Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Thursday, 22 February 2024 at 10.00am

(Day 008)

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. Yes, Mr Fraser?

MR FRASER: Thank you, Commissioner. Commissioner, the next witness to be called is Mitchell Clancy. I think, unless anyone else has any other matters, we are ready to proceed to Mr Clancy's evidence. We've taken the liberty of putting him in the witness box.

<MITCHELL CLANCY, affirmed: [10.01am]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Mr Clancy, could you give your full name, please?
A. Mitchell Clancy.

Q. And it is correct, isn't it, that you are the district procurement manager for the South Western Sydney Local Health District; is that right?
A. Correct.

Q. Mr Clancy, how long have you been in that role?
A. I'm now moving into my third year at South Western Sydney.

Q. I didn't catch that. Was that third year or --
A. Third year, yes.

Q. Before you were in this role, what were you doing?
A. I was working at Western Sydney Local Health District as an assets and compliance manager.

Q. So in the same field?
A. Yes.

Q. But effectively one rung down; is that correct?
A. Similar - well, same level, but different portfolio, so mainly focusing on assets and engineering.

Q. As opposed to procurement?
A. Still procurement role but focused primarily on engineering and similar type contracts.

Q. I believe you chair a number of committees; is that right?
A. Correct.

Q. Within the district?
A. Yes.

Q. Are they the tender review committee?
A. Yes.

Q. And the strategic procurement advisory board?
A. Yes.

Q. And can you tell us what each of those do in general terms?
A. Sure. Starting with the strategic procurement advisory board, that's an executive level meeting whereby we have local health district representatives, generally executive, and we also have a Ministry of Health chief procurement officer sitting on that committee and also a HealthShare representative.

So basically it's a meeting where we discuss procurement initiatives and once that has been discussed and agreed upon, we then move into the formal procurement process from there. And we also share data regarding current procurement projects and brainstorm matters that are new initiatives related to procurement in our district.

Q. Thank you. And the tender review committee obviously has a role in relation to tenders?
A. Yes.

Q. But is that just district membership or --
A. It is district membership only, yes.

Q. And what does it actually do in relation to tenders?
A. So the role of the tender review committee is to provide governance for all procurement activities completed within South Western Sydney, and essentially, the role of the TRC is to ensure value for money is achieved, probity and procurement process has been adhered to, and just as an external set of eyes to make sure we've got the best outcome for the district.

Q. So is that a committee that is involved at the beginning of the tender process, during - whilst a tender, a request for tender, is being formulated, in the evaluation, secondly, or the subsequent operation of the following contract, or in all three or a combination?
A. It's generally at the very end of procurement

activities. So once the local procurement team have conducted the tender, it then gets shared for the tender review committee and they provide final endorsement that it has achieved value for money, probity has been adhered to, and it makes sense to have that contract in the district. And from there, the tender review committee makes a recommendation to the chief executive to allow the award of the contract to that preferred vendor.

Q. And just in general terms, value for money, other than what the dollar amount is, which is clearly a factor in that --
A. Yes.

Q. -- what else is generally factored in to value for money?
A. Look, predominantly it is just about money and ensuring that there might be potential savings but also reviewing any potential value-adds that might have been tendered as part of that process, so it might be - as part of procurement activity a tenderer might provide education and training and extra potential support that might be considered additional to what was normal practice.

Q. I will just ask you, are you familiar with the terms "value based health care" and "value based procurement"?
A. Yes.

Q. And in looking at those - at value, do you look at benefits that might not be directly financial?
A. Yes, we do look at things like work, workforce efficiencies, which we do consider a saving or efficiency for our district as part of that process.

Q. You manage a team; is that right?
A. Correct.

Q. I think they're termed - are they termed - your team members, are they termed category managers?
A. Some are category managers and others are in different roles to the category managers.

Q. How big is your team?
A. When it's at full capacity, 19FTE, within procurement and I'm currently involved in fleet as well and sustainability within our district.

Q. Fleet? Can you just keep your voice up a little, maybe come a little bit closer to the microphone.
A. Sorry, sure.

Q. But that's a separate - fleet is a separate --
A. It's a separate function.

Q. -- function?
A. To procurement, yes.

Q. But 19 in procurement?
A. Yes.

Q. And between your team, you oversee all the procurement within the district; is that right?
A. Correct, excluding some of the work that is done in capital works and our redevelopment teams, but then I would review that as part of our tender review committee process.

Q. I'll just leave capital works to one side. It's not a - you have some oversight but not commissioning the procurement itself - is that right - in shorthand?
A. Correct.

Q. In terms of your procurement, that includes procurement done through both HealthShare and eHealth; is that right?
A. Yes.

Q. Can we just focus on HealthShare first. If there's an issue with a statewide contract, are you the point of escalation?
A. From the local health district?

Q. From the local health district to HealthShare?
A. Yes, generally. But there are times when my category managers will directly liaise with HealthShare as well.

Q. And what kinds of things get escalated to HealthShare, either by you or a category manager.
A. There are several things, first one being vendor performance. So if a vendor isn't performing to what we consider to be satisfactory, and that can be in line with some key performance indicators within our contracts, we'll manage that locally, but when required we will escalate that as that well to HealthShare for their assistance at that state level.

Q. And are there other matters that tend to be the subject of --
A. There is.

Q. -- escalation?
A. Assets, for example. So if some of our medical imaging equipment goes down and there's an outage, we again escalate that through to HealthShare because the vendors are subject to key performance indicators on the state contracts and when they don't meet those key performance indicators we can receive abatements for that non-performance.

Q. You mentioned medical imaging as an example there?
A. Yes.

Q. Whoever the contract for, say, ultrasound devices, is with, if they break down more than a prescribed amount within a certain period, then there's an abatement that is due under the contract; is that right?
A. Yes. If they breach the KPI there is an abatement payable to the districts.

Q. But that is raised with HealthShare, is it?
A. Yes.

Q. And no doubt is a matter that's relevant to whether statewide contracts are awarded in the future?
A. Yes.

Q. You mentioned KPIs?
A. Mmm-hmm.

Q. All the statewide contracts have KPIs for suppliers; is that right?
A. Correct.

Q. And they can cover a wide range of things presumably?
A. Yes.

Q. Such as timeliness in deliveries, breaking down of equipment --
A. Yes.

Q. -- if it's equipment?
A. Yeah, complaints as well.

Q. Complaints as well?
A. Yes.

Q. And how are you aware of what the KPIs are for the statewide contracts?
A. All the KPIs are listed in the state contracts which are listed on Portt Discover, which is the state's contract database.

Q. So that's the database for all the statewide health contracts; is that right?
A. Correct.

Q. When you escalate concerns of one type or another to HealthShare, how do you find the responsiveness from HealthShare?
A. I would say good. They are very responsive to what we do escalate and they are generally very willing to give us a hand and work through negotiations or issue resolution as required.

Q. Issue resolution?
A. If there's some sort of discrepancy or something we're not happy with, they're a part of that process and they can become a bit of a mediator as part of our process.

Q. Between --
A. Us.

Q. "Us" - you and the vendor?
A. Correct.

Q. Within your district, presumably there's sometimes a product recall; is that right?
A. Correct.

Q. And if there's a product recall, perhaps the vendor contacts, obviously, the district and says, "Look, this batch of" - whatever it may be - "is subject to a recall". Do you, within the district, have, at the moment, the ability to trace items through to patients?
A. Yes, we can. So particularly for prosthetics, so we use the h-trak program and that's our record of what prostheses have been in which procedure, installed by the clinician that did that work.

Q. So your district uses h-trak?
A. We do.

Q. We have heard some evidence already about h-trak, thank you. What about DeliverEASE, has that been rolled out in your district yet?
A. It has been partially rolled out. So we're fully implemented at Liverpool Hospital.

Q. Fully rolled out at Liverpool?
A. Correct. And we're at 60 per cent for Bankstown Hospital, no, sorry, disregard that. It was Fairfield Hospital, and we're working through Bankstown and Campbelltown Hospital in mid May.

Q. So it's in the process through Campbelltown - in the other hospitals?
A. Correct.

THE COMMISSIONER: Q. Have you had any feedback about DeliverEASE at Liverpool and whether it's improved things?
A. Yes, Commissioner. There's been positive feedback as part of that installation or that implementation of DeliverEASE. So we've got greater compliance with infection control standards, which is good; we've got more efficient ordering practices; and there's less over-ordering. So we should have reduced our stock at completion of that project as well.

Q. The staff that are using it feel as though it's an improvement?
A. Yeah, that's the feedback that I've got. They're happy with the program at the moment, yes.

MR FRASER: Q. So it's made differences, in your opinion?
A. The feedback that I've received indicates that, yes, it has, but we are in the process of doing a post-project survey to get some data on that.

Q. So feedback has been informal but not formal yet; is that right?
A. Yes.

Q. When do you expect it will be fully rolled out across all the facilities in the district?
A. By the end of the financial year.

Q. I just want to ask you some questions in relation to the tender process and the involvement of the district when new statewide contracts are established or they're up for review and renewal.
A. Mmm-hmm.

Q. Do you have a role in that, on behalf of the district?
A. I have a huge role in that, yes.

Q. Do you want to explain that, please?
A. So initially a business case will be developed of the key stakeholders, to determine the business need for that particular good or service. So that would generally be in the form of a brief that is written to the chief executive and that would detail what the business requirement is, the current spend and details of procurement process that would be undertaken.

Depending on the project, that will obviously be discussed at the strategic procurement advisory board as well and brainstormed, and then that will then get added to the brief as well, that that's already been through that process and has been endorsed by the SPAB.

From that process, we go into a very lengthy procurement process but it's obviously dependent on the level of spend required as part of the procurement process. So when drafting that brief to the chief executive we do what's called a "tender risk assessment" and that determines the type of tender process we're to follow when conducting that procurement activity. So if it's less than $250,000 it's not as complex, but anything over $250,000 is a more complex process where we're required to engage HealthShare as part of that tender activity.

Q. Is it true that engagement - that sometimes a procurement process might turn into a statewide contract?
A. Generally not - if it's being conducted by the district it will not be a statewide contract, it will purely just be a local procurement activity.

Q. At least from where you sit in the district, is it clear to you how it's decided what things become the subject of statewide contracts as opposed to district procurements?
A. Yes.

Q. How does that occur?
A. When we complete a local procurement activity, that's purely just for our district, but HealthShare manage all the statewide contracts and the tendering process for that.

Q. Yes, but in terms of new statewide contracts, there's a new technology?
A. Yes.

Q. Your clinicians have become aware of it and the district wants it?
A. Yes.

Q. But it might be relevant to other districts across the state. How does it come to the point where HealthShare might say, "We're going to do this on a statewide level"? Is that through your strategic procurement advisory board?
A. That would be probably the first point where that would be discussed, because we've got ministry and HealthShare as part of that board. So that will be shared, "There's a business need here, there might be potential to make that into a state contract." And then we'll open up discussions with HealthShare and then we'll work through the strategy. But after that point HealthShare takes over that procurement activity and they come back to us for advice on what they'd like to have involved or incorporated into that procurement activity.

Q. Clearly, if it's going to be statewide they do the process?
A. They do, yeah.

Q. If it's going to be a significant procurement but done at a local level, it's - HealthShare have some oversight but you're doing the process?
A. Correct.

Q. Where it's a statewide contract, and it has been renewed or there's, for instance - or it's a new statewide contract, what role do you have for the district?
A. So I would be part of the process in facilitating either clinicians or other stakeholders that might be able to participate in that statewide contract on behalf of South Western Sydney Local Health District. And there may be times when our own procurement staff will sit on those statewide contracts to help ensure we get the best outcome

as part of that process.

Q. How do they do that?
A. Get the best outcome?

Q. Yes.
A. So you want to have subject matter experts involved in all the decision-making when it comes to tendering. So if it's - if you've got a piece of equipment that might be biomedical equipment, you want to have a biomedical engineer provide that advice on that statewide contract to ensure we get the best outcome for health.

Q. So there's sometimes, effectively, experts from your district that you, you know, link up the procurement process with; is that right?
A. Correct.

Q. And they're involved in the evaluation process?
A. Yes.

Q. And sometimes that will be clinicians; is that right?
A. It will be clinicians, when it's a clinical type product, for example, prostheses and other similar type things, we will engage clinicians to ensure that they have the opportunity to have input into the tender outcome.

Q. How do you identify them? Do you go to the relevant department and --
A. We know who the subject matter experts are in our organisation, but if we're not too sure, I'll send it out to their stream manager or director and say, "I need someone that can provide this input", and they'll know the person that should be invited into that process.

