many of these patients haven't got the financial ability to pay.

Q. So that's a specific example of a lack of engagement in the contract planning process; is that right?
A. Correct.

Q. And the lack of engagement by whom with the LHD?
A. That was negotiated by HealthShare, and we have had

that discussion with HealthShare to make sure that in future, the local health districts, and particularly our clinicians, are much more actively involved in those negotiations.

Q. In the first sentence, or the first half of the first sentence of paragraph 121, you raise the issue that where there is that lack of engagement, price rather than value can end up being the primary driver. What were you referring to when you said that in your statement?
A. Because the new contract is cheaper, but it has a consequence, and the consequence is that there's a flow-on effect for our patients.

Q. Paragraph 21(f), just have a read of that and let me know when you are finished.
A. Yes, thank you.

Q. There you refer to the engagement of clinicians in making decisions in relation to goods and services. Are there opportunities for others within the LHD to be engaged in the decision-making process around goods and services that might be provided to the LHD, whether on a whole of government or whole of health contract or locally?
A. Yes.

Q. How does that occur?
A. We have a wide range of structures that enable clinicians to give input into the decision-making of the organisation. There are a number of committees that we mention - I mention in my statement. But also we have regular meetings with our clinical streams that are headed by senior clinicians and they have discussions with heads of department. Staff are aware of escalation processes that we have within the district to raise issues. When we have new procedures, that will often be discussed with the heads of department and then will be escalated through the normal governance structures.

Q. So they are processes for clinician involvement on clinical issues; correct?
A. Yes.

Q. What about more operational issues? So you gave an example earlier where a contract had been implemented that had perhaps some unintended consequences?
A. Mmm-hmm.

Q. Are there opportunities for what might be described as operational staff to have input into these processes?
A. Oh, absolutely.

Q. How does that occur?
A. The same mechanisms. We don't separate out the clinicians and the operational staff. They come together.

Q. How do you ensure that the representation is wide and varied on these processes?
A. We do it through a range of mechanisms - people who volunteer; we also, if we feel that there isn't a good distribution of people - for example, in some of the committees, it's been really clear that we haven't had enough junior medical staff or junior nursing staff involved, and so we will go to our various structures to get volunteers or to tap people on the shoulder.

Q. When you refer in your statement and in your answers a moment ago to "clinicians", who do you include in that description?
A. Clinicians are nurses, doctors, allied health, imaging technicians - so "clinician" really is someone who deals directly with a patient.

THE COMMISSIONER: Q. You were taken to the terms of reference for the major procurement asset and imaging steering committee, and it's got all the members. It's outlining all the kinds of people and the positions you're describing?
A. That's right, nurses, doctors, allied health, yes.

MR GLOVER: Q. Would you jump ahead to paragraph 58, please. In this section of your statement you describe a number of mechanisms by which your LHD can acquire goods and services through a range of arrangements. I'm just going to ask you a few questions about some of those particular arrangements.

In paragraph 63 you refer to the medications formulary, and you touched on that earlier in your answer, as part of a recent part of the reform package; is that right?
A. Yes.

Q. What is it?

A. So historically, each local health district, and sometimes each hospital, managed their own formulary, which is the list of medications that can be used within that facility, and to streamline processes we've centralised and have one medicines - medications formulary for the whole of the state for inpatient initiated medications, and that has involved local health districts as well as Ministry of Health and the pillars.

Q. What are the benefits of that, to your district?
A. The benefits are in terms of consistency, a reduction in clinical variation, because we're all singing from the same hymn sheet, also mobility of staff, so if we've got junior medical staff who rotate from one hospital to another, they have the same formulary from which to work.

Q. Are there any limitations?
A. We are still in the process of rolling out the formulary, so there are some challenges in terms of brands of medication that might be appropriate for one purpose but aren't for another. So I give the example of products that might be for intramuscular injection only and we may need it for intravenous administration, and there is a mechanism for us to be able to escalate to get access to that.

Q. In this passage of your statement, if I can summarise - tell me if you disagree - the effect of it is that your district utilises the centralised services and statewide and whole of health contracts to the maximum extent possible; is that right?
A. That's right.

Q. Have you ever come across or been made aware of an occasion within your district where a supplier might make an approach to a clinician to start using a new product or one of their products?
A. Yes.

Q. How is that handled within your district?
A. The clinicians have been educated that they need to escalate that to the procurement team.

Q. And how is it handled from there, to your knowledge?
A. The procurement team would have a discussion with that vendor and link them in with HealthShare.

Q. Are you aware of any instances where things might have

been used without that process having been undertaken?
A. Not recently. Historically, yes. So we put in processes to restrict who can go into, for example, operating theatres and what they can take into the operating theatre, but I think - I haven't heard of anything lately.

Q. Could we jump ahead to paragraph 80, please. In this section of your statement, you deal with supply chain issues, and in paragraph 80 you refer to some that were in existence prior to COVID becoming part of our lives. What did you have in mind?
A. From time to time, there might be a shortage of particular medications, it could be in relation to equipment, it could be in relation to any goods that we receive, but prior to COVID, those disruptions were pretty minimal, but since COVID it's been more challenging.

Q. In what way?
A. Some suppliers have - are no longer in business; you know, even something like Aspro Clear is not available at the moment.

Q. Are there arrangements to acquire or share stock between districts? So if you have sufficient quantity and another district doesn't, can they come to you and acquire what they need?
A. Yes.

Q. Is that done by a formal arrangement or is it on an ad hoc basis?
A. It's ad hoc because it's not something that happens all of the time, but we document what we lend or what is lent to us, and then it's replaced.

Q. Is there any part of the procurement reforms that are being undertaken likely to assist in that sort of process?
A. The implementation of SmartChain will increase the visibility through better data of where the supply chain is up to.

Q. In paragraph 87 you say:

It is recognised that there are disadvantages and limitations of the current procurement and service delivery arrangements applicable within [the Sydney

LHD]. This is why the NSW Health Procurement Reform is under way.

What are the limitations and disadvantages that you're referring to there?
A. So we're in the process of the reform, so DeliverEASE, which is an inventory management system for our wards - and that's particularly looking at medical consumables for our wards - we're in the process of implementing that. We haven't finished implementing that across the state, and in Sydney Local Health District, we commenced with RPA, we have now completed Concord, we're soon to implement it at Canterbury and Sydney Dental Hospital.

Q. So that's a response to the limitations?
A. Correct.

Q. What were the disadvantages and limitations that you had in mind in that sentence?
A. So storerooms, stock rooms, are a challenge in all health systems and big organisations where you're using significant consumables, when you've got busy wards, and being able to track those consumables and make sure that they are replenished, but also making sure that there is no waste. So we don't want to overstock those storerooms because we have expiry dates on medical consumables. So DeliverEASE aims to give us much greater visibility of our stock and that we are managing the stock really just in time so that we do not have wastage through expiry of those consumables.

Q. Any other disadvantages or limitations that you had in mind in that sentence?
A. I think visibility of data is one of the things that has been a challenge for all of us. No matter where you are in the system, being able to get visibility of our spend in procurement is really important. And also compliance, compliance against the whole of government and the whole of health contracts and ensuring that we are making and realising the savings that were anticipated.

So SmartChain is being rolled out, it hasn't been completely rolled out as yet. We have a number of dashboards, and I mentioned the contract implementation dashboard as an example.

Q. You started that answer by mentioning "visibility of

data". What data in particular do you have in mind?
A. So the data is our performance against those whole of government and whole of health contracts and making sure we are realising the savings, so the proportion of our spend on those contracts, but also greater visibility of what is happening at a ward level so that we can ensure that our busy staff are able to have the goods that they require to provide the services at the time that they do.