Q. I would just like to ask you about statewide contracts generally.
A. Sure.

Q. Once it's a statewide contract, effectively, you have to use it; that's right, isn't it?
A. Yes, correct.

Q. Just in terms of your perspective, do you perceive that your district, South Western Sydney, gets the best value out of those contracts all the time?
A. I wouldn't say all the time. I think there is

definite opportunity to achieve further savings for metro local health districts.

Q. Metropolitan districts?
A. Yes, because we are close to shipping and airports, et cetera. So there is more efficiency for the vendors in giving us better pricing rather than, say, for example, shipping goods and services out west. So I think there are definite opportunities to potentially do better in the metro LHDs.

Q. Are there any particular areas that, you know, in your mind, fall in that category?
A. Potentially medical imaging, where it's quite expensive to put a large piece of medical imaging equipment on a truck and transport it, whereas if it's coming off a shipping container into a metro LHD, those costs would be reduced.

Q. So it's really your perception of that saving is particularly because of transport costs, shipping costs and the like; is that right?
A. Correct.

Q. How would you see that working for metropolitan districts? Would it be separate contracts or would it be different provision and pricing structures within the contracts?
A. I think having the ability to conduct local further tender offers that are only applicable to the local health district completing that activity is where you could get greatest value for money. So at the moment, they've got what's called "continuous best price", so if a vendor offers a good price to our local health district, they may be required to apply that across the whole entire state on certain contracts.

Q. And you might not be able to answer this, but would that potentially drive up the price for regional LHDs?
A. It could potentially. So the overall strategy is to achieve best price across the district as a whole, and so generally those far west local health districts, they leverage off the back of the good pricing that is given to metro LHDs.

Q. I would just like to ask you some questions now generally about eHealth. Just one moment, if I may. So in

relation to, obviously, eHealth, they deal with information technology equipment for the district?
A. Correct.

Q. And they don't just deal with procurement of equipment, they also provide some services; is that right?
A. Yes.

Q. And are there services that you're required to comply with or use?
A. I can't talk too much to eHealth and their services, that's more the ICT. I can really talk more about the ICT procurement and our relationship with eHealth, yeah.

Q. So in relation to that process, procurement, were there any reflections you have on that process, of procuring ICT things through eHealth? Does it cause any difficulties for the district?
A. eHealth are quite rigid in their processes, and in procurement there are more efficient ways to conduct procurement that can honestly save money and time, and I'd like to think that our team is quite mature in the way we conduct our procurement activities and we know where we can be more efficient. Where we do share those ideas, we don't always necessarily get approval to do that work and that might be because of their interpretation of what the policy is, but we have a different interpretation on certain aspects of what that policy actually states.

Q. Can you give us an example?
A. I might talk about direct negotiations. So under the procurement policy there is ability to conduct direct negotiations, if you've got a strong business case to do so. For example, we're in the process of working through a managed print service contract. And working through that process with eHealth, we requested to do direct negotiations with a vendor off the back that another LHD recently conducted procurement activity. So rather than go through that whole entire process and come to the same outcome, we requested to do direct negotiations.

So once that was escalated to the senior exec within eHealth that was approved but at that lower level it took a fair bit of time and conversation to get to that point, because they couldn't understand our strategy and what the benefits actually were if we were to go through that process.

Q. So you got there but it took quite a bit of time; is that what --
A. It did, yes.

Q. Just in terms of the process of ICT procurement, it differs a little to procurement through HealthShare; is that right?
A. It does but it is very similar.

Q. Just as a general process, how does it operate?
A. I would say it is not as efficient as the HealthShare process, so there's a lot more detail and information required to get to market, compared to HealthShare, which takes time.

Q. Which takes time?
A. Yes.

Q. And what is it that causes the need for more detail and information than sort of a comparable procurement through HealthShare?
A. I'm guessing - I speculate, potentially just because the ICT procurement processes that they've got might be different to the HealthShare ones but I'm not entirely sure.

Q. Do all procurements of ICT equipment - at what level does it require e health to be involved?
A. It does depend on the dollar value.

Q. In the same way as it does for HealthShare?
A. It does, yes. But I have an ICT category manager that liaises very closely with eHealth on all matters ICT procurement related.

Q. So are there any procurements you're able to just not go to eHealth at all?
A. Sorry?

Q. Is there a low-value ICT procurement that you don't need to engage with eHealth at all?
A. Yeah. For example, IT software below a certain threshold, we're not required to engage the ICT - sorry, the eHealth procurement team, but we still need to liaise with eHealth on the cybersecurity aspect of that project.

Q. We'll come back to cybersecurity in a moment. Is there then a level that you have to get approval from eHealth and, as you have said, you are then able to do it yourself, like the direct negotiation that you have just mentioned?
A. This is a challenging part of our relationship at the moment. So we do request to have the same approach as what we do with HealthShare. So HealthShare have what's called a level 1 or a tender light engagement whereby they purely just manage the tender box and we run the full procurement activity and everything goes in that tender box and we liaise with HealthShare to provide them documentation and everything else that's required as part of that procurement activity, but we essentially run that activity.

Q. So they, effectively, oversight it?
A. They check, making sure that we're --

Q. They make sure that you're following the right processes?
A. Yes.

Q. And the documents are there for them to see, but you're doing it all?
A. Yes.

Q. Is there not an equivalent with eHealth?
A. eHealth prefer to be more hands-on, is my experience. And we're now working through what that sort of looks like and what sort of freedom we can have to conduct our procurement activities because we have the intimate understanding of what the procurement activity is. We've got a very mature team in the way we conduct our procurement activities, and when you rely on another party to conduct the procurement activity it's dependent on their time and their schedule.

Q. Is it not clearly set out in a policy as to what - when you can do it yourself and when you can't?
A. It depends on the engagement that's listed by eHealth and HealthShare. So that's dependent on - there's a procurement policy that says we must engage them, but that interpretation of how you engage them is what can be interpreted in different ways. So we meet that requirement with HealthShare via our tender light submission, sorry, engagement, whereby they manage that tender box, and that provides compliance with the procurement policy.

So we see the same thing with our relationship with eHealth, we're still engaging them but we still - we think we can run it more efficiently than what they can.

Q. But they don't relax control as much as HealthShare; is that one way of putting it?
A. It's more challenging to get that freedom to conduct that procurement activity with that vendor.

Q. Presumably there is large-scale ICT procurement --
A. Yes.

Q. -- as there is with HealthShare that has to be done through eHealth?
A. Yes.

Q. For instance, if you were replacing the entire IT system within the whole district, for instance?
A. Yes.

Q. I'll just come back to cybersecurity. What is it that you have to engage with eHealth about in relation to cybersecurity?
A. So for all goods and services related to ICT, there needs to be a cybersecurity assessment done, which is called - under the privacy security assessment framework.

Q. I think, there are some documents we've seen, I think it might be the privacy security assurance framework.
A. Yeah. Yes.

Q. Is that something relatively new or is that --
A. It was released last year.

Q. So 2023. And that's an eHealth policy, is it?
A. It is.

Q. No doubt we can get that if we need to from eHealth. What does it require?
A. It requires a security - a cybersecurity assessment done for all ICT goods and services that would have some sort of connection to our cloud or servers, et cetera.

Q. I see. And that includes, I think you said earlier, your small-scale software procurement, so you need two licences for Adobe, for instance?

A. Yes.

Q. There has to be an assessment of that done?
A. That's my understanding, yes.

Q. Even though it might be software that is being used in every single LHD?
A. Yes. So we've been advised that we need to do retrospective assessments as well for things that we're currently using where an assessment hasn't been done.

Q. If it was something that was procured through eHealth originally, presumably in that process it would have been done by them - is that right - already?
A. Not necessarily.

Q. Not necessarily. All right. How does that cybersecurity assessment get done? Who does it?
A. eHealth.

Q. And is there a charge for it?
A. There is a charge, dependent on the complexity of that good or service.

Q. Before this policy of last year, how would that - did this occur?
A. I can't talk to that too much because that was more of an ICT remit. It's only really come to my knowledge when we were completing a new procurement activity, that is certainly a requirement that we need to conduct. So we do have an in-house cybersecurity manager that can work through those projects locally as well.

Q. So the fee varies depending on the complexity --
A. Yeah.

Q. -- which makes sense. And would you say that --

THE COMMISSIONER: But does the fee vary? Is that an assumption or --

MR FRASER: I think that's what the witness said.

Q. Does the fee vary?
A. It should, but depending on the complexity, yes, so --

Q. It should, but does it?

A. It will. So we're still working through that now and going through that process of what that looks like. So our ICT team could probably provide more information on that.

Q. What sort of range is the fee?
A. Ten to $30,000 is what I've understood.

Q. Sorry, 10 to $30,000?
A. Yes.

Q. Are you resourced for that? Is there a funding stream for that?
A. Not to my knowledge, no.

THE COMMISSIONER: Q. Is it charged as a lump sum for doing a particular service or is there an hourly rate or --
A. I'm not sure, to be honest. I just - when we get that initial - when we engage with eHealth on what that project is, they give us, like, an indicative figure of "This is what it should cost to complete that PSAF".

MR FRASER: Q. So, effectively, it becomes an additional cost of the procurement?
A. Yes.

Q. For the new procurement?
A. Yes.

Q. And in terms of having to do retrospective assessments, firstly, how long have you been given to do them?
A. It's something that --

Q. Or have them done, I should say?
A. The chief information officer from our district would probably be best placed to comment on that. I'm not aware of a timeline but -- -

Q. And the fact that they're retrospective tends to suggest that they're assessments that weren't done previously?
A. Correct. Under that particular framework.

Q. So it may have been different assessments were done but not those that met the requirements in the framework?
A. Potentially, yes.

Q. And in relation to the retrospective assessments, is there any additional funding that has come to the district that you are aware of?
A. Not that I'm aware of.

Q. And you referred to having - you have some in-house ICT capability; is that right?
A. We do. Within the ICT team there's a cybersecurity manager employed full time to conduct local assessments.

Q. To conduct these type of assessments?
A. That's what they're employed to do, is my understanding.

Q. Is he able to conduct the assessments to satisfy this policy?
A. The initial conversations I have had with that person are yes, they can, and the chief information officer, I believe, is discussing that with eHealth on what local arrangements might be able to facilitate compliance with that policy.

Q. So at the moment, to your knowledge, that's a matter under discussion but hasn't been resolved?
A. Correct.

Q. Either way.
A. Yes.

Q. At least from your knowledge of the policy - I appreciate you work in one district - if there's something that has been rolled out in every district, is every district having to do its own assessment?
A. To my knowledge, yes. So we have had discussions with eHealth where we'd like to piggyback off the back of another local health district that might have completed that work so we can save the money and the time to go through that process.

Q. So presumably - and I appreciate you're not a cybersecurity expert --
A. Yes.

Q. -- but even if it was a standard piece of software that had been utilised in every district, every district would have to do its own. That's your understanding?
A. That's my understanding as it stands today, yes.

Q. And again are we talking the same sort of numbers, 10 to 30,000 for each one?
A. Yes.

Q. And in total, do you know how much you've been spending on an annual basis? I mean, I appreciate it's only come in last year, so it might not be a full year yet.
A. My last discussion with my ICT procurement category manager was $2.4 million.

Q. 2.4?
A. Million dollars.

Q. And is that for year to date, for the financial year to date?
A. That's what we've projected that we need to spend to meet compliance with that policy.

Q. I see. So that's the projected spend for this financial year?
A. Should we progress or proceed with all those assessments.

Q. If you were to complete all the assessments that you're required to?
A. Yes.

Q. Is that solely the retrospective ones?
A. That's retrospective, yes. So that's current projects where it hasn't been done, we need to spend that money to meet compliance with the framework.

Q. Generally, does eHealth have an understanding of what the capabilities of ICT are, to your perception, within the district's capabilities?
A. In regards to cybersecurity you mean?

Q. Cybersecurity and ICT generally?
A. I couldn't comment on that. I don't work closely enough to eHealth.

Q. You mentioned the printer fleet, I think?
A. Yes.

Q. And you had to do a lot of work to get approval to directly negotiate with the provider. Could that have been

a more efficient process?
A. I think it could have been more efficient, potentially through the frontline eHealth procurement team having, like, a better awareness or potentially better or greater delegation to escalate direct negotiations. We did go back and forth and provide what we thought was a good business case and we escalated that through to the exec of eHealth for his approval to allow us to complete direct negotiations.

Q. Have you raised this with eHealth?
A. Yes. It's been discussed. So the executive discussion was held between eHealth, the chief procurement officer and our chief information officer about getting approval for direct negotiations for that project.

Q. All right, for that project. Is there any result of that that might equal a more efficient approach in the future?
A. Not at this stage, no.

Q. You've referred to this framework, the privacy security assurance framework, which came out last year. Are there other policies that get rolled out by eHealth on a regular basis?
A. This is the first one that's impacted my work, and I can't comment to what's happened in the past, yes.

Q. Certainly. And before that was put in place, was there any consultation or engagement with the districts?
A. There may have been but it didn't filter through to me and it - it did seem to catch our ICT team off guard as well, and they, you would think, would be the most - they should be consulted as part of that whole entire rollout process and to my knowledge they weren't.

Q. In terms of procurement generally, whether it be eHealth or HealthShare, are there any aspects of it or a general approach that you see could benefit from improvement, from the district's perspective?
A. I think if the dollar threshold to engage HealthShare and eHealth was potentially increased, it could increase my local procurement team's efficiency in getting through projects. Because when we run things in-house, we're far more efficient, work through the schedule, engage our stakeholders efficiently and we get through the projects relatively quick.

Q. Those dollar thresholds, they're set out in HealthShare or eHealth policies as applicable?
A. In the procurement policy.

Q. In their procurement policies?
A. Yes.

Q. What about the engagement with clinicians or others on-the-ground stakeholders?
A. In just general procurement do you mean, or what --

Q. Yes, in the procurement process? Are they engaged sufficiently, from your perspective, by eHealth and HealthShare?
A. Oh, by eHealth and HealthShare?

Q. Yes.
A. I think just engaging clinicians generally is very challenging because they're busy people, they're probably - their core business is patient care, and to step outside of that to do procurement activities can be challenging and time consuming and potentially, in their view, not really benefit them or their service.

So I think that's always going to be challenge getting clinician involvement, so we always ensure they are given the opportunity to consult or be a part of those processes, but generally speaking, that's just - clinical engagement is just always going to be an issue when they're as busy as they currently are.

Q. Do you find there are some areas that they engage more on than others?
A. They obviously care most about their core business and the instruments they're going to use, so if you have somebody that's working in endoscopy, they're going to care most about endoscopy scopes, et cetera, and the same with surgeons using prosthetics, they're going to be most closely interested in those processes.

Q. Are there any efficiencies in your mind, or from what you can see, that might arise from greater standardisation of, say, prostheses or other items?
A. Prosthesis is a very complex thing to standardise. We have issues just trying to standardise across an LHD. To standardise across the state would be a huge undertaking

and it would be a very challenging project, I would think, to achieve. But yes, if you could make that happen, you would get some dramatic savings in the prosthetic spend across health. But there will always be that clinical need to go outside of large agreements based on the particular procedure or that individual patient that might be having a procedure.

MR FRASER: Commissioner, those are my questions for Mr Clancy.

THE COMMISSIONER: Thank you.

Any questions, Mr Gyles?

MR GYLES: Yes, if I might just briefly, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Mr Clancy, in terms of cybersecurity, cyber risk, that's obviously a pretty important part of your business, because you've got people's personal information that needs to be protected; you agree?
A. Correct.

Q. And those who are causing the cybersecurity risk are pretty sophisticated and it's an area that moves along pretty quickly?
A. Yes.

Q. So having regard to the fact that it's an important matter to appropriately protect people's information, you've got a particular person on board to deal with that issue - that is, you've got a full-time person to deal with cybersecurity risk?
A. That person is not in my team,, that's in the ICT directorate, so that's not a procurement person.

Q. Yes, but in terms of ICT - so you have brought someone on board and you've told us that there is an anticipated spend to bring the current systems up to scope with the current - with the policy that came in last year?
A. Correct.

Q. And that's now a real cost for you --
A. Yes.

Q. -- in procuring that service. Can we take it that eHealth - you are in discussions or your IT people are in discussions with eHealth about bringing about that outcome - that is, bringing all of the services you've got up to scope or up to spec with the policy?
A. Yes.

Q. And you have an anticipation of what that cost might be from eHealth?
A. Yes.

Q. But you've brought someone on board with a particular expertise in that area within the ICT team?
A. Yes.

Q. And from a procurement point of view, you're going to be trying to deliver that outcome - that is, a compliant information technology system, compliant with the cybersecurity policy, in a way which is cost efficient, if that's able to be done?
A. Correct.

Q. And you'll do that hand in hand with eHealth?
A. Yes.

Q. And one of the things you'll look into is whether or not there can be savings because, as you observed in your evidence earlier, there may well be that, in other LHDs, these things have been looked at and there may be some efficiencies and some cost savings that can arise from that?
A. Yes.

Q. And there may be also some cost savings that can arise from you doing some things in-house?
A. Correct.

Q. And your ICT manager would be alive to that?
A. Yes.

Q. Because it is a large cost item that you'll be trying to bring down if you can?
A. Yes.

Q. And the reason that there is a need for retrospectivity in that area is that this is a new policy and you've had software systems and systems that have been

in place for some years which need to be brought up to that standard?
A. Correct.

Q. So once that's all done, once that is brought up to spec, it will then be for new systems that will require that, and potentially for upgrading the old systems as the cybersecurity risk alters and changes, as it necessarily will going forward?
A. Correct.

Q. But it must be an area where, having access to the eHealth experience in other LHDs and expertise would be of potential benefit to you?
A. Yes, they are.

Q. As a resource?
A. Yes.

Q. Finally, early on in your evidence you were asked about KPIs and KPIs in statewide contracts?
A. Mmm-hmm.

Q. So essentially in your procurement world you've got statewide contracts and you've got contracts which are at LHD level, and you have access to the LHD contracts because often they're negotiated by your team?
A. Correct.

Q. And obviously you're aware of the KPIs in those agreements and you've got access to the wording of those agreements?
A. Yes.

Q. And I think your answer that by use of Portt Discover --
A. Yes.

Q. -- you can also access the statewide contracts?
A. Correct.

Q. So just explain to the Commission what that is? Is that something that's able to be searched? Is that an app or is that a means by which you can search across a database?
A. It's the database for all state contracts. So once the state procurement activity is complete, it's then up

loaded into Portt Discover and then we can view those contracts and we can purchase off those contracts, and it's got the key details like pricing schedules, quick links for information, key contact details, and then the actual contracts themselves that we can see.

Q. As you understand it, that would be information that, through that means of search, would be available to all of the procurement officers?
A. Correct.

Q. Or directors across the LHDs --
A. Correct.

Q. -- as you understand it. That's not something that just happens to be available to you?
A. No, it's available to everyone that's in procurement and other people that have access to Portt Discover.

Q. So if there is a new statewide contract or a statewide contract is renewed or altered in any way, that would go on to that system and be available in that way?
A. That's the one spot to store all contracts in the state.

MR GYLES: Thank you very much. Thank you, Commissioner.

MR FRASER: Just one matter of clarification, Commissioner.

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Just picking up on those questions you were asked about the Portt Discover database, does that include KPIs - does it include things that might be ordered through DeliverEASE from the - in terms of bulk consumables and the like?
A. They are stored there as well, the information related to those agreements is stored there as well, but the catalogue is separate to that.

Q. But information about those contracts is in the Portt Discover database?
A. Yes.

MR FRASER: Thank you. Nothing further, Commissioner.

THE COMMISSIONER: Thank you very much, sir. Did you have to wait around yesterday?

THE WITNESS: No, I didn't.

THE COMMISSIONER: That's good. Thank you very much for your time. It is greatly appreciated. You are excused.

<THE WITNESS WITHDREW

MR FRASER: Mr Glover is taking the next witness.

MR GLOVER: The next witness is Sonia Marshall.

<SONIA MARSHALL, sworn: [10.54am]

THE COMMISSIONER: Mr Glover will ask you some questions and Mr Gyles for health may as well at some stage.

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. State your full name, please?
A. Sonia Marshall.

Q. You are chief executive of the South Western Sydney Local Health District?
A. That's correct.

Q. As of January 2024?
A. 29 January, 2024.

Q. And you acted in that position from September 2023 until you your substantive appointment; is that right?
A. That's correct.

Q. Prior to that, you were the executive director nursing, midwifery and performance in the district from October 2018; is that correct?
A. That's correct.

Q. You made a statement to assist the Commission. The statement is exhibit B .007 [MOH.0001.0261.0001]. Do you have a copy of it there?
A. I do.

Q. Have you read it again before giving evidence today?
A. Yes, I have.

Q. Is it true and correct to the best of your knowledge and belief?
A. Yes, it is.

Q. I'm just going to ask you some questions by reference to your statement, and I'll just direct you to some paragraphs in it as we go. If anything is unclear at any stage, you just let me know.
A. Okay.

Q. Can we start at paragraph 18, please. Just have a read of that paragraph to yourself and let me know when you have finished.
A. Yes.

Q. When you refer to the "recent reform" at the district in the first line, what are you referring to?
A. In 2020, the ministry engaged KPMG to assist the district in undertaking a review of our procurement processes to ascertain whether there are any opportunities for improvement in terms of value add as well as governance. From that review in 2020, in 2021, based on the recommendations of the review, the district underwent a discovery and change process with what was then our supply unit and created a procurement unit, and we appointed positions into that procurement unit. At the beginning of 2022, we employed the manager, and then we launched the procurement hub, being the unit, in July 2022.

Q. Is that what is referred to as "stronger procurement governance" in the second line of that paragraph?
A. Yes, that's correct.

Q. What about "improved record keeping", that's also referred to in that paragraph? What was done in that area?
A. Yes, so in line with the review and the establishment of the procurement hub, we ensured that all of the district followed the necessary policies and procedures; there was an establishment of the strategic procurement advisory board that met monthly to provide overall governance; and we ensured that the appropriate portal was used to manage the contracts in the district.

Q. When you say the "appropriate portal" was used to manage the contracts, what do you mean by that?
A. "Portt" is actually the name of the eHealth portal

that all of our tenders are held on, and it allows there to be open and transparent access to the contracts and ensures that, you know, any contract over 120,000 is then made available, with GIPAA, to - for access to the public.

Q. Is there part of that system that is only accessible to some staff within the district?
A. Yes.

Q. What are those areas?
A. Finance and our procurement team.

Q. You then referred to, in paragraph 18, "establishing procurement roadmaps"?
A. Yes.

Q. How was that done?
A. So through the review of - that KPMG undertook and then the implementation that was rolled out across the district, and through the governance of the strategic procurement advisory board, a number of roadmaps were established in regards to moving on to whole of government and whole of health contracts to deliver value savings, and they were tracked through the strategic procurement advisory board to ensure that, one, we had appropriate clinician engagement but, two, that we were actually delivering what was suggested with the plans.

Q. We'll come to the board in a moment, but from that answer, do I understand that prior to that initiative, a number of statewide or whole of health contracts were not being utilised within the district; is that right?
A. I can't answer that because I don't have that history of that far back.

Q. In paragraph 18 you say those reforms have led to savings. How have you measured that?
A. So through the strategic procurement advisory board, a savings initiative is put forth to that board, assessed whether it will go forward or not through the committee, and then, through that committee, we actually track the savings.

So, for example, when we went forward with our hand hygiene products, we were able to track the value as we moved on to a consistent alcohol-based product; same with our prosthetics, we were actually able to track the

savings.

Q. So that's done on a category-by-category or product-by-product basis?
A. A category-by-category basis, yes.

Q. These are initiatives driven at the local level?
A. So obviously state of procurement strategies that we sign up to, such as pharmaceuticals, and as part of our strategic advisory board, we have both HealthShare and the chief procurement officer sit on that board so that we can actually work with them and ensure that if we are missing any of the state savings, they can inform us on, you know, what's coming, but also so that they have that awareness of what we're working on.

Q. But whilst there's mechanisms to collaborate with the shared services in that way, the reforms that you're referring to in paragraph 18 and that you've explained in your answers this morning are driven within the LHD; is that right?
A. That's correct.

Q. Can we turn to paragraph 20 and the strategic procurement advisory board. You refer to some terms of reference and I will ask the operator to bring them up on the screen. It is [MOH.0001.0423.0001] that's exhibit B.023 at tab 122. This is the terms of reference for the board that you have mentioned this morning; is that right?
A. That's correct.

Q. And it lists its membership under point 2.
A. Correct.

Q. Was this established prior to your appointment, either as acting or substantive CE.
A. Yes, that's right.

Q. Were you a member of the board prior to your appointment?
A. Yes, I was, in my director of nursing, midwifery and performance role.

Q. Are you aware of how the membership of the board was arrived at - that is, how the membership was selected?
A. I believe it was based on the requirement at the time

to look at how we could have better governance and what partners we needed to involve to ensure that we had that governance, and partnerships with HealthShare and the ministry.