Q. When you say "realising" savings under whole of health contracts, do you mean that your LHD is utilising those contracts to the maximum extent possible?
A. We know that there are particular contracts that we are. As we progress, there are some contracts that we believe we can get better value from and that's why we're tracking them.

Q. When you say you think there are contracts you can get better value from, what do you mean by that?
A. It's making sure that all of our wards, all of our staff, are ordering from those particular contracts and not ordering off contract.

Q. How would someone order off contract?
A. Through iProcurement and through free text.

Q. So when someone orders free text, to your understanding, they are not ordering off a whole of government or whole of health contract; is that right?
A. In terms of the data that we currently have, some areas look like it's free text. So if we look at h-trak, in the system at the moment it comes up as free text, but as we refine the information systems and have better integration of them from h-trak to other parts of Oracle, that will become clearer.

Q. But from an earlier answer, do I understand that the ultimate goal is to have people ordering off the contract rather than free text?
A. Yes, and that will be less time consuming.

Q. Why?
A. Because they will be able to go to that particular item and because that item number is described well within the system, that will take the clinician less time than typing out a description.

Q. Is the master catalogue initiative part of that process?
A. It is.

Q. Do you have a view on its benefits?
A. Yes.

Q. What is it?
A. So we've been implementing the master catalogue since the end of January. Historically, every local health district had its own catalogue, and this again is giving consistency across the state. It will help in terms of getting a greater understanding of our purchasing power as a state, so that we can use that purchasing power to get better value out of our contract negotiations; and also assisting with reducing variation amongst local health districts, increasing equity, so people are able to get visibility and therefore access particular goods; and also assisting with the mobility of staff because our staff do move across local health districts.

Q. When you say decrease variability, what did you have in mind?
A. So the variability that we have in different consumables can cause confusion to clinicians and to other staff. So having consistency means that when you, you know, go from one ward to another or one district to another, one hospital to another, we're using the same goods and services.

Q. In paragraph 88 you refer to the challenge of getting the balance right between maximising purchasing power and standardisation whilst addressing local needs. Do you see that?
A. Yes.

Q. Why is that balance important in your view?
A. Standardisation is something we all aim for. It's different to centralising, because if you centralise and you don't partner with local health districts who are on the front line and providing services, then although you might get a standardisation in those goods and services, they might not be meeting the needs of our frontline staff.

Q. If you turn ahead to paragraph 91, please?
A. Yes.

Q. If you just read paragraphs 91 and 92 to yourself and let me know when you have done that, please?
A. Yes.

Q. In paragraph 92 you refer to savings of $5.9 million as of 30 November 2023, since the contracts commenced in 2023/2024. Do you see that?
A. Yes.

Q. So do we take it that those contracts commenced at the beginning of the 2023/2024 financial year?
A. Yes.

Q. So 1 June - or 1 July sorry?
A. 1 July, yes.

Q. How have you measured the savings of 5.9 million in that period?
A. So that data we collect centrally in NSW Health so that we're using the same methodology across all local health districts and we track that each month, and it's looking at those particular pharmaceutical contracts that we've negotiated at a state level. So that saving is on those particular contracts.

Q. So that's the saving that has been realised since the contracts were implemented against what was being spent on those same items prior; is that right?
A. Yes, yes. And I think that demonstrates that critical mass, using the buying power of NSW Health, has supported in those savings.

Q. That takes me to the next issue, which is raised in paragraph 95. In paragraph 95 you say:

> *Through Whole of Health contracts and Standing Offer arrangements, LHDs and NSW Health can:*
>
> *a. Achieve greater savings through increased volume and buying power ...*

One of the examples of that is the pharmaceutical contracts to which you have referred?
A. Yes.

Q. Do any others come to mind?

A. There are some of our orthopaedic prostheses contracts that we've entered into in the last 18 months.

Q. Any others?
A. There are a whole range of them but I can't remember them.

Q. When you're referring to whole of health contracts and standing offer arrangements in that paragraph, did you have in mind something other than pharmaceuticals and prostheses?
A. Yes, that includes - let me think.

Q. Does it include consumables, for example?
A. Oh, absolutely.

Q. Are you aware of whether that conclusion - that is, that using those arrangements achieves savings through increased volume and buying power - is tested at any time?
A. It's tested against our historical spend.

Q. By whom?
A. HealthShare.

Q. Is that testing, the results of that testing, shared with you?
A. At the procurement reform steering committee.

Q. If you weren't on that committee would it be available to you as a CE of an LHD?
A. There's a lot of communication that occurs across the state in relation to the procurement reform, and my understanding is all of the districts have visibility of those dashboards.

Q. Are you aware of any testing that's done once statewide or whole of health contracts are established to make sure they're still delivering that type of value?
A. That's a question for HealthShare.

Q. In paragraph 95(b), another of the benefits of whole of health contracts and standing offer arrangements that you identify is having standardised processes that reduce risk. How do those standardised processes reduce risk?
A. So again, it's around having consistency so that our staff are not having to use different products in different environments.

Q. And is that driven by local policy rather than procurement practices - that is, local clinical policy as to what is to be used - or is it driven by the approach to procurement of those items?
A. It's both.

Q. How?
A. It's informed by feedback from our clinicians on the ground, and that might be in relation to our IV giving sets - you know, there's a feedback loop. As we're - we have clinical product managers who work with our clinicians on the ground, our clinical nurse consultants talk to, again, our nurses and doctors around what are the goods and consumables that they require, and if there's a change of practice that informs those processes, we escalate that through the local health district. We have communication with HealthShare in relation to those. And there are processes for getting clinician input into the various tenders that we have.

THE COMMISSIONER: Just before we go on, I just might need a little bit of help with a question and answer.

Q. Mr Glover was asking you about 95(b) of your statement where you say that through whole of health contracts and standing offer arrangements, LHDs and health can have standardised processes that reduce risk,and Mr Glover asked you how do those standardised processes reduce risk, and you said:

> *It's around having consistency so that our staff are not having to use different products in different environments.*

Can you just explain that a bit more for me, what you mean by "different products in different environments"?
A. So an example might be a syringe driver. You can imagine the risks that might occur if a nurse had to use a syringe driver on the ward which was very different --

Q. If I knew what a syringe driver was I'd - yes?
A. A syringe driver is a piece of equipment that delivers a medication over a period of time.

Q. That would have been my guess.
A. So you put the syringe in the driver and it will

administer it in a time that is determined by the clinicians. And if you've got a syringe driver that has a particular way of working and then you go to another ward and there's a syringe driver that has a different mechanism, that nurse has to be able to adjust their practice for that, so we don't like that.

Q. It introduces an obvious element of risk in that?
A. Yes.

Q. Because of the different operation of equipment for the same - the same process --
A. Yes.

Q. -- but different operation of equipment?
A. Yes.

THE COMMISSIONER: Got it, okay, thanks. Sorry.

MR GLOVER: Q. So that clinical standardisation that you are talking about there, that's driven by processes within the LHD; is that right?
A. In the LHD and within NSW Health as a whole.

Q. How is it done within NSW Health as a whole?
A. We have a range of mechanisms to look at new ways of working and that includes the Clinical Excellence Commission. There might have been an incident that occurred in one LHD that informs our processes and identifies that we need, you know, a different piece of equipment or to address a risk. That might get escalated to HealthShare and to the LHDs.

Q. There might be some elements of standardisation that don't rise to that level, though; correct?
A. Correct.

Q. So an approach to the use of wound care kits, for example, might be different in your LHD to another; is that right?
A. Yes.