Q. Was a wide range of representation from across the LHD part of that consideration, to your knowledge?
A. Yes, in terms, though - because it is a strategic committee, so it is fed back down through the organisation, but ensuring that we had representation from corporate services; clinical, in one of our senior clinical directors, being a medical officer; I was there as the nursing representative.

Q. How is it fed back down through the LHD - that is, the work of this board?
A. So through the general managers meeting, through the finance and performance meetings held with each site, and in my previous role, I fed that down through the directors of nursing and midwifery meeting that was held with the sites and services.

Q. Putting your current hat on as CE, how does this board assist you in the performance of your duty?
A. The board allows me to have ideas presented based on business cases to show where there are opportunities to value add and save money for the district, and through the use of the committee, the board, to make a decision as to whether it is time to make a move on those savings, whether the person who is presenting - so usually a category manager - has consulted with the necessary clinical staff before putting forth the strategy, and then whether there's going to be enough value add to focus on that strategy for whatever period of time it's proposed.

Q. You mentioned the membership of a HealthShare representative earlier. What benefit does that bring to the work of this board?
A. HealthShare sit on there to be able to provide the linkage to - for, one, what is coming down from the state level in terms of procurement projects that we can sign up to and be part of; but also, two, so that they're aware of what we're driving. They also provide us with reports for those statewide strategies that we have signed up for, such as pharmaceutical savings.

Q. And is that an effective communication stream, in your

observation?
A. At a very high level, yes, it is.

Q. Are there other methods by which you engage - that is, you in your role as CE - with HealthShare?
A. Yes, there is. So we have quarterly performance meetings with HealthShare and they bring their senior executive along, and we're actually able to talk in terms of different categories, so, for example, patient transport, food services, et cetera.

Q. So things will be reported up to you - is that right - for the purposes of those meetings?
A. I participate in those meetings. So those meetings allow me to, one, see how we're tracking in terms of spend; if we've got any savings initiatives that we're working on in relation to these key function areas and how they're tracking; and also improve the partnership that we have with HealthShare so that when we're working on joint projects together, a good one is patient transport services, how that's going.

Q. Is that an opportunity for you to raise issues of performance, whether it be of statewide contracts, whole of health contracts, et cetera, with HealthShare?
A. If it's aligned to one of those services that we're discussing, definitely. But most of the times, issues are raised at the time, rather than waiting for a quarterly meeting.

Q. If the operator could just scroll down in the document, please, just on the screen to your right there, you will see the document. Under the heading 6, there is the purpose. You might have that in front of you, do you? You have come prepared?
A. Yes.

Q. Just have a read of that paragraph under "Purpose" for me and let me know when you've done that?
A. Yes.

Q. Do you see the concept "Value based procurement" in the second line?
A. Yes.

Q. What does that mean to you?
A. So "value based" means not only savings in terms of

financial savings but ensuring that we're considering the lifecycle of the product, whether it's a piece of equipment, maintenance contract as well, and that it meets the actual need that it is designed for, so that it - and goes through an assessment process to be able to deliver what's required from that. So true value based, not just financial, but financial plays a big part.

Q. Is patient outcomes part of that consideration?
A. Definitely. For the type of - depending on the type of product or service that we're looking at.

Q. And are they principles that are deployed through your LHD in its procurement practices?
A. Yes, definitely.

Q. How?
A. Through our category managers. So in the establishment of our procurement team, we set up six category managers that service different parts of the business to look at value base for their category - so whether that be clinical products, prostheses, corporate services - and to look at the contracts, so, for example, hand hygiene, delivering not only value in terms of cost and effectiveness but does it meet the needs of the clinicians, the infection control purpose, et cetera.

Q. How does the work of this board advance that principle?
A. So the category managers actually put forward proposals to the SPAB to get endorsement and support to be able to move forward to enact those potential savings. So before we went - before the team went out to negotiate for the hand hygiene contracts, for example, that proposal came up through the SPAB to be supported by the SPAB and the chief executive prior to the team actually going - moving forward with that.

Q. You just said "SPAB". Is that the acronym for this board?
A. Yes, apologies.

Q. That's all right. If we move ahead to paragraph 21, please, there you set out the framework for the use of centralised services for the procurement of goods and services. And then into paragraph 23 you set out where HealthShare is engaged in those processes. Just have

a read of paragraph 23 and let me know when you've finished, please.
A. Yes.

Q. In that paragraph you refer to the scenarios in subparagraphs a, b and d of paragraph 21. Does your LHD engage with HealthShare in relation to the scenario that's set out in paragraph 21c?
A. Yes.

Q. In what way?
A. A recent example is we wanted to piggyback on a large contract for managed print services and so we sought approval from the chief procurement officer to move down that path.

Q. What role, if any, did HealthShare play in that process?
A. They play a governance role to ensure that we're following probity and procedural --

Q. Where HealthShare provides your LHD with the administrative support or the purchase order creation and tendering processes and policy and procedural oversight, et cetera, that you refer to in paragraph 23, is there a cost to the LHD involved?
A. Yes.

Q. Are you aware of how those costs are calculated?
A. Not in this early stage.

Q. Are you aware of the level of cost charged to the LHD, say, this financial year for those types of services?
A. We receive our charges from HealthShare, they go down into a level of detail. I haven't yet met with HealthShare and my finance director to understand the level of detail.

Q. And tell me if you don't know, but how are those charges levied to the LHD? When you say, "We receive our charges", how is that actually done, do you know?
A. No, I couldn't answer that.

Q. That's someone else's remit?
A. Yes.

Q. Who might that be?
A. My director of finance would be able to answer that

one.

Q. In paragraph 25, you set out the process for procuring ICT-related goods and services?
A. Yes.

Q. And that involves engaging with eHealth; is that right?
A. Yes.

Q. And similarly, when eHealth is engaged on those matters, is there a cost to the LHD for that?
A. Yes.

Q. And do I take it that the director of finance would be the person to speak to about the costs associated with those items?
A. Both director of finance and the director of digital health.

Q. Thank you. Would you turn to paragraph 30, please. Would you just refresh your memory about what's in paragraph 30?
A. Yes.

Q. This question may be in same category, but in the last line, the last sentence there, you say that eHealth services obtained by the LHD are bundled in the sense that they include both service and licence fees together?
A. Yes.

Q. What do you mean by that?
A. When we receive our breakdown of costs, both the licence and the ongoing maintenance fee for the licence is included in that cost for that line item.

Q. Do you mean that they're not itemised, that it's one cost and you can't tell which is which?
A. That's correct.

Q. Would you prefer to have an itemisation of those charges?
A. For me at my level, I look at the overall costs, but feedback from my director of digital health, he would appreciate the transparency.

Q. Did he tell you why?

A. Just to know what is actually being delivered - what the actual fee covers.

THE COMMISSIONER: Q. I'm not suggesting there's anything wrong with this arrangement, but just so I'm certain, when, in paragraph 28, for example, and also paragraph 30, we're talking about South Western Sydney LHD engaging HealthShare or eHealth, that's pursuant to the determination referred to in paragraph 15?
A. Yes, that's correct.

THE COMMISSIONER: Thanks.

MR GLOVER: Q. Paragraph 33, please. Just have a read of that and review the table for me and let me know when you have done that.
A. Yes.

Q. I appreciate these figures pre-date your tenure as CE, but are you able to speak to what is within these categories of cost that are set out - that is, are you able to tell us - where it's HealthShare NSW 2022/23, 72,988,000, are you able to tell us what that cost comprises?
A. Yes. So to the best of my understanding, the HealthShare costs include our food, linen, patient transport, so all of the categories as listed, our purchasing, costs through the warehouse, receipting, et cetera.

Q. And what about the fees charged by HealthShare for their services, is that within that spend as well or that figure as well?
A. To the best of my knowledge.

Q. What about eHealth?
A. Same, in terms of their fees, licences and any other services or products that we've engaged with eHealth.

Q. Thank you. The second row "NSW Ministry Managed". What does that mean?
A. From the best of my knowledge, they are the services that we pay for - things like ACI, CEC, those types of services.

Q. I'll come to that now. In paragraph 35 you say:

The support provided from the Pillars is paid for via the statewide intra-health settlement and transacted through the weekly NSW Ministry of Health subsidy.

Is that what falls within "NSW Ministry Managed" or is that something different?
A. No, that's my understanding.

Q. Can you just describe what support the LHD is paying for that's delivered by the pillars?
A. For example, the ACI, obviously in terms of looking at clinical procedures, pulling together networks to ensure that we've got the best evidence-based practice, the development of statewide policies and guidelines to support the system, the research and - the research. This year they're developing the research plan for the state, which the LHDs will then link in to. CEC, it's overarching clinical governance of the system, oversight, sharing of lessons, the ability to access experts across the system, et cetera.

Q. And so the costs of that work being done are charged to the LHDs; is that right?
A. As far as I'm aware.

Q. Is that the $32,951,000 figure for the 2022/2023 financial year?
A. I couldn't - I couldn't tell you exactly what's made up in that "Ministry Managed".

Q. But part of it at least --
A. Part of it is that.

Q. -- is what is being paid to the pillars for the performance of their function; is that right?
A. Yes, my understanding.

Q. When you say it is done by the "statewide intra-health settlement", what is that process?
A. I haven't got clarity on the actual process. It's a financial process that occurs in the background.

Q. Paragraph 34. Just have a read of that paragraph and let me know when you've finished, please.
A. Yes.

Q. Where you say the district has significant involvement in determining procurement outcomes for HealthShare administered New South Wales whole of government and whole of health contracts, what do you mean by that?
A. So, for example, our hand hygiene contracts - so we were able to negotiate contracts based on the state arrangement and then actually deliver further efficiencies for our LHD by moving to two different providers, one for alcohol-based hand sanitiser and one for the soaps that occur on the ward.

Q. So that is an example of leveraging whole of health contracts and improving the situation for your LHD; is that right?
A. That's correct.

Q. Did you have anything else in mind when writing that sentence?
A. We do a number of those types of - where we are able to negotiate off the - on the - a better deal based on the statewide contracts. So that's what I was meaning in that way.

Q. And then in the second sentence you go on to say the district:

> *... can only control volumes to an extent for shared services and ... Ministry of Health managed ...*

et cetera. When you say you can "only control volumes", were you seeking to draw a distinction with some other aspect of those arrangements that you can't control, or your district can't control?
A. We're not able to negotiate price for those types of things; for example, food services, we can only control the volume that we're ordering. Same with patient transport services: we can only really - we can't negotiate with them to deliver a different rate per kilometre or a different rate for booking fees. What we can control is the number that we order or process through them.

Q. So in that sentence are you referring to the services that the Commissioner referred to earlier - that is, that you're required to engage either HealthShare or eHealth to perform by reason of the direction?
A. Yes, that's correct.

Q. Would you turn to paragraph 38, please. Just have a read of that and let me know when you're finished.
A. Yes.

Q. There's an assessment there that by using whole of health or statewide contracts, there's been a saving to the district of 9.9 million. Are you aware of how that assessment was undertaken?
A. My understanding is through what we were previously purchasing based on moving to the new contract and the savings that we've been able to get on the new contract, based through new pharmaceutical contracts and also prostheses.

Q. Are there circumstances where you consider that your district may be able to achieve prices more favourable than those available under whole of health or whole of government contracts that you're not able to access?
A. I'm sure there are. I just can't think of any off the top of my head at this point.

Q. Are assessments of the kind that you referred to in paragraph 38 undertaken on a wide range of categories?
A. Those ones specific in that paragraph are usually based on the state procurement objectives at the time, and we measure them again through our strategic procurement advisory board, of which HealthShare provide how we're tracking on those specific programs.

Q. So these are assessments done by HealthShare?
A. Yes, that's correct.

Q. Do you do any similar assessments at the LHD level?
A. Definitely - particularly for the programs that we're running locally, as I've mentioned, the hand hygiene ones have been key ones that we've delivered, but we also do track those prosthetic ones, for example.

Q. Would you turn to paragraph 44, please.

THE COMMISSIONER: I'd better give people a break, soon.

MR GLOVER: Yes, I'm moving to a slightly different area, Commissioner, so now is a convenient time, yes.

THE COMMISSIONER: All right. We will have a break until

quarter to 12, 11.45. We'll adjourn until then, thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Just before we recommence with the witness, I was just waiting to find something out, but I should say that, at my request to the premier yesterday, there was a meeting of the executive council and for the purposes of the people here, the reporting time frame for this Inquiry has been extended from 24 August to 26 March 2025. There have been some minor, I think, amendments, I would describe them as, to the terms of reference, including the term of reference we're dealing with here, at least term of reference E. Do you have a copy of that, Mr Gyles?

MR GYLES: Somewhere.

THE COMMISSIONER: It won't make any difference to what we're doing. Plus some additional powers that I don't anticipate having to use.

I think also there's been some advice given in light of anticipating that timing change for some hearings commencing on 15 April in relation to term of reference B, governance, and I'm not sure health, at least, has been advised, or anyone else. I wouldn't describe it as completely final yet, but in relation to regional visits, which will cover all of the terms of reference, obviously it's known a visit to Murrumbidgee from 15 March and in the following week, but at this stage, the Inquiry intends to head to Western and Far Western New South Wales from the week of 13 May, and we also anticipate going to Southern New South Wales in the week commencing 19 August, and to northern parts of the state in the week commencing 9 September, but there will be some more information and finalisation about that and other hearing blocks that, on our current schedule, go right up until late December this year. Everyone will be advised about that shortly. All right.

Does anything arise out of what was just whispered in your ear?

MR GLOVER: No, Commissioner. There was a concern that your face wasn't projected on to the internet when you first came on, but your words have been recorded, so that's

all that matters.

THE COMMISSIONER: Okay, very good. We'll continue with the witness, then.

MR GLOVER: Thank you.

Q. Ms Marshall, if you would turn to paragraph 44 of your statement, please?
A. Mmm-hmm.

Q. Just refresh yourself with - in fact, if you refresh yourself from paragraphs 44 to 46, and I'll ask you some questions about those paragraphs.
A. Yes.

Q. Just starting with paragraph 44, the first concept introduced there is you say there are limitations in the current arrangements in that only partial savings are achievable to your district?
A. That's correct.

Q. What did you have in mind when you wrote that sentence?
A. The true savings are delivered when we engage with the clinicians and actually get them to change their practice and utilise the products that we have been able to negotiate better prices for.

Q. So what is the limitation in the system that you're referring to in that sentence?
A. So it's fantastic that HealthShare are able to negotiate better prices for us at the state level, but it comes down to the relationships and us being able to influence our clinicians to actually deliver those savings.

Q. Is that an issue with implementation of those arrangements at the local level?
A. Yes, that's correct.

Q. Is that something that your district receives support from HealthShare to do?
A. No. The relationships need to come locally. So locally, we need to be able to find the influencers in each of the specialty categories - so, for example, if we're looking at orthopaedic prosthetics, we need to find who the orthopaedic surgeons are best going to listen to and engage

with them and then work with surgeons to utilise the prosthetics within the band that has been negotiated.

Q. So how do you do that --

THE COMMISSIONER: Q. Sorry, is that an example of what you mean by "operational understanding" in paragraph 44?
A. That's correct.

MR GLOVER: Q. How do you achieve that outcome?
A. So through our category managers, they engage with our clinicians - so in the example of orthopaedics, they'll engage with the orthopaedic heads of department and provide them with the necessary information to help them leverage and encourage their - the partners, so the other orthopaedic surgeons, to change the prosthetics that they may be using.

Q. Is that the process that you describe in paragraph 45?
A. Yes, that's correct.

Q. When you say "encourage", do I take it that it's not a question of standardisation rather than attempting to bring the cohort in the same direction?
A. Yes. So whilst we attempt to standardise wherever possible, there will always be a clinical requirement to have other options. What we're trying to do is ensure that those clinical options are the few rather than the majority, so that we can actually get that value out of the negotiated price.

Q. You've used "prosthesis" in that example, does it apply to any other categories?
A. It can apply to equipment, such as in our cardiac catheter labs we have moved to certain types of stents and catheters based on a contract that was able to be negotiated for a better price. Again, that means that you have to engage with the clinicians to get them on board to use that product rather than what potentially they've previously used.

Q. And just so I'm clear, you see that as being a process that's appropriately driven at the local level; is that right?
A. It has to be, because it's driven by relationships. Where the state can assist is through the ACI clinical networks. If they were able to be engaged in the process

of the "why", before the contracts are actually negotiated, so that there's some clinical input across the system in that, that would then help filter down through the clinicians. But there would still be the need, at the local level, to work with our clinicians to bring them on board.

Q. Can you just describe in a little bit more detail the process of engagement, perhaps, through the ACI that you've referred to? What is it that you consider would be beneficial that is currently not being undertaken?
A. So the ACI have clinical networks for a variety of specialties right across the state, whereby they bring together multidisciplinary clinicians from all LHDs to work on areas of best practice. In those working groups, to look at areas of best practice, it would be helpful if there's also discussions around products, particularly with those high-cost things such as prosthetics.

Q. Is that something that's not currently happening, to your observation?
A. Not to my knowledge.

Q. Is it an issue that has been raised?
A. Through - locally, yes.

Q. When you say "locally", as in your district has raised it with the ministry; is that what you mean?
A. My clinicians have raised it with me.

Q. And have you taken it up with the ministry or the ACI?
A. Not at this stage.

Q. No criticism intended given you've been in the role for six weeks or so. All right. Paragraph 46, please.
A. Yes.

Q. So there you refer to that the current procurement arrangements can at times disadvantage the district by capping price reductions. Can you just explain what you're referring to there, please?
A. So, for example, there are certain things that we obviously can't negotiate on, because it would disadvantage rural LHDs, for example. South Western Sydney is a large LHD. We do a lot of work, therefore we use a lot of products, and we're close and on the transport routes, so things don't cost as much to be delivered to South West as

they do, for example, to Far West or even Western New South Wales. So there is at times the opportunity that we feel that we could negotiate a better deal based on where we are and the volume that we do, but then, if the state can't leverage off that, then it disadvantages others.

Q. Let's just step that through. So do I understand you to be saying that the district is currently prevented from seeking those opportunities to obtain a better price?
A. At times, yes.

Q. How?
A. Particularly through our big redevelopments, of which we've got a significant number across the LHD, where we could be negotiating to - with, for example, contract cleaning, bringing those in at a cheaper price for us.

Q. Do you have a practical example that you can call to mind of where this issue has arisen?
A. Not off the top of my head. I'd have to go back to my procurement manager.

Q. When you said in an earlier answer that part of the reason why a district is unable to pursue these opportunities is because it may disadvantage rural or regional LHDs, can you just explain what you meant by that, please?
A. So if we're able to negotiate a price based on where we are, that's then not able to be leveraged for the rest of the state, that will then disadvantage. So if we're paying a lower price than, for example, Western New South Wales, then that disadvantages them.

Q. In what way?
A. Because they're paying a higher price than what we would be paying.

Q. So you see the disadvantage being that there would be different prices charged to different LHDs; is that right?
A. Yes. And that happens already.

Q. Do I understand your evidence to be that, inherent in these arrangements, is the concept that, well, you may pay a bit more, but it will benefit the system as a whole because rural and remote districts will pay less than they otherwise would. Is that the concept?
A. That's my understanding.

Q. Are you aware of whether that concept is the subject of any analysis or testing, either by HealthShare or the ministry?
A. I'm - not that I'm aware of.

Q. Are you able to undertake any assessments to determine the extent of the disadvantage, the financial disadvantage, to your district, on being unable to pursue the opportunities that you've described - that is, to negotiate better prices on these that are subject to the whole of health or whole of government arrangements?
A. I'm sure they could but at this point in time I haven't got that level of detail.

THE COMMISSIONER: It must have been analysed, otherwise it just doesn't make any sense. If a metro LHD can secure a lower price that doesn't affect what regional LHDs are paying, then you'd let the metropolitan LHD get the better price. It would only be if doing it statewide, somehow, when all the sums are done, it ends up best for everyone, or lower for everybody, that it makes sense. So there must be that analysis somewhere, it seems. It would be odd.

MR GLOVER: Mr Muston might take that up with some other people.

THE COMMISSIONER: Yes, sure.

MR GLOVER: Q. Paragraph 48, please. Just have a read of that and let me know when you are finished.
A. Yes.

Q. In this section of your statement you are referring to - you have identified some opportunities to improve policies and processes that would benefit your LHD and others; correct?
A. That's correct.

Q. In relation to what you've described as "statewide computerised system enhancement", what is the statewide computerised system that you're referring to?
A. So SmartChain. So that's what's currently being rolled out, and that, at this point in time, obviously allows better reporting and at the user end allows better both ordering and receipting of goods.

Q. But you've identified some further opportunities in addition to those measures. Is that what the purpose of paragraph 48 is?
A. Yes. So in November 2019, we introduced h-trak into the LHD, and that allows us to scan products in to the system and scan them and relate them to a patient and a procedure so that we can actually both identify the true costs of that procedure, but also, if there was a product recall, we've got that down to that patient level.

Q. So that's scanning of products as they're being used; is that right?
A. That's correct.

Q. And is that something that will be part of the suite of initiatives under the banner "SmartChain"?
A. My understanding, that it is to come, but at this stage, it doesn't.

Q. And the rollout of that suite of initiatives under the banner of SmartChain, will it affect your use of the h-trak system?
A. We will continue to use the h-trak until such time as the SmartChain system allows us to scan those products in.

Q. In paragraph 48a you describe an opportunity as being the "integration of standalone operational computer systems", and you give an example. Why is that an opportunity that ought be pursued in your view?
A. Because currently, with iPharmacy, it doesn't talk to the financial system Oracle, so therefore, we actually employ four people to then order and then receipt the products as they're received because the one system doesn't talk to the other.

Q. Can you just explain that process to me, please?
A. So the pharmacist will order A, B and C, and then a clerk has to order - on the iPharmacy, so the pharmacy system, from the pharmacy system, then, a clerk has to then get that order, enter it into the Oracle system so that that purchase order can be raised, and then they use the Oracle system to then receipt it as the products are delivered to site.

Q. And is that integration or lack of integration something that will be addressed by the range of procurement reforms, whether under the DeliverEASE or

SmartChain banner, to your knowledge?
A. I don't have that level of detail, but I would hope so.

Q. In 48b you refer to "the completion of the statewide master catalogue and the elimination of 'free text' ordering." Why is the elimination of free text ordering, about which we have heard something over the last few days, important in your view?
A. One, there is a cost for every free text order that's put in; two, if a product is being ordered on a regular basis, then it needs a HIMF number and be on the catalogue.

Q. Are there any other benefits that would be realised from the elimination of free text ordering within the LHD?
A. One would think that it would make it easier for the staff ordering if it was actually on the product catalogue.

Q. In the last sentence of paragraph 48b, you refer to the rationalisation of choice and locking in consistent pricing. Is that a benefit to be derived from the master catalogue or the elimination of free text ordering?
A. A combination of both.

Q. How will the elimination of free text ordering in the context of the master catalogue rationalise choice?
A. It will - if it's all on the - if the majority of the stock that are ordered on a regular basis are in the catalogue, the state is then obviously able to negotiate that product price to have it on the catalogue and be delivered from the warehouse rather than the free text ordering of products that might be similar but slightly different, that are often ordered via the free text.

Q. When you said there was a cost for every free text ordering, what's that cost?
A. To my knowledge, it's around $7.

Q. And who is that paid to?
A. That's paid to HealthShare.

Q. So it's a cost associated with managing the free text order?
A. That's correct.

Q. Each and every free text order?
A. That's correct.

Q. And is the elimination of free text ordering something that's being addressed by the current suite of procurement reforms to your knowledge?
A. So there's both the local reforms as well as the state-based reforms, so obviously the product catalogue will assist. But locally, it's educating the clinicians or the ordering staff on actually doing the due diligence to look for the HIMF number when they're ordering or to look for something that may be similar that's already on the catalogue rather than the free text. A lot of the time, staff don't actually understand the additional cost that's incurred.

Q. So it's a dual effort, both statewide reform and local education programs?
A. That's correct.

Q. And do I take it from your evidence today that you would like to get to a position where there was no free text ordering within your district?
A. It would be good to have very little.

Q. 48c, you identify as an opportunity "improved system-wide reporting"?
A. That's correct.

Q. Why is that something you would like to see implemented?
A. At this point in time, it's very time consuming to go through all of the line items to be able to identify who's ordering what, and the system makes that challenging. It's - we download Excel spreadsheets and have to sort in that way. It would be good to be able to identify what the spend is by clinician or by department down to that prosthetic, for example, much more easily rather than the time-consuming manual process that we currently have.

Q. That visibility of data, would that assist you in your consultation with clinicians of the kind you've described earlier in your evidence?
A. Definitely.

Q. In 48d you identify as an opportunity an improved Oracle inventory management system that enables better forecasting and planning. What do you have in mind?
A. So if we're able to have better suite of reporting to

look at, for example, are there any trends in products being used at certain times of the year, we would be then able to, you know, predict that, rather than at the moment, it's all, you know, ad hoc, just operational business as usual. There's no predictive work to try and work out what we will be spending next winter, for example, based on historical trends.