Q. So how does the procurement process ensure standardisation in that context?
A. So within Sydney Local Health District, wound care - we have a wound care committee that is made up of nurses, doctors, pharmacists and others, and that has informed our

procedures around wound care and we have consistency in the particular products that we use. And again, that's to make sure that if you're in one environment, that you are able to easily understand what that product will be used for in a different environment.

Q. So that's a local policy derived to standardise an approach to that issue within your LHD; correct?
A. Yes.

Q. When it's determined what will be used - that is, when there is a decision made that our approach to wound care will involve the use of a particular product --
A. Mmm-hmm.

Q. -- who is involved in that process?
A. Depending on the quantum of money that that might involve, that may happen just at a local facility level, but it may happen at a district level, a brief would be written to myself and we would approve that based on the recommendation of the committee.

Q. Tell me if you're not in a position to answer this, but when orders are placed for wound care products via the master catalogue, might there be a range of products in addition to those that have been approved for use within your LHD?
A. Yes.

Q. How do you ensure that the right thing is ordered?
A. That is monitored on the dashboards with DeliverEASE and there is oversight by the relevant managers.

Q. So again a local process?
A. Yes.

Q. Finally in 95 you refer to the benefit of whole of health contracts and standing offer arrangements being to support staff mobility across LHDs?
A. Mmm-hmm.

Q. How does it do that?
A. Just as we were talking about consistency across wards, similarly, having that consistency across local health districts means that when our staff rotate - junior medical staff in particular - they're using the same products, the same processes; they're not having to

relearn.

Q. What level of consistency is there, in your view, at the moment across LHDs in matters of that kind?
A. We're in a process - it's not complete at the moment. So even within Sydney Local Health District, as I said, with DeliverEASE, we're haven't completely rolled out and so it's a work in progress.

Q. But DeliverEASE will be a standard method of ordering, for example, and setting up of storerooms, but what about standardisation of the use of equipment and products? How is that standardised to the extent it is at the moment across LHDs?
A. It's variable.

Q. Are you aware of any work being done to improve the standardisation in that area across LHDs?
A. We're in that process as part of the procurement reform, but it is a work in progress.

Q. Which part of procurement reform is directed to that issue?
A. Part of that is around getting the standard contracts and having panels for particular equipment. So if I look at imaging equipment, for example, there is a panel of suppliers, but that then is assessed at a local level against the needs of each local health district, depending on their clinical mix.

Q. How do you balance, in that context, centralisation on the one hand and local need on the other?
A. It's always going to be a work in progress because there will be differences between hospitals and also differences between local health districts. So if I look at Canterbury Hospital, compared to a big quaternary hospital, their needs in terms of imaging will be different, and so the modalities have different needs.

If you aim to have the same level of, say, modalities in CT scanning at Canterbury compared to RPA, where the patient mix is quite different, then you either overspecify, so you pay too much for the equipment for Canterbury, and it is overspec-ed, or you underspec the equipment for big quaternary hospitals. So you are going to have some variation.

Q. From that, do we understand that standardisation is something that can't or should not be desired across the board - is that right - because there are different needs in different areas?
A. Standardisation where it's possible is a good thing, but we're not franchises. Hospitals have different populations and different services. So RPA is the only liver transplant hospital in New South Wales. There are things that it will have that no other hospital has. Concord and RPA - sorry, Royal North Shore, are burns hospitals, and they see the very severe burns, so there will be things they have that are not available, and should not be available, in other hospitals.

Q. Leaving aside highly specialised services and equipment of the kind you're referring to --
A. Mmm-hmm.

Q. -- in your earlier answers where you said that this work to standardisation is under way, were you referring to more standard items of consumables that are going to be used across the board and things like that --
A. Mmm, mmm.

Q. -- rather than highly specialised or technical pieces of equipment?
A. Yes. Highly specialised pieces of equipment we need to make sure that it matches what the clinical mix of those hospitals and services are.

Q. Indeed, anything in the hospital should meet the clinical mix of what's being delivered and the needs of the hospital; is that fair?
A. Yes.

Q. Paragraph 105. Would you just have a read of that, please.

THE COMMISSIONER: You may be doing it in your order, but I was wondering if you were going to ask a question about the last sentence of 104.

MR GLOVER: Yes, I can do that now.

THE COMMISSIONER: You can do it in your order, but --

MR GLOVER: Q. Just have a read of 104 as well, please.

THE COMMISSIONER: Or my order.

MR GLOVER: I will do it in your order, Commissioner. Your order is almost always better.

THE COMMISSIONER: Q. I'm just wondering, there, where you say, Dr Anderson - you are talking about DeliverEASE, obviously, "This needs ongoing oversight at a LHD level for its sustainability", what does that mean, in more expansive terms?
A. Yes, thank you. One of the great things about DeliverEASE is we have very neat storerooms now, but like all human beings, we need to have constant processes in place to make sure that that's maintained. DeliverEASE itself can't be the solution to ensuring that we've got the right inventory all on its own. It needs human beings.

Q. It needs humans as well, yes.
A. And you do need to undertake regular stocktakes so that you know how much stock is there and patients don't come in with variable conditions all at regular times, and so you may have an influx of particular patient cohorts and conditions, so you may use more of particular consumables at that time. So it's --

Q. It is not a perfect --
A. -- got to be a dynamic process.

Q. It's not perfect, yes, understood. That's what you meant by it?
A. That's what I meant. And that has to happen at a local level.

Q. Yes.
A. You know, it can't happen at an office in HealthShare.

MR GLOVER: Is that a convenient moment for a short mid-afternoon break?

THE COMMISSIONER: Yes, we will take a break until 3.10, then, to give the reporting staff and everyone else a break. So we will come back at 3.10, thanks.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover?

MR GLOVER: Thank you, Commissioner.

Q. Dr Anderson, if you have paragraph 105 of your statement?
A. Yes.

Q. Just have a re-read of that to yourself and let me know when you have done that.
A. Yes.

Q. First sentence, you refer to "the current arrangement"?
A. Yes.

Q. What is the current arrangement to which you refer?
A. The current arrangement is the partnership that we have between local health districts, the ministry and the pillars and the work that we're doing on the NSW Health reform, procurement reform.

Q. Why do you say that arrangement supports operational decision-making and service planning within your LHD to various degrees?
A. Yes, because we're in the process of implementing the strategies of the procurement reform, so DeliverEASE being one of those, but also the new operating model in relation to contract management, and so we're in the process of implementing that at the moment.

Q. What's the new operating model in relation to contract management that you are referring to?
A. So this is the employment - the funding that the ministry have provided to each of the local health districts to support the implementation of the statewide contracts, and that process we haven't done for every contract yet, and so we've embedded the contract implementation teams within every local health district, and that is assisting us in getting the returns for those investments sooner and for those contracts. As I indicated previously, changing a contract, implementing a contract, is not just identifying it in the system; there is work that is required.

Q. Are there any areas in respect of the current arrangement - that is, the one you've described a moment ago - that do not support operational decision making and

service planning within your LHD to the extent that you would desire?
A. So with SmartChain we still do not have full transparency of data that would be beneficial to the local health districts. So one area is, although h-trak is linked to Oracle, because it is not fully integrated, information that we used to have visibility of in h-trak we currently don't have.

Q. So you've lost visibility of data?
A. Yes. And HealthShare and eHealth are working on that, but that issue hasn't been resolved yet.

Q. Any other areas where the current arrangement, as you've described it, doesn't support operational decision-making and service planning within your LHD to the extent you would desire?
A. Sometimes we don't have visibility of what is planned in terms of new contracts, and what would be really helpful is to be doing more of that planning together, so we can forward plan within the local health districts.