Q. Will any of the suite of procurement reforms go to addressing that deficiency, in your view?
A. I'm hoping that the reporting as SmartChain develops will go some way to that, and then it will be the local knowledge and analysis that will assist with the future planning.

Q. Finally, in 48e you identify as an opportunity the utilisation of AI technology to enhance transactional efficiencies by automating functions. Can you just describe what you have in mind in that space, please?
A. Yes. So utilising technology - for example, if a ward is consistently ordering 50 boxes of gloves on a monthly basis, to actually have the system to be able to do that rather than that manual process, and being able to use much better technology to be able to - linking back to the point above - predict what we're going to be ordering and using, because it's fairly standard in most of our units.

Q. Is part of that opportunity to reduce clinician time in these what you've described as routine ordering functions?
A. Definitely.

Q. If you turn to paragraph 52, please, just have a read of that and let me know when you have finished.
A. Yes.

Q. In 52 you identify there being a lack of clarity across NSW Health regarding supplier relationships and management. You give some particular examples, but at a general level, can you just explain what is the issue that you're raising in this paragraph?
A. I think it's the lack of understanding of the time taken by the districts to actually manage the contracts and the relationships with the contract providers at that local level.
So for every contract that we hold at the LHD level, that requires a relationship with the provider to ensure

that the maintenance arrangements, the escalation, whatever - whether it be a service or a product - is meeting the agreed requirements of the original contract in the first place. That all takes time.

Q. You referred to contracts at the local level. What about statewide or whole of health contracts?
A. Same thing. Unless it's - a lot of the work is done by the local team. For example, CTs, we have at times issues with a provider. We're doing the negotiations around, you know, not meeting the maintenance requirements or the downtime of that particular product, and it's the LHD that's managing that, and I guess it's not until we reach out to eHealth to see whether there's a statewide issue with that provider or when we're not getting a satisfactory resolution, do we get the assistance.

Q. Is that the issue that you are referring to in paragraph 52a?
A. Yes, that's right.

Q. In 52b you refer to the role of the strategic procurement advisory board, et cetera. Then you say:

> *...[the district] will engage with major suppliers and initiate discussions on business opportunities and improved outcomes. This is over and above the state-wide "Accelerated Savings Program".*

What's the statewide accelerated savings program that you refer to?
A. So that's the savings that HealthShare will negotiate with different providers to ensure that there's a statewide price for, for example, hand hygiene products, and then, you know, we have undertaken the work to be able to negotiate a better price for our LHD.

Q. How does that sit with the issue that you raised earlier about not always being able to access better prices because it may disadvantage other LHDs in doing so?
A. We obviously have to get permission off HealthShare to be able to undertake those negotiations.

Q. So what's the opportunity in this area that you're raising in paragraph 52b?
A. To be able - well, it's the opportunity - yes, that

there's more of those opportunities to be able to be gained.

Q. The issue in 52c, that's something you've touched on in an earlier answer, is it?
A. Yes, that's correct.

Q. You refer to an example of that issue being the "high level of price variation holds that occur." What is a price variation hold?
A. So we might, for example, negotiate a product with, for example, hand hygiene product - negotiate a lower price, but in the system, it's still at the state price, and so that then sits on hold because of the variance in what we've agreed to pay, because at times we're unable to get it changed in the system.

Q. So does that mean you're unable to access the lower price that you've been able to negotiate?
A. No, we still are able to, but in the system, it looks like we're not achieving that.

Q. So what's the consequence of that?
A. Well, one, for transparency; and, two, when the staff go in to order it, it makes it look like we're paying a higher price than what we've negotiated.

Q. In the last sentence of paragraph 52c you give an example of contractual disputes that have been left to the district to resolve. Are these contractual disputes that relate to statewide or whole of health contracts?
A. They're part of contracts. However, they've been negotiated at the local level for the LHD, and where there's a dispute around pricing or deliverable of the service, the LHD manages that conflict.

Q. So just stepping that through, is it the case that there's a whole of health or statewide arrangement, and then, sitting beneath that, there's a local arrangement put in place?
A. That's correct.

Q. And if there's a dispute in that context, it's left to the LHD to resolve?
A. That's right.

Q. And do we understand that you would like to see some

support from HealthShare in this case in managing those disputes?
A. Yes.

Q. Paragraph 54, please, if you would just have a read of that and let me know when you've finished.
A. Yes.

Q. In the second half of that paragraph you refer to the opportunity to create efficiencies through the sharing of resources and information. What particular resources or information do you have in mind that could be shared between districts like yours and those in rural or regional areas?
A. The expertise that we've been able to develop in our procurement team would be well utilised by a neighbouring LHD if there were formal arrangements to be able to support that. Likewise, for things like cybersecurity, for example, if an LHD is assessing a particular product, that that's actually done for the state rather than each LHD having to do that individually and paying the fee for it.

Q. So the issue you're raising here is the opportunity to create more formal arrangements whereby this sharing can be done for the benefit of other districts and thus the system as a whole; is that right?
A. That's right.

Q. Does it happen at an ad hoc level?
A. Yes, it does.

Q. Finally, we heard some evidence this morning about the privacy security assurance framework. Is that something you're familiar with?
A. I'm aware of it. I'm not across a lot of detail.

Q. Are you aware of the costs involved in it?
A. I know that it's a significant cost that we have to pay to eHealth for any assessment done on any software.

Q. Do you receive any additional funding or budget supplementation to meet that cost?
A. Not that I'm aware of.

MR GLOVER: Thank you, Ms Marshall. Thank you, Commissioner. They are my questions.

THE COMMISSIONER: Mr Gyles, do you want to ask any questions?

MR GYLES: I don't have any questions, Commissioner.

THE COMMISSIONER: Thank you very much. Thank you for your time, it is greatly appreciated.

THE WITNESS: Thank you.

THE COMMISSIONER: You are free to go.

<THE WITNESS WITHDREW

THE COMMISSIONER: Yes, Mr Fraser.

MR FRASER: Thank you, Commissioner. I call Jacinta Ducat. Ms Ducat is outside.

<JACINTA DUCAT, sworn: [12.19pm]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Is your name Jacinta Ducat --
A. Yes, it is.

Q. -- firstly? And is your surname spelled D-U-C-A-T?
A. Correct.

Q. And am I pronouncing it correctly?
A. You are, yes.

Q. Fantastic. Ms Ducat, is it right that you are the chief information officer for the Southern NSW Local Health District and the Murrumbidgee Local Health District?
A. That's correct.

Q. Or CIO is the acronym; is that right?
A. Correct, yes.

Q. Which of those two districts is your employer?
A. The employer is Southern NSW Local Health District and we operate on a shared service arrangement with Murrumbidgee Local Health District.

Q. If I may ask - firstly, how long have you been in that role?

A. Just over two and a half years.

Q. Was it a shared service arrangement before you took up the post?
A. Yes, it was.

Q. So it's not a new development?
A. No.

Q. Bearing in mind it pre-dated your taking up the role --
A. Yes.

Q. -- has it always been an arrangement of that type since the two districts were formed, do you know?
A. As far as I'm aware.

Q. You have a team; is that right?
A. I do, yes.

Q. And is it the same position for your team - are they all employed by Southern --
A. Not quite.

Q. No?
A. So I have some - the majority of the team are employed by Southern NSW Local Health District. I do have some team members that are dedicated to Murrumbidgee Local Health District.

Q. Thank you. To be clear, is it one team or separate - there are some dedicated --
A. It's one team.

Q. One team?
A. Correct.

Q. Although there are some individuals that focus on one district or the other?
A. Correct.

Q. Is your team based centrally or is it spread out throughout the two --
A. Very geographically diverse. So I have team members across both local health districts.

Q. And how big is your team?

A. I have 65 people in the team.

Q. Just briefly, what are the things that your team does?
A. So we look after the IT operations for the districts, for both of those districts, across 84 sites, with a very broad geographic area. So operations, clinical applications that are locally procured and managed; corporate applications again that are locally procured and managed; some cybersecurity where we have that local focus on it; and also again I have project managers that focus on some of our redevelopment projects where we've got IT expertise required.

Q. And does that team include undertaking or being involved in procurement of IT systems for --
A. Yes, it does.

Q. For the districts?
A. Yes, for both of the districts.

Q. For both districts? Does that also include telephone services; is that right?
A. It does, yes.

Q. And I think there may be some other items that fall within that, including duress alarms; is that right?
A. That's correct, yes.

Q. We'll come back to those in a minute. I just want to ask you some questions about the procurement and ICT matters generally. So firstly, generally, there are a number of systems, presumably, that are procured under statewide contracts; is that right?
A. Yes, the majority.

Q. And what type of things are we referring to there?
A. Under the statewide contracts?

Q. Yes.
A. So our telephony services, the telecommunications provider. Most of the providers we have are either on statewide contract or they're suppliers who are on the statewide services scheme. So they've essentially been pre-vetted, and that's usually our first port of call.

Q. So telephony and also all your IT --
A. All IT.

Q. -- systems?
A. Yes, correct. So if we are procuring computers, headsets, servers, we will typically go to our statewide contracts first; if there isn't a statewide contract in place, then our second port of call is to go to the statewide service providers that have been pre-vetted; and then, thirdly, if there is no provider that's suitable, then we would go to a local procurement approach.

Q. So that would be for some smaller-scale localised product?
A. Correct. Typically it's small things. It could be an education content management system, for example. It might be a few thousand dollars or a couple of hundred dollars a month. We would undertake an assessment of that, if there isn't already an existing provider in place for that solution.

Q. Presumably, in all these processes you have contact with eHealth NSW --
A. Yes.

Q. -- in your role? And eHealth play, obviously depending on the nature of that procurement, a role; is that right?
A. They do, yes.

Q. Just in relation to the last of those categories --
A. Mmm-hmm.

Q. -- those smaller-scale procurements that you are undertaking locally --
A. Yes.

Q. -- does eHealth have a role in that procurement?
A. It depends on the dollar value. So under policy, if there are professional services that we require over $30,000, then we would need to go through eHealth. Anything over $150,000, even if we're procuring it locally, we need to get approval from eHealth as part of that process.

Q. Is there also a particular involvement for any software?
A. There's - the dollar amount is whether it's software or hardware, it doesn't differentiate.

Q. Are there any assessments that eHealth need to undertake in relation to - from a cybersecurity point of view?
A. So cybersecurity in my districts, if it's been procured locally, we may conduct some cybersecurity assessments if it's not a statewide solution or if it doesn't meet that dollar amount to go through to eHealth. So we may conduct that cybersecurity assessment ourselves under the same process that eHealth operates under. eHealth, where typically it is a larger solution, a higher dollar value or particularly where it's got personal, sensitive information, that's where we may refer that to eHealth to conduct that assessment for us.

Q. We've heard some evidence from another witness in relation to the requirements of the privacy and security assurance framework.
A. Yes.

Q. Are you familiar with that?
A. I am very familiar, yes.

Q. We understand that's a relatively new framework --
A. Correct.

Q. -- that may have come in last year, is that --
A. Probably a little bit longer than that, yes.

Q. In the last couple of years?
A. Yes, absolutely.

Q. That framework imposes some requirements in relation to cybersecurity assessments of new software?
A. Yes.

Q. Or new IT procurements?
A. Correct.

Q. And also retrospective assessments of --
A. Yes.

Q. -- existing IT solutions, et cetera?
A. Correct, yes.

Q. In relation to those retrospective assessments, in your LHD, are they undertaken locally or by eHealth?

A. For - if they're locally managed solutions, then we will undertake them locally. Any of the eHealth managed solutions, we will leave that to eHealth to conduct those assessments. But if we were to procure something, we need to check to see whether a privacy and security assessment has been conducted.

Q. Now, in relation to those assessments that are done by eHealth --
A. Yes.

Q. -- is there a cost to the district?
A. Yes, there is.

Q. And what's the scale of that cost, if you know?
A. It could be anywhere from $20,000 to $40,000. It really depends on the solution that we're looking for.

Q. And that can include for the retrospective ones?
A. Yes.

Q. And when that framework came into place and, therefore, put the obligation into place in relation to retrospective assessments, was there any funding that came with that?
A. No, not that I'm aware of.

Q. You have said that telephony services are a statewide contract?
A. So our Telstra contract, yes, that's a statewide one.

Q. So they are the provider of the actual telephone service?
A. So that's the phone calls, so that's the - yes, so if you're dialling for a - a landline or a mobile phone, so the contract to use Telstra, for example, is part of a statewide contract.

Q. What about the hardware?
A. The hardware is local.

Q. The handsets --
A. Local.

Q. -- headsets, mobile telephones?
A. Yes, local.

Q. Locally procured?
A. Correct.

Q. And do eHealth have any involvement in that?
A. No.

Q. From your standpoint, do you have any understanding of why that is?
A. No. I don't know why that's not on a state contract.