Local health districts have a lot of things that they've got to do, and having the timetable for the implementation of those contracts set separately to the local health district sometimes means that it's all happening at once, and so being able to plan it with the local health districts means we can also plan our resources and how they're allocated.

Q. These are new, whole of health or whole of government contracts that you're referring to?
A. Mmm-hmm, yes.

Q. Why is it important, from you at an LHD level, to have advance notice of when those contracts are coming into force?
A. Because we have to allocate staff to implement them, not just the contract implementation staff but our staff on the ward - we have to train them. So you can imagine, if you are training the staff about a whole range of different contracts all at the same time, as well as implementing other new models of care and other priorities within the local health district.

Q. And is that the case at the moment, that at least from time to time, you, being the LHD, your LHD, is becoming

aware of a new contract at the time it's coming into force?
A. Yes, without a - we haven't planned it together, so part of it is a communication issue from the local health districts. We need to communicate better with HealthShare and the ministry about some of the programs we're implementing; and we also need to have more advanced knowledge of what is being planned.

Q. How frequent is an occurrence of the kind that you've just described?
A. It's a reasonably common occurrence.

Q. Does that have a negative impact on operations within the LHD when it occurs?
A. It has an impact on our available resources, and sometimes we have to divert resources from other parts of the operations in order to be able to do that.

Q. Does that have a negative impact operationally within your LHD when you have to do that?
A. Sometimes it can be hard to juggle everything, so, yes, it has an impact, but we always find a way around it to be able to do it, by reallocating staff, reorganising priorities.

Q. In finding a way to deal with it, does that have knock-on effects to other things that were happening within your district at the time?
A. Yes, sometimes we have to stop some of the things that we might be doing. It might be a new initiative that we would want to implement, we might have to put that on hold for a period of time so that we can focus on that particular contract.

Q. And in that scenario, the initiative that you've had to put on hold would necessarily be delayed in its implementation within the district; is that right?
A. Yes.

Q. Look at paragraph 107, please. Just have a read of that paragraph.
A. Yes.

Q. Let me know when you have done that. You refer in the last sentence to a return of - in the first year of operation, a return on investment of 208 per cent?
A. Yes.

Q. How was that calculated?
A. It was calculated on the investment in the increase in contract implementation staff, so three staff and an analyst, and the savings achieved by the implementation of those specific contracts. So I can't remember the exact figure, but we were anticipating that the savings would be, as I indicated, around 600,000, and in fact, we achieved around 1.2 million.

Q. Would you turn to paragraph 113, please. In this section of your statement from paragraph 113 and following, you deal with a series of what you describe as "disadvantages" of the current system. Would you just have a read of paragraph 113 for me and let me know when you have done that?
A. Yes.

Q. Did you have a particular example in mind when you wrote that paragraph?
A. No. It's a risk that has been raised by clinicians and staff, but - and one can understand that, if we had one - we are a very large organisation, NSW Health, you know, over 200 hospitals. If a contract was negotiated with a particular supplier and they were the only supplier for that particular good, then there is a risk that's associated with one, a monopoly, other suppliers not gaining some of the business and therefore putting their business at risk, but also the lack of then ongoing competition could increase price.

However, the procurement reform aims to give greater visibility about what the volume of goods and services we need is, getting competitive pricing, but also having multi-supplier contracts. So I gave the example previously of there's more than one supplier of imaging equipment on the state panel.

Q. So just so I make sure I understand, this is a risk --
A. A risk.

Q. -- that has been highlighted but not one that you've seen materialise; is that correct?
A. Correct.

Q. Paragraph 114, please. Just have a read of that and let me know when you've finished.

A. Yes.

Q. Do you have a particular example in mind when raising that issue in that paragraph?
A. Yes. Local health districts previously negotiated independently with suppliers and there was no doubt the larger local health districts were, because of the volume of cases and therefore the volume of prostheses that were being purchased, able to negotiate a better price. However, we are one system and so the negotiation of the contract, particularly the initial statewide contracts, some of the local health districts like mine, ended up paying more for some of the prostheses, but it's looking at the benefit for the whole, including our rural local health districts.

Q. Are there any other areas other than prostheses that you had in mind when writing paragraph 114?
A. That's the main issue.

Q. And are you able to assess the difference in price that you were paying previously to what you would pay now?
A. I don't have that on me but --

Q. That is something that's measurable?
A. Yes.

Q. In paragraph 116, you refer to the switch savings program?
A. Yes.

Q. Can you just describe how that operates, please?
A. So this is a savings program with HealthShare where there are alternatives to medical consumables that would result in savings for local health districts. So we will get a list of them saying, "If you switched from this product to this product, you will make X amount of savings."

But the issue that we have is that it doesn't take into account the whole context, necessarily, of that medical consumable. So, for example, we may get a cheaper price on syringes, but if it doesn't fit into our syringe drivers, then we're not going to realise those savings.

Q. The notification from HealthShare - are they by way of direction or suggestion?

A. Suggestion.

Q. So is there any disadvantage to the LHD in not taking up the suggestion?
A. Only in terms of expectations of savings.

Q. When you say "expectations of savings", what do you mean?
A. So HealthShare will regularly report on what the savings could be if we maximise the switching of those goods. So we have good and robust conversation.

Q. So you may be reported on not - in that scenario, not having taken up a saving which may, on its face, seem to be a negative report, but that report doesn't take into account the sort of feature that you've described?
A. Yes.

Q. Is that right?
A. Yes.

Q. And when you say you have "good and robust" discussion, what do you mean?
A. So we indicate why, and part of the reform is being able to more accurately document why we haven't taken up those savings.

Q. And by identifying savings in the way that it does under that program, is that an example where there might be a focus on price rather than wider value concepts; is that fair?
A. Correct, yes.

Q. Paragraph 120, please.
A. Yes.

Q. Why do you say there's a need for greater transparency in fees and charges by shared services?
A. The district, all of our districts are paying HealthShare and eHealth fees for undertaking work for us, and just like we would expect from any vendor, we expect transparency in those fees. That is part of the procurement reform, is to give us, at a local health district, much more visibility of those, the quantum of those fees and how we might be able to make some savings on them.

Q. What don't you currently have that you would like to have by way of information about fees and charges charged to your LHD by the shared services?

THE COMMISSIONER: Or can we go what do we get, first, and then --

MR GLOVER: Yes.

THE COMMISSIONER: Q. What particularisation do you get from shared services about what they are charging you?
A. It's more global, not granular enough.

Q. So you get one big figure that you have to pay?
A. Yes.

Q. Without it being broken down as to --
A. We get a - it's broken down a little, but not to the level that we would expect from an external service provider.

Q. From your lawyers?
A. Yes, I get that.

Q. Are there hourly rates? I mean, how is it --
A. No, it's a figure, yeah.

Q. I'm not sure I understand at all how it --
A. It's not an hourly rate.

MR GLOVER: Q. Perhaps to use a practical example, one of the shared services you use, linen services through HealthShare, for example?
A. Mmm-hmm.

Q. How is that charged to you, or your LHD, I should say?
A. So we have price per item, so we get that. But then on top of that there are fees, charges for providing the service, there's the granular detail around the price for item, but then there are other fees that are charged.

Q. So do I understand from that answer that you understand the price per item?
A. Yes.

Q. And that's sufficient for your purposes?
A. Sometimes not so much. So food is a good example.

Q. All right.
A. So in our food charges, we again have regular performance meetings with HealthShare, and we have indicated to HealthShare that we want more detail about how particular charges occur, and particularly for special meals - so for some of our clinical areas, the patients do need special diets - and how that additional cost is made up, comprised.

Q. And, in addition, there's a fee charged to [sic] the shared services for their services, if I can put it that way?
A. (Witness nods).

Q. Is that something that you would wish to have more transparency of --
A. Yes.

Q. -- as to how those fees are arrived at and charged; is that right?
A. Yes.

Q. How does the charging work? Does the LHD receive a monthly invoice, a quarterly invoice? How does it happen in practice?
A. There are inter-health transfers, so that occurs on a monthly basis. It's an automatic charge --

Q. So what reconciliation do you --
A. -- for the services provided.

Q. I'm sorry, I didn't mean to cut you off? Continue.
A. My apologies.

Q. No, it is my fault entirely. What reconciliation do you get or itemisation do you get of charges for food or linen services?
A. So we do get a regular report on the charges per patient, so volume and price, but we don't get the level of detail that we would like.

Q. I'm just trying to understand quite the level of detail that you want.

THE COMMISSIONER: Q. What's the detail that's missing?
A. And the fees, all the fees, the fees over - so for

example if HealthShare are assisting us with a tender for equipment, understanding what staff were involved in that and what the charge is - the detail of the charge would be really helpful.

MR GLOVER: Q. As opposed to a global figure?
A. Yes.

Q. I understand. What about in items like linen and food? Are there additional levels of detail in linen and food or food that you would like to see?
A. It's mainly in relation to those discretionary items and in the special meals. The standard meals, we've got pretty good detail.

Q. And what is it about the special meals that you - what extra information or data about the charges for special meals do you require?
A. Understanding how the price is determined.

THE COMMISSIONER: Q. Can I just go back to the example you gave of assistance with a tender for equipment?
A. Mmm-hmm.

Q. You get some form of invoice?
A. Mmm-hmm.

Q. That has a figure on it?
A. Mmm-hmm.

Q. It doesn't have how many hours spent assisting you?
A. No.

Q. Or the people involved?
A. No.

Q. Right. I can understand why that's hard to work out from there. I mean, no doubt at HealthShare's end there must be some record-keeping that ends up with the figure, but you don't know how they do it?
A. No.

MR GLOVER: Q. For the services that are supplied to your LHD by the shared services, are there KPIs or performance metrics?
A. The KPIs with the shared services are really with the ministry, just as the local health districts have KPIs and

performance expectations to the ministry. Certainly as the local health district, I would like to have more visibility of those KPIs, because they're providing a service to the district.

Q. What about KPIs or performance metrics to you and your district from the shared services? Is that something you would like to see?
A. Yes.

Q. Why?
A. Because at the end of the day, I'm responsible for a budget, and the services that we provide to our patients and the community, and therefore, as I would with any vendor, I would like to have visibility of the KPIs so I can monitor the performance of the services that are provided to my district.

Q. Monitor their performance and hold them to account if they don't meet those performance expectations?
A. Correct, yes.

Q. Is that right?
A. Yes.

Q. Are you able to hold the shared services to account to the same level as a private vendor at the moment?
A. No.

Q. Why?
A. Because the accountability is to the ministry, not to the districts.

Q. Is this an issue that has been raised --
A. Yes.

Q. -- by you?
A. Yes.

Q. What has happened after you raised the issue, if anything?
A. It's a discussion that we're having about how we can improve that accountability to each other.

Q. A discussion with whom?
A. With the ministry and the shared services.

Q. Is there any work currently being undertaken beyond discussion level about that, that you're aware of?
A. Not that I'm aware of, no.

Q. Paragraph 122. Just have a read of that and let me know when you finish, please.
A. Yes.

Q. Why do you say the focus on standardisation can result in a loss of innovation at local level?
A. If we focus too much on just standardising and saying, "No-one can operate outside that standardisation", we can actually lose the innovation that occurs on the front line from the people who are interacting with the patients or providing the services. So we need a mechanism to make sure that innovation isn't stopped just at the cost of standardisation.

So an example is the inventory tracking system. A number of local health districts have implemented a surgical tracking - an inventory tracking system, and that is informing the statewide system, but if we were to jump straight to the statewide system, it does not have all of the functionality that we have developed in the existing systems that the local health districts are using.

Q. Is that h-trak?
A. Yes.

Q. By that answer do I understand that if you were to jump to the traceability function within SmartChain, you would lose functionality at the moment?
A. We would.

Q. Is there a process or procedure in place to mitigate that from your perspective?
A. Yes. The districts that are using h-trak have not been compelled to use traceability, and we have indicated that when traceability is able to have all of the functionality that we currently have, then, of course, we would be very happy to move to that at the appropriate time.

Q. Any particular reason you are aware of why h-trak wasn't broadened to other LHDs as opposed to designing the traceability solution within the SmartChain program?
A. No, I can't comment on that.

Q. And when you were speaking of standardisation in the earlier answer, were you referring to both standardisation of clinical practice and other operational processes?
A. Yes.

Q. In the second sentence of paragraph 122, you say that there needs to be better mechanisms to encourage local innovation which can lead to better models of care and patient outcomes.
A. Yes.

Q. You refer in the example to the inventory tracking system that you've referred to in your answer?
A. Yes.

Q. Are there any other examples that you can call to mind of why there's a need for that better --
A. Integration mix?

Q. -- integration?
A. So when we starting implementing RPA virtual, there was a request to go to a standard platform. The problem was that standard virtual platform did not have the functionality that we required. We were able to negotiate with eHealth and the ministry around that, and the development of RPA virtual, which is a virtual - the provision of virtual health care through a whole range of different models of care, has actually helped to inform virtual care across New South Wales and across the country. So it's an example really of being listened to, but the request was initially to use a standard platform that wouldn't have enabled us to do the complexity of work that we were doing.

MR GLOVER: Thank you, Commissioner. Those are my questions.

THE COMMISSIONER: Thank you. Mr Gyles?

MR GYLES: I do not have any questions, thank you, Commissioner.

THE COMMISSIONER: All right. Thank you very much for your attendance, we are very grateful for your time.

THE WITNESS: Thank you.

THE COMMISSIONER: You are excused.

<THE WITNESS WITHDREW

DR WATERHOUSE: Commissioner, I would like to call Michelle Swingler, spelt S-W-I-N-G-L-E-R.

<MICHELLE NADIA SWINGLER, sworn: [3.45pm]

<EXAMINATION BY DR WATERHOUSE:

DR WATERHOUSE: Q. Can you please state your full name and what position you hold?
A. My name is Michelle Nadia Swingler, or known in health as Michelle Spina, by my maiden name, and I'm the corporate category procurement manager for South Western Sydney Local Health District.

Q. Does your role cover all of the facilities and hospitals in the district?
A. Yes, it does.

Q. What does "corporate category" mean in relation to goods and services?
A. So we have a number of corporate - a number of category managers. There's assets, ICT, clinical, products, commercial. Corporate are, I guess, all the others that don't fall under those categories, not biomed, not medical assets, not ICT. So there's a broad range.

Q. How long have you been in this role?
A. In this particular role, two years, February 2022.

Q. Have you done similar roles prior to that?
A. I've been in supply for 18 years, so purchasing and so forth. It is primarily different - it is different to the previous roles I've held but I did work with a clinical products manager in a similar capacity, but under a completely different structure. So the approach was completely different but the essence of it, purchasing goods and services, advising on goods and services is the same.

Q. Do you work as part of a team?
A. Yes. There are three corporate category managers. There's a senior and two in the same position as myself.