Q. And from your perspective, can you see any benefits in that being centralised?
A. Absolutely. One of the benefits we have in terms of standardisation across the state is that we can then leverage the scale that we have, so rather than having each district negotiate themselves for a particular solution, we get the benefit of scale, if that does become more of a centralised contract.

Q. I'm going to ask you some questions now about those contracts that are managed by eHealth.
A. Mmm-hmm.

Q. Do they involve some significant costs that are paid to eHealth?
A. Yes, it's a large portion of our budget - of my IT budget.

Q. What do those - is there any choice in relation to those services that you're paying for?
A. For some of them, no; some of them, yes.

Q. And in relation to those services that you're required to use, are you required to use all aspects of, say - is there bundling of services in relation to these agreements?
A. So some of the services will provide the solution itself - it might be some software - and in addition to that is professional services, which we may or may not need, but that's bundled as part of the overall agreement. Yes.

Q. And those services are provided by whom?
A. By eHealth.

Q. So there are instances where you consider that your local staff would be able to provide that management?
A. In some cases, yes.

Q. And are there instances where you do that?
A. Yes, there are.

Q. But you're still required to pay for the --
A. Yes.

Q. -- eHealth --
A. Correct.

Q. -- bundled service?
A. Yes. It's provided as a single service to us, whether we fully utilise all aspects of that service or not, in some instances.

Q. In relation to those contracts, as they come into existence, in your experience, what level of engagement is there from eHealth as to local capabilities?
A. It varies again, depending on the solution. Usually, there will be an engagement early on with the districts around what it is that is being sought to be delivered. That then needs to be considered, I guess, from a statewide, more of a centralised perspective, so each district may have their own views, but it goes into an overall decision that's made from a statewide perspective.

Q. In relation to new services, systems or programs that are being rolled out by eHealth, is there, firstly, funding for implementation?
A. So typically there will be. We'll be provided funding to support, often from a resourcing perspective, because we usually operate with quite a lean team in the districts, so usually we will be supported with funding for the implementation.

Q. What about ongoing maintenance and management?
A. Typically not.

Q. I see.
A. That's absorbed by the district.

Q. So you're required to use a new system, you get a portion of money to have it - to assist you with putting it into place. What kind of costs are involved with ongoing maintenance and management?
A. It varies significantly. And in some cases, we might get supplementation, possibly for the first year, some

budget supplementation, and then beyond that we need to support that from a district perspective. In other cases, we don't get that supplementation and once it's implemented then we absorb those costs.

Q. I just wanted to ask you about pricing of eHealth services.
A. Mmm-hmm.

Q. Do those prices vary? Do they change, I should say?
A. They can change, yes.

Q. Where there's incoming changes to prices, is there engagement in advance, so that you're able to budget for it?
A. Sometimes. Sometimes not.

Q. Are there any examples of "sometimes not" that you can think of?
A. So one of them was some work that was being done on our firewalls with some proxy server software. The initial pricing we were given was substantially different from the pricing that we ended up being charged.

Q. And that pricing changed at short notice?
A. Yes.

Q. Is there any reason that you can understand for that change at short notice?
A. I don't know.

Q. Not that you have been told?
A. Not that I've been advised, no.

Q. And are we talking 1.5 times the original cost, twice, three times?
A. More than that, nine times.

Q. Nine times.
A. (Witness nods).

Q. So is there any transparency from where you sit as to how those costs get arrived at?
A. No, unless - sometimes we do need to ask the question as to why there has been a change, but that's often after the fact, once we've noticed a change come through. It's more the exception.

THE COMMISSIONER: Q. Obviously nine times doesn't reflect inflation, it must reflect something else. Was it nine times - what particular figure are we talking about?
A. Sorry, can you ask that again?

Q. What figure was nine times more? What are we starting with?
A. So from $9 to $63.

Q. That's seven times.
A. Seven times, sorry, yes.

Q. It's still a lot.
A. I need to work on my maths.

Q. And you don't know why something went up by that amount?
A. No, I'm not sure in that particular situation why it was increased, but with technology, there's often a lot of complexity.

Q. Sure.
A. So they may have uncovered something as they were going through that has led to the increase.

MR FRASER: Q. Presumably short notice changes to costs from eHealth make meeting your budget a challenge?
A. Yes, it does.

Q. Are you aware of whether that's been raised with eHealth?
A. I'm not sure.

Q. If it was, would that be raised at a level above you? Is that why you're not sure?
A. Often the directors of finance would be where some of those discussions take place.

Q. What direct contact do you have with eHealth? Do you sit on any committees or groups that--
A. Yes. Yes, so we have a statewide CIO executive leadership group and that's a partnership between eHealth and the CIOs of all of the local districts. So that's a forum where we get updates, we have opportunities to discuss new areas of focus, new technologies and raise issues. There are other steering committees and working

groups that I'm a part of as well.

Q. In relation to specific areas?
A. Correct.

THE COMMISSIONER: Q. The example you gave of seven times, though, it relates to - your answer was about work that was being done on your firewalls with some proxy server software --
A. Correct, yes.

Q. -- going from $9 to $63, but is it a one-off payment or is it multiple?
A. No, sorry, that's per proxy per month.

THE COMMISSIONER: I see. Okay, got it.

MR FRASER: Q. And at what stage of the process were you told about the price increase?
A. I believe that was after the fact - after it had gone in.

Q. After it had gone in?
A. Yes.

Q. So presumably, there had been some work done around the cost prior to that?
A. I couldn't speak to that.

Q. I'd like to ask you about the development of new IT solutions from a central - that are developed centrally --
A. Mmm-hmm.

Q. -- via eHealth. Firstly, in relation to their development, what level of engagement with the districts is there?
A. It varies, depending on what it is that is going to be implemented, and we've got a vast array from quite technical to some clinically focused. So typically, there will be a call-out for engagement or representation from the districts. The intention is to have cross-representation across metros, regionals and rurals, to capture some of those unique requirements that we have, because all of us have different areas of focus and different ways of operating, in some cases. So usually, that would be quite early on in the process. Depends on the level of engagement the LHDs actually provide, then,

sometimes, in terms of the quality of the outcome.

Q. And in relation to those sort of development of new initiatives --
A. Mmm-hmm.

Q. -- and obviously they're the subject of business cases that are developed?
A. (Witness nods).

Q. From your experience, are they developed from a system-wide perspective or a central eHealth perspective?
A. I believe that it's from more of an eHealth perspective rather than the full sector perspective, given that some of those ongoing costs to the districts are not necessarily known at the time of a new solution being implemented.

Q. So if a business case is being put forward, a lot of the cost is going to be borne by the district?
A. Correct.

Q. Can you give an example of this? I mean, I'll ask you about a very significant one.
A. Yeah.

Q. Obviously it is known that currently, the single patient digital record is under development?
A. Yes, it is, yes.

Q. Clearly, it's probably one of the most significant statewide IT initiatives within NSW Health?
A. Absolutely.

Q. And so in relation to that, do you have forward knowledge about how that is going to impact on you from a cost perspective at the district level?
A. Not at this point

Q. And a resourcing level?
A. Not at that point. We know we will need to be engaged in the process and involved in the process, particularly around design, but the quantum of resources required is not yet clear to me.

Q. And do you understand whether you will be engaged or not in that process?

A. The expectation is that we will be engaged, that we will need to contribute to the various design working groups. So typically, more so probably clinicians being involved.

Q. So clinicians being involved, no doubt as to how it works and operates to make sure that it is functional?
A. Fit for purpose, yes.

Q. But in terms of engagement about matters from maintenance resourcing from an ICT perspective, do you anticipate you'll be engaged about that?
A. The - there's a shift in the resourcing model that will come with the single digital patient record. So more of it is moving to a centralised model. We don't yet - it's not clear yet what that implication on an ongoing basis would be, but most of the resources would go to that centralised model, as we work towards that single medical record for our communities.

Q. I will just ask you this: have you had experience of changes to ICT systems having a direct impact on your need for staffing?
A. Yes. Yes, we have.

Q. So sometimes, a system will be rolled out and you'll need to take on extra staff?
A. Correct, yes.

Q. And again, is there good information flow about those impending requirements?
A. The visibility around exactly what's needed at a local level is not always clear at the time where we're looking to do the implementation, or where we're considering the implementation.

Q. So effectively, you learn of it as you're going along?
A. In some cases.

Q. In some cases. Not in every case?
A. Not in every case.

Q. I should have asked you this earlier. In your districts, between the two of them, currently, do you operate the same systems or different systems?
A. Predominantly the same systems, and we aim to use those same systems, particularly because of the flow of

staff between systems as well. So where we can, being a shared service and to enhance the support of those solutions, we do look to have a single solution, where we can, providing it meets the needs - providing it meets the needs of both districts.

Q. So certainly when you take on or procure new systems, you try to procure a single system --
A. Yes.

Q. -- for the two?
A. Yes, absolutely.

Q. So there are efficiencies in that?
A. Absolutely.

Q. Can I ask you this, you sit on forums with all the other CIOs --
A. Yes.

Q. -- are there other parts of the state that operate on a shared services model, do you know?
A. Yes, there are. There are several of them. So another rural local health district, Western NSW, and Far West NSW, they operate on a shared service arrangement as well; and Northern NSW, Mid North Coast; and I believe South West Sydney, Nepean Blue Mountains do, and I believe that South East Sydney and Illawarra Shoalhaven also do. I think the nature of those agreements or those shared services may vary.

Q. The detail may vary?
A. Correct.

Q. I understand. In terms of your procurement that involves eHealth and the operation of systems, are there any other issues that you wish to draw to the Commission's attention before I move on?
A. No, not at this point.

Q. All right. I'd like to ask you some questions about duress systems.
A. Yes.

Q. Or duress alarms.
A. Mmm-hmm.

Q. Firstly, at what level are they procured? Are they a statewide contract or a local --
A. Local.

Q. A local procurement?
A. Local procurement from - and the vendor that we work with is on the ICT services scheme, so they're a prequalified vendor.

Q. So there's a prequalified vendor?
A. Yes.

Q. And how many prequalified vendors are there, do you know? Is there more than one?
A. Oh - yes, but I don't know how many.

Q. When you're procuring duress alarms - and just to be clear, we're talking about the mobile duress alarms here --
A. Yes.

Q. -- that staff members carry?
A. Yes.

Q. When you're procuring those, there's some baseline requirements that are set out in policy; is that right?
A. Yes, under the "Protecting People and Property" policy.

MR FRASER: We might just briefly bring that up. It's tab B.053, [SCI.0003.0020.0001]. Can we just scroll through that?

THE COMMISSIONER: What B number was that?

MR FRASER: B.053, Commissioner. I believe I've got that right. Can we just go to section 11 - the problem is I've lost my page. Thank you. Page 39. Thank you. That's the page I was after.

Q. Under 11.2.2, we have the requirements:

All personal duress alarm units must have the following features ...

A. Yes.

Q. And the procurement of these personal duress alarms,

was that undertaken whilst - recently?
A. No. The solution we have has been in place for a number of years - many years, I believe.

Q. So prior to your time in the position?
A. Yes, yes.

Q. Do you use the same solution or the same product throughout all the facilities in both --
A. Yes.

Q. -- districts?
A. Yes. We have the one mobile duress solution across all of the facilities within my district.

Q. Within both districts?
A. Yes, within both of them, yes.

Q. And separately, of course, there are also fixed-point duress alarms?
A. Correct, yes.

Q. That are on walls?
A. Yes, yes.

Q. I would just like to briefly ask you about how they actually operate.
A. Mmm-hmm.

Q. You're familiar with how they operate?
A. I am. Not the subject matter expert, but I am familiar.

Q. I see. So we understand generally they're issued to a staff member on a shift basis, when they start work?
A. Yes, yes.

Q. So they'll take their tag at the beginning of the shift?
A. Yes.

Q. And it looks like a - we've seen some pictures, I think. They look a lot like a card on a --
A. It's like a security access card or a larger - slightly larger than a credit card, yes, with buttons on it and a display.

Q. And it attaches to your clothing; is that right?
A. Correct.

Q. I should ask, what is the brand or make of device?
A. So we use AirISTA.

Q. And each particular card has a unique identifier; is that right?
A. That's correct.

Q. And when you're issued with your card - they're operated by battery; that's right, isn't it?
A. Yes, correct.

Q. Presumably, they charge when they're not in use?
A. Yes. So the staff member at the start of the shift will take them from a charging bay.

Q. Are there any tests they perform to make sure it operates?
A. Yes. So at the start of the shift the staff are to do a quick press on the button to indicate that there's sufficient battery and that the tag is working okay.