Q. And do you supervise other staff?
A. No, I don't.

Q. Who do you report to, yourself?
A. I report to the senior corporate category manager, who reports up to the procurement manager.

Q. So can you please just explain a bit further, what exactly your position involves?
A. So there's a range - there's advisory, so people within the district will call up, they want to know where to purchase goods and services from, they might want further information on existing contracts, wanting to know if there are contracts in place for the goods they want to purchase. It can be as small as just knowing how to purchase it in the system or it might be wanting to know, like, who are the companies that they need to contact, how do they go about doing that. So there's the advisory aspect of it.

There is the liaison aspect. So I manage the hand hygiene and the waste contract within our district. So I will liaise between our facilities and the suppliers on those contracts, and I'll also look at governance on it, so ensuring people are purchasing correctly off that contract, making sure we're being charged correctly off the contract, processing invoices for those contracts as well.

Q. We might need to slow down. It is the end of the day and the reporters have had a long day, so both of us, probably, need to slow down a little bit.
A. No worries.

Q. So that's the sort of advisory role, and you said that you're responsible for hand hygiene products and waste collection.
A. Yes.

Q. I'll come back to those in a moment. Do you have sort of a liaison role? What do you do in that regard?
A. I do liaise. I liaise between the facilities and - it is a three-way liaison, I guess, between the facilities, the suppliers and also HealthShare or treasury, whoever may be the main contract manager. So for the sake of the hand hygiene, it's an all of health contract. For waste, it's an all of government. So I will liaise within HealthShare

and also sometimes to the treasury level.

Q. Do you find that staff escalate issues to you?
A. They do, particularly with waste. It's been very tumultuous over the last two years since I've taken over. I will be copied in. Whenever there's an issue, I ask for the facilities to notify me. I won't necessarily do anything in the first instance, it may just be that they are advising me of a missed service and they've contacted the supplier, but if they don't get a resolution, they'll escalate that to myself. I'll get in contact and escalate that to my supplier contacts/account managers, and if I don't get a resolution, I'll then escalate that further to HealthShare to ask them to intervene and assist.

Q. What happens if you need to escalate it to HealthShare? How does that work?
A. So there's - I've got a very good relationship with the category managers for waste within HealthShare, so normally it would be by way of email, so we've got a documented record that there's been an issue. Sometimes, it might be a very quick phone call to the category manager, depending what the issue is. If it's something that needs urgent attention, it'll be an email and a phone call asking them if they've got a person further up the chain that they can deal with at the supplier end because we're not getting a resolution.

If it's something that's not as urgent but still needs to be escalated, then it may just be by email that I will get in contact with them, let them know what we've attempted to do and ask that they intervene or provide some information or guidance on where I can go to get a resolution.

Q. And do you generally find that HealthShare is responsive to those requests to intervene?
A. When it comes to the waste contract, yes. I haven't had to escalate anything with my - too much with the hand hygiene, I haven't had as good a response when it comes to that side of things. So I have a very mixed relationship with HealthShare. It all comes down to whoever the individual category manager is that I've got to deal with or whoever - whatever department need to deal with. So often it's responsive, but there have been times where we don't quite get the assistance we need.

Q. To clarify, that's what you mean by "mixed", that sometimes, if you know the person, it's very responsive, but at other times, not; is that right?
A. That's correct. Yes, that's correct.

Q. How often would you have to escalate something to HealthShare?
A. Luckily now it's not - it would probably be one issue a month at most that I've had to escalate. If we were looking at this a year ago, it was almost one a day, one a week, depending on what stream. There are multiple streams in waste, so - and we were having a lot of issues with one of our providers, but that seems to have slowed down, so it's not as frequent now.

Q. On those occasions when the communication has not been quite what you had hoped, what has been the outcome?
A. I've often - because I've worked in the health for 18 years, I've got contacts in all sorts of little places, and so I've just had to go around them and work out a different way.

So to give you an example, I was having a pricing issue in the system with the hand hygiene, having the price updated to be reflected in the system. I'm still waiting to this day, a year later, for a response to an email. So I've worked it out between the facilities, our finance departments, the price in our system is not reflecting the price we're paying. So I'm managing that with the - directly with the supplier. We're aware that we're getting charged the correct price, it's just that it's coming up incorrect in the system, and when the supplier receives a purchase order, it's coming through with the wrong price, so I'm just making - I've just changed the way I do things to ensure that we're getting what we need to get from it and, effectively, not wasting my time trying to contact a path that I'm not getting a response on.

Q. So for someone who doesn't have your level of experience in the health field, have you thought about ways that it could work better so you don't have to find those workarounds?
A. Look, I think the only way in that scenario, the only way it can be fixed is for HealthShare to respond, for those particular category managers to respond. It's a bit - I guess it's something that's probably outside of my scope on how you could correct it so that it would not

happen again if it - you know, because it does come down to the individuals involved and I don't know the background to why it's not happening, so I couldn't answer that 100 per cent.

Q. Can I just clarify, do you have any sort of reporting or governance function as part of your role?
A. I do need to report back to my manager, who reports back further up to finance, on how we're tracking. So obviously with the hand hygiene, I report back, you know, what our spends were over the last financial year, how we're tracking this financial year, so they can see the savings that have come about as a result of us implementing that contract.

The waste contract, the reporting is done at a higher level, so the companies are reporting directly to treasury. However, I've taken it upon myself to report that back to the facilities so they have an understanding of what's happening with their budgets and where their money is going.

Q. Do you keep records of the sorts of issues that have escalated to you?
A. Yes, so I have my own spreadsheet, database, where I do record it and it's saved on a central drive, and obviously by email. I will - if it's urgent, obviously that gets reported back to HealthShare as it comes up, but then also when they have their reviews, they will reach out to me and ask me for issues, and I have my own spreadsheet that I can share with them so they can see the instances that I've been made aware of, because obviously there are instances that I don't get made aware of, so --

Q. When it comes to invoicing, do you have oversight of the amount the district is being charged?
A. Yes, I do. So I will have the invoices sent. When they get sent to HealthShare, the suppliers will actually copy me in on the waste contracts.

As far as the hand hygiene, because it's ordered through a number of different ways, some of the products are ordered directly through Onelink warehouse, so it all gets done through the internal system, I can still see that, I can see that in Oracle, I can run reports whenever I need to to see what we're ordering and how much is being spent.

As far as what's being charged by the suppliers from the items that we're ordering directly from the suppliers, I can run accounts payable reports to look at those, and that's what I'm doing since some of the products aren't reflecting the correct price.

Q. Do you ever see discrepancies between what you expected to see on an invoice and the amount that has been charged?
A. Yeah, most definitely. There have been times when there have been errors made. So most recently on the whole of government waste contract, we have a set price for the bins that get picked up for secure destruction. It's pretty obvious it's a pretty good rate, but on one of the lines that stood out, we were being charged four times the amount on that invoice. So I sent an email directly to the supplier to notify them of that.

I also escalated it to HealthShare to let them be aware and copied in treasury as well, because as it turned out, it ended up being a statewide problem, it was when they changed their reporting system, some of our sites dropped off the rate card and were being charged incorrectly. So we'll be credited for those.

Q. So once you did escalate that big discrepancy, that was followed through by HealthShare?
A. Yes, it was. So immediately. They've written back and informed me to notify me that, yes, it wasn't just myself, it was the whole state, and not just health, it was other agencies as well, and they'll be credited. So we're still waiting on the credit. That's still a work in progress, that one.

Q. So just looking in a bit more detail at hand hygiene products, I think since the pandemic we're all a bit more familiar with these, but can you just cover what sorts of products you're talking about, the range of things?
A. Certainly. We've split our hand hygiene into two groups. We had initially gone out to seek a better offer to go with one company for all of our products, but because of - for value-wise, we've decided to split it in two.

So the first group is alcohol-based hand rub, so the Aquiums, the gels that you see here, everywhere, so we've gone with one supplier for that. Straight off the state

contract, the hand hygiene state contract, the best price available for that one is who we've chosen, and we're just going to standardise across the district because, as you can imagine from the pandemic, we've got multiple brands out there, things left over from the state stockpile, different facilities using different brands historically or what they could get during the pandemic, so now we're looking to streamline them back into one brand at the best price.

The other range of products, which is from the second supplier, are your general hand soap that you find, hand and body wash that you find in your bathrooms and kitchens and what-not; surgical scrubs, so obviously used in surgery; and there's also a 2 per cent chlorhexidine, which is available on the wards, just a secondary option for staff who may need that rather than the general hand soap.

Q. So to be clear, there have been a whole lot of different suppliers of these products and you're trying to get it down to two; is that right?
A. That's correct, yes.

Q. What sort of issues have arisen due to having lots of different suppliers?
A. It's the - mainly the oversight. So not knowing which facility - for myself, I experienced, you know, not knowing what facility was using which brand. So if someone called me up and said, "Where do I order my soap from", I had to figure out what hospital they were from, where they were getting that from, which brand they were using, and sometimes even in the one hospital, you could have one brand down in the old wards and the old departments and then the newer sections would have a completely different brand. So having oversight of what brand to recommend to them to purchase, it was a lot more time consuming. And then ultimately, what we sought to do was also leverage better pricing from having the one brand, by having, you know, I guess, that leverage of, you know, quantity you purchase, so --

Q. What sort of process have you followed to narrow it down to these two suppliers?
A. So South West Sydney went out for a request for quotation under the hand hygiene state contract. We did the initial contact with the hand hygiene category managers at HealthShare, advised them that we would be putting out

this process, and released a select RFQ to a select number of suppliers. So they weren't all new suppliers, they've been already used in our facilities, so we weren't going totally off the books.

We put together a tender evaluation committee to, you know, assess the criteria, which was both product value goods based as well as price based. And there was a selection, so there was general services as well as infection control on the tender evaluation committee to look at these items. We invited them in to come and have a look at the stands, the dispensers and what-not.

Following the TEC's assessment of it all, that's when we made the determination of who we'll go with, and that's where we determined that we would split it into two groups as well. Initially we wanted just one company for everything, so from alcohol-based hand rubs through to surgical soaps. That was not going to - that proved not to be viable, which is why we made the decision to split the offering into two companies.

Then once that decision was made, it had to be presented. We've got an internal tender review committee. So the tender evaluation committee signed off. We presented it to the tender review committee. Once they gave their approval, it went up to chief executive approval before we rolled it out.

Q. Just going through that in a bit of detail, so when you talk about infection control involvement, is that clinicians that have actually participated in that role?
A. So it was - there was the district's infection control manager and an infection control manager from one of the other facilities - from the Campbelltown facility. So the district infection control manager from Liverpool - well, had worked in Liverpool, sorry, and so she had primarily worked with one particular brand we were looking at. The infection control manager from Campbelltown had worked with the other brand, so we thought it was good to have both on there because they'd be familiar with the two primary products that were being presented. And the third one, that was invited to provide a quotation was used across both areas, so they were familiar with both.

Q. Your role in that process - were you involved yourself?

A. I was involved in the tender evaluation committee. So I was just starting off in my role as a corporate category manager at the time, so I was effectively in training at the time. I'd never sat on an evaluation committee before, so I was assisting the senior corporate category manager in all the processes involved.

We don't tell the evaluation committee what they need to do, we guide them in the process on what they should be looking at, things to look out for, but ultimately, it was up to the evaluation committee to make a determination on what they thought was best. So that's why we get a group of people from across the district to be involved.

Q. You mentioned that as well as price, one of the things that was looked at was value. Can you go into a bit of detail about what that means - what sorts of aspects of value were considered?
A. So there's the straightforward - the price. So I did do a 12-month summary of what we currently, at that time, were spending on hand hygiene, and did some modelling up against the prices that were being offered to us from the different companies.

We also looked at, you know, whether there was like for like, for example, one particular soap appeared to be half the price of another soap, but then when I looked into it further, it required two pumps versus one pump. So having to just, you know, do those adjustments in there. So that's a straightforward, like, as far as price, value, that's the cost of it.

We also asked our suppliers to provide, if they've got any value add options that they can do. Most of them, because they come off the state contract, they've already been preselected for their value adds and they are very similar in the sense that they'll provide education, hand hygiene education, they'll come on site and provide training for new staff wherever called. And they were all very similar and all seemed to score exactly the same across that range. They all would, effectively, offer whatever we required from them.

Q. What happened in terms of communication out to the staff, the clinical staff in particular, once the decision was made to change and narrow down what they could order?
A. So we've got a number of different communication

streams that we're using because not everybody looks at email or not everybody goes on the intranet. So we do have memos that were sent out, starting with the general managers of the different facilities, working down into the general services departments. So the senior corporate category manager who I report to was in charge of writing out those memos and sending them out.

As we were ready to do each facility in advance we'd issue a memo that would be distributed to that facility. Alongside that, we have our intranet page for hand hygiene project, it is dedicated to that project where I update that quite regularly with where we're up to. It shows what products we've been using, what we're moving to, also communicating with the people who are in charge of updating their imprest list, so the automatic scanning, the DeliverEASE team to make sure that they are aware so that they can make sure that the storerooms get the proper barcodes in place, so that they can try and make it as seamless as possible with the departments that need to do the ordering.

DR WATERHOUSE: Commissioner, I'm mindful of the time. I think I will only be another few minutes. Are you happy to continue?

THE COMMISSIONER: Yes, we don't want the witness to have to come back, so you keep going.

DR WATERHOUSE: Thank you.

Q. Do you find that, having gone through this process, some staff are still actually ordering outside the contract for these products?
A. Not so much in the soap side of things, because they usually require a dispenser. So that controls it as well. We did have a few instances where they've ordered the wrong soap, and because we're still in the rollout, we are still in the rollout phase, we are still - we've just finished our last facility and about to roll out to the community health centres, so we're able to move that stock around rather than having to return it. We can move it internally.

With the alcohol-based hand rub, that is still in its - well, I would say not infancy, but it's midway through the project, and we are finding that we are having

some staff who are ordering outside of that, but by running reports regularly, I can spot those people, see what it is, why it is that they are ordering it. Often it's because someone's been on leave and they've missed the memo and they've just ordered the wrong thing manually, so just training them up where they can find the correct HIMF. But it's not as widespread, again because a lot of things fit into brackets, so the brackets, they will see that, they'll know that they have to buy that particular product.

Q. So you follow up with anyone who's ordering off contract?
A. Yes.

Q. Are there limits on the amount, or the quantity, of hand hygiene products that the unit can order?
A. Yes, there are. So we use the DeliverEASE system or the imprest for those that haven't been moved across to DeliverEASE, and there is a max level set in there. There is min/max, but the min at the moment doesn't mean much because they're not scanning as they are coming on and off the shelf, so it doesn't work in that sense.

So the max level indicates what - when they scan it, how much it's going to order. So we set the max level. So we can control that as far as when they scan it, what's the maximum amount they can order off that. But we don't - we're not able to control how often they scan it, so are they scanning it every day or are they only scanning it once a week?

I will regularly - when I'm checking to see that people are ordering the correct things, I can see if someone's attempted to over-order by scanning it three or four times, find out why - did they have a spike or did they have an error or what's going on, and address it with them directly.

Q. Could a situation arise where a unit runs out of a specific hand hygiene product - say a surgical soap - and that they urgently need?
A. For that to occur - I mean, I don't work directly in there, so I can only go off past examples where that has happened. There was an instance where someone assumed somebody else had ordered it, and they hadn't, and somebody else had done it - it's a Friday special. People usually leave it to Friday to find out that they don't have enough

stock. It's very rarely happened. It has happened a few times during the transition just because of people being aware of which soap - being unaware of which soap they had to order, being a little bit confused.

But from that, when we're rolling out in a facility, we have a pallet of stock sitting down in the warehouse, so - on the loading dock, I should say, for the facility, and just communicating with general services to run them up some stock, we can certainly do that for them. I've not had the issue with surgical soap, as far as I'm aware.

Q. But you were able to resolve that urgently when there has been a shortage of something?
A. Yeah, so I was able to resolve it for the general soap. I've not had an issue where surgical soap has run out in our facilities.

Q. I'd like to ask just a couple of questions about pricing. So can the district negotiate with the supplier for a better price than the state contract on a hand hygiene product?
A. Yes, under the procurement policy, we can.

Q. So how could this be done?
A. So we did this through the online request for quotation, e-tendering site. That's how we advertised this particular - for our contract, and we were allowed to choose whether we wanted it to be select, so we selected - and which is what we did. So we selected three suppliers who were already in the district, substantially in the district, and issued out an email, through the system. They were issued out an email to be invited to submit a quotation under the list of products that we provided that we requested for.

Q. And has that worked well?
A. In this instance, I do believe it has. What it has highlighted to me is that we can't necessarily go for one full scope - so what I mentioned to you before about wanting to get alcohol-based hand rub and the whole list of products.

There were confusions from the suppliers as well. One of the suppliers provided quotation on a product that's not on the existing state contract hand hygiene contract, and we had to explain to them that, no, we are only looking for

items as they are on the existing contract. We're not looking to go for anything off contract. We're just looking for better pricing off that.

Then as I mentioned, we're having issues with the price being reflected in the system. So I've requested to HealthShare to update the price on the HIMF based on our state contract - sorry, on our local contract, that, "We were able to obtain better pricing on one particular item. Can you please reflect that on the HIMF?" They've updated that. But then once they do a system upload from their state contract, their state contract pricing is overriding what they've put in for us, and that's been the difficulty, and that's why we're having the wrong price reflected in the system.

Q. Now, the Inquiry has heard quite a bit of evidence in relation to procurement of goods, but I'd like to just touch on procurement of a service, given you are responsible for waste collection. So firstly, you said that this is a whole of government contract; is that correct?
A. That's correct.

Q. And it's just the one contract? Is it the one provider?
A. No. So the whole of government waste contract is broken down per your region. So for South West Sydney we have a provider for general and recycling, a separate provider for secure destruction, so your paper shredding destruction, and a separate provider for clinical waste products.

Q. Do the providers vary at all depending on the site or, like, the size of the hospital or geography?
A. We have the one provider for the entire site, but, for example, clinical - I will talk about the clinical waste pickup, the contractor is Cleanaway Daniels, however, they may use a different branch for their - for the southern facility. So Bowral being so far south from, say, Bankstown, will not necessarily come out of the same branch. Veolia, who does our general and recycling, they will use subcontractors down in the Bowral region because they don't have plants or trucks close enough. I believe it's JR Richards, from memory, so they will subcontract.

Q. And what does your role involve day-to-day, as the

contract manager, for waste collection?
A. Day-to-day I'm liaising - I'm liaising with the different facilities to ensure that everything is going smoothly. It's surprising how much - how many issues come up with waste. You'd think they just have to come and pick up the rubbish and just turn up, they've got one job, but no, it doesn't always seem to run that smoothly. It could be they're wanting bins urgently.

I think with the nature of waste in the facility as well, because it's so busy and there's so much of it, most facilities are escalating quite frequently because they don't have time to be, you know, counting bins and what-not. So they'll get to a point where it's, like, say, for example, Friday afternoon, "We need bins, Michelle. Can you help us out?" So they're escalating to me, you know, quite frequently.

Otherwise I'm looking at reporting - if I'm not dealing with the facilities directly I'm looking at reporting, I'm checking the invoices. They do come through staggered when they come through from the supplier. So they don't all come in once, they'll come through staggered. You'll get your monthly reports, and just working through the reports, looking for anomalies. For example, a particular site might regularly have futile call charges, which means the bins aren't being put out or the bins are empty whenever the trucks are coming up, so trying to work out the patterns, liaising with the facilities to see what needs to be done, liaising with the suppliers to see do they know what's going on.

In one instance there was a futile call charge for recycling bins at Campbelltown. They were being charged for not putting their bins out. It turns out they didn't have recycling bins at Campbelltown. So just getting on top of that, trying to work out what's going on there, getting that resolved, liaising with the suppliers for that.

Then when I'm not doing that, it's education, so waste education, so walking around the facilities, checking for posters. Last year I did a week where I went to each different facility, set up a table and just had posters and spoke to the staff who walked past, "Do you know how to recycle? Do you know where the coffee cup needs to go", to try to improve the correct, you know, waste disposal within

the facilities, and that will improve, you know, our charges and costs and so forth.

Q. Finally, I just want to ask a couple of general questions about how you manage contracts. So just to clarify, firstly, your role is to manage them not just to implement them; is that correct?
A. That's correct.

Q. So how did you develop the skills to manage the contracts that you are responsible for? Has this come from training or mainly from your long experience in the health system?
A. I think it's both. I've had on-the-job training, so I was shadowing the senior corporate category manager in the initial stages, so like I mentioned to you, the hand hygiene, I'd never sat on a TEC before so - and I don't just sit in on evaluation committees for projects that I'm undertaking; I will sit in with the commercial manager to see how he's doing - how he's undertaking it, so offer up my secretarial services to, you know, do the paperwork so I can learn there.

There are also online courses. My manager is very supportive of education, so any educational courses we want to do, procurement courses, ICAC, online "lunch and learns", anything we want to do education-wise, we're doing that as well, and also just the experience of 18 years, not necessarily in the role, but it's amazing what you pick up.

Q. Are there policies or guidelines locally to assist you in managing the contracts?
A. We have procedures put in place by our procurement manager and he's also guiding me through the different steps. So the initial - so we will - sorry, we will run a quarterly contract review meeting with our contractors. The initial ones, I was buddied up either with a senior category manager or with the procurement manager, who spoke me through the process, and then I was able to pick up and run from there.

Q. And do you receive support from HealthShare at all in terms of managing contracts, if a contract issue arises?
A. Again, it depends on the contract. So with the waste contract, fantastic support there. I can ring, email, send a message on Teams whenever I need to get whatever guidance I can.

The hand hygiene contract, like I said, I haven't heard from them in over a year. I'm not getting much guidance from them at all - not getting any guidance from them at all.

DR WATERHOUSE: Commissioner, that completes the questions I have for the witness.

THE COMMISSIONER: Thank you. Is there anything, Mr Gyles?

MR GYLES: No, thank you, Commissioner.

THE COMMISSIONER: All right. Thank you. Thank you very much for your time. We're very grateful. You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. Is there anything else other than adjourning until tomorrow? Right. We will adjourn until 10 tomorrow, thanks.

AT 4.18PM THE COMMISSION WAS ADJOURNED TO THURSDAY, 22 FEBRUARY 2024 AT 10AM

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