Q. And then you return it back to the charging station at the end?
A. Correct.

Q. So that it recharges?
A. Yes.

Q. Now, there's a number of things that it does. It's set out here. But firstly, does it operate - it's supposed to, when operated, send a notification somewhere that a duress alarm has been triggered; is that right?
A. Yes. So it will send a message to the duress system. It uses our wi-fi system, so that - there are different grades of wi-fi. What's needed for that system is a real-time location or RTLS grade wi-fi, so that it can pinpoint more of a - the more distinct location of the team member.

If that tag is pressed and triggered, that notification will go to all other tags - all other staff members that are wearing those tags. So they will get an alert to indicate where a particular duress incident might be occurring or potential incident.

Q. There is a little screen, I think, on the device?
A. Correct, yes, yes. It's a very small - just a single line.

Q. And that would tell you the location where the --
A. Correct.

Q. Where the alarm has been triggered?
A. Yes.

Q. And presumably, that location ties to the wi-fi access point?
A. Correct.

Q. That it has gone through?
A. Yes, that's correct.

Q. Now, those access points, are they simply like wi-fi routers or do they take a different form?
A. They're wi-fi routers, so they will basically attach to the ceiling. The concentration of those is something that we would work with our vendor on to make sure that we've got the right number of access points to give coverage across a site, because there may be walls, there may be other equipment that could interfere with that, so we need to make sure that we get a site survey that indicates that we've got appropriate coverage before we would then overlay that with the configuration of the duress around different zones within the system.

Q. I understand. So as you walk, say, from one ward to another that's, say, within the area that's supposed to be covered --
A. Yes, yes.

Q. -- you would be handed off from one point to the next point?
A. Correct, correct

Q. Like a mobile phone tower, in effect; is that right?
A. Yes, yes, essentially.

Q. And theoretically, you should be accessing the closest point to you?
A. Yes.

Q. But, of course, you may not be directly underneath the point?
A. Correct. That's where that survey is really important, to make sure that we do have the coverage.

Q. And they can be triggered by the user --
A. Yes.

Q. -- or they also have an automated feature where the person - what's known as the man down --
A. Man down, yes.

Q. -- facility?
A. Yes.

Q. Where the person --

THE COMMISSIONER: It is called "person down" in this document.

MR FRASER: Yes. The evidence we have heard has been "man down", but that's absolutely --

THE WITNESS: We refer to it colloquially as "man down".

MR FRASER: Q. That's where they go down and there's no movement; is that right?
A. Correct, yes. The staff member would be typically in a horizontal position so they've fallen to the ground and the alarm would automatically trigger after a defined period of time.

Q. Now, issues with these products --
A. Mmm-hmm.

Q. -- are they dealt with by your team?
A. Yes.

Q. So --
A. Working with the vendor.

Q. Sorry?
A. Working with the vendor.

Q. Working with the vendor?
A. We have quite a close relationship with the vendor, yes.

Q. So, for instance, if there weren't enough of them, that would be - six have broken, we don't have enough, that would come to your team?
A. Of the tags themselves?

Q. Of the tags?
A. Yes. And we would place an order with the vendor.

Q. I should have asked, when an alarm triggers --
A. Yes.

Q. -- does that also go to security?
A. To an external security company, yes.

Q. An external security company?
A. Yes.

Q. Now, we've heard some - in fact, not in relation to your district - evidence from a nurse who has to travel from one area of the hospital, mental health ward, to the emergency department, having to use different tags?
A. Mmm-hmm.

Q. Should that arise in your area, because you're using the same tags everywhere?
A. No, same - if the tag is the mobile duress solution, the AirISTA duress solution that's been rolled out to the whole site, then no, there's the one tag that's required, regardless of where they walk on that facility.

Q. Take one of your bigger facilities, say, Wagga Base Hospital.
A. Yes.

Q. Wherever within that facility a staff member needs to go, will they be covered?
A. Yes.

Q. Now, if they were to get into a car and go to a different facility within the district?
A. That's not covered.

Q. That would be different?
A. Correct.

Q. So they're mapped to the physical facility?

A. Correct.

Q. That makes sense. Thank you. And is there monitoring and testing for black spots?
A. So --

Q. In the coverage?
A. So in terms of black spots, there's a process that we have at least monthly where the facility manager or the director of nursing for a site is responsible for conducting walk-around tests, so they will walk around with the tags to see if any black spots are detected.

THE COMMISSIONER: Q. Does it come to your attention if any of these personal duress alarms don't work, malfunction --
A. If it's --

Q. -- don't activate?
A. If it has come through as an incident. So if there's actually been an incident that's occurred and it's logged on our incident management system, then, yes, I - that would come to my attention. If there's an issue with the - someone's identified that the location might not quite be right, then that needs to be logged on our central statewide IT system. So depending on what the issue is, then it may not necessarily come directly to me, but it may go to my team.

Q. What if there is a test made and it doesn't work; does that come to your attention?
A. If it is logged on the system it would go to my team members' attention.

Q. Anything that's logged on the system --
A. Correct.

Q. -- technically, could come to your attention, or the people that assist you?
A. Yes, to my team.

Q. Are you aware whether, at least in relation to the two LHDs that you are the chief information officer for --
A. Yes.

Q. -- do they - and tell me if you don't know, because you may not - do they activate with a reliability of

98 per cent or more, as far as you know?
A. I couldn't answer that question.

Q. You don't know one way or the other?
A. Yeah, I don't know.

Q. Has it been reported to you that sometimes they don't work?
A. Yes. It has, yes.

Q. More than once?
A. Yes.

Q. And again, tell me if you don't know, but do you know if there was consultation or discussion with the clinicians and the workers that have to wear these alarms, before they were procured?
A. I'm not aware. It's been in place for many years.

MR FRASER: Q. We've heard some evidence of a particular ongoing - from one clinician about an ongoing issue at Yass District Hospital?
A. Yes.

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

Q. According to his evidence, effectively, they haven't worked for the entire time he's worked there. Is that something you are aware of?
A. So what I would say to that is, when issues are identified, we - so we've actually implemented the AirISTA duress system across the entire site and included additional buildings. After it's been implemented, if there are issues that arise, my team will work with the local side around addressing those issues.

Q. Are you aware of those issues being addressed at Yass?
A. Yes.

THE COMMISSIONER: Q. Satisfactorily?

MR FRASER: Q. Are they likely to be resolved?
A. I think there are ongoing issues that could occur at any time. We might have one of the access points that doesn't work properly; there might be tags that need to be replaced; there could - so multiple issues could arise, and

we just work through those with the team on a day - as part of our normal management of the system, and we also have remote monitoring of the system which we have extended to the access points and the duress system as well, to support that ongoing monitoring of the site. But if issues are raised with us, my team will work on those.

THE COMMISSIONER: How much longer do you expect to be with Ms Ducat?

MR FRASER: About one minute.

THE COMMISSIONER: Right. Okay, let's finish.

MR FRASER: Indeed.

Q. Just to be clear, his evidence is that when they are faulty, they are removed and not replaced, and there are not enough of them. Are you aware of that issue?
A. So the process as it is intended to work is that if there are faulty tags that come - so as part of that check first thing, at the start of a shift, they should be removed from use so that we don't have people working with faulty tags. A ticket would need to be raised to replace that particular faulty tag, and then we would go through the normal procurement process. So, you know, within delegations of authority, the cost centre manager would need to approve any expenditures, and then once we have that approval we would then procure the replacement tags and configure them.

THE COMMISSIONER: Q. That's the process as it is supposed to work?
A. Yes.

Q. Do you know whether that is working there, or you don't know the answer?
A. To my knowledge, it is working that way.

MR FRASER: Those are my questions, Commissioner.

THE COMMISSIONER: Thank you.

Mr Gyles, is there anything from you?

MR GYLES: Just one aspect which the witness may or may not be able to assist in relation to.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. You were dealing with connectivity and the fact that part of the process is that there will be, essentially through wi-fi --
A. Yes.

Q. -- the location, the system working properly, you will be able to track where a person - where the card is --
A. Yes.

Q, -- and necessarily, the person who is wearing the card, where they are?
A. Yes.

Q. And in terms of the connectivity or levels of wi-fi that might be available, does that have an impact on that, to your knowledge?
A. On the location of the person?

Q. Let's say the operation of the system more generally?
A. The wi-fi is very integrated. It is very tightly integrated to the solution. So if there are issues with the wi-fi, that will affect the duress system.

Q. Is that something that you are aware of being an issue in the past, in respect of --
A. Yes.

Q. And is that something that you - if that was the problem, or at least was a cause of issues with the serviceability of the personal duress alarms, is that something you would then take up?
A. Absolutely, yes.

Q. In other words, try to improve the wi-fi?
A. Absolutely. So if we're aware - made aware of issues, we will do, essentially - my team will do some first-level support and try to resolve the issue themselves. If they can't resolve it then they would escalate that through to our vendor and get them to assist.

Q. What are the circumstances where, in your experience, those sorts of issues can arise, in terms of the facility?
A. So it could be congestion on the network. New equipment that is implemented on site can interfere with

the frequency of the wi-fi. So at any given time, there could be a change to the way the system works or to the functioning of that system, with these other additional components that might be added in to the environment.

Q. And places like Yass, as compared to Wagga, as compared to the different hospitals that come within your responsibility, is that not a - sorry, can there be differences in terms of the connectivity and strength and nature of the wi-fi in different locations?
A. It - we have a consistent standard in terms of the wi-fi that we implement across sites. With redevelopments, we can get some variation between newer areas that might have been redeveloped, particularly when we look at the likes of a brownfield site, so a brownfield site being we're upgrading or redeveloping one ward or one area of a site, so that can end up with compatibility issues.

Q. And if there was a redevelopment - sorry, assuming that there was a redevelopment at Yass, is that the sort of issue, teething issue, you might get --
A. Yes.

Q. -- where you've got a new building or an old building which is redeveloped, as compared to what you describe as a brownfield site?
A. Yes.

THE COMMISSIONER: The alarms still have to work.

MR GYLES: Of course they do.

THE WITNESS: They do, yes.

MR GYLES: Q. Picking up the Commissioner's question or point, if it's a wi-fi issue that is causing the problem, the wi-fi has to be dealt with?
A. Yes, absolutely, and we've done quite a lot of work at Yass in particular around the wi-fi system, expanding the wi-fi system, replacing the fixed duress system as well so we have better connectivity to the external provider. There's been quite a lot of work done at that site.

MR GYLES: All right. Thank you. Thank you, Commissioner.

THE COMMISSIONER: Thank you very much for your time. It

is greatly appreciated. You are excused.

THE WITNESS: You are welcome.

<THE WITNESS WITHDREW

THE COMMISSIONER: All right. We will adjourn until 10 past 2.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes.

MR GLOVER: Commissioner, the next witness is Michael Dickinson.

<MICHAEL DICKINSON, sworn: [2.10pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Would you state your full name, please?
A. Michael Lance Dickinson.

Q. What's your current role?
A. I'm the chief information officer and director of digital health at South Western Sydney Local Health District.

Q. How long have you held that role?
A. Formally for the last 12 months?

Q. When you say "formally", were you acting in the role prior?
A. I was acting in the role for six months prior to that.

Q. In relation to your role as director of digital health, what does that entail?
A. So I'm responsible for ensuring the 19 - or 18,000 plus staff of South Western Sydney have access to the digital systems within the LHD and to ensure that we're able provide clinical care or the clinicians are able to provide that clinical care across the district, and also responsible for the procurement of a number of components of digital infrastructure within the district, and also for planning for the future of the digital needs for the organisation.

Q. Do you have a team that assists you in those roles?
A. I do.

Q. How large is it?
A. The team is - it ebbs and flows depending on what projects we might have but currently it's approximately 140.

Q. 140 did you say?
A. 140.

Q. Are they spread out across the facilities within your district?
A. The majority are central; however, there are staff across other facilities, yes.

Q. And what type of roles do members of your team fulfil?
A. So there are technical support roles and technical administrative roles and there are clinical roles to ensure the system operates clinically, looking after the EMR. We have trainers. We have project management staff.

Q. You used an acronym EMR. What does that mean?
A. Sorry, that's the electronic medical record. So that's the system that stores all clinical information for all patients across the South Western Sydney district.

Q. That's the current system?
A. That's the current system.

Q. That's different to the single digital patient record that is on the horizon?
A. It provides the same - it provides the same function but it's a separate company that --

Q. I see. You mentioned in an earlier answer that you have a role in the procurement of ICT goods and services within the district?
A. Correct.

Q. What is that role?
A. Generally, it's an approver of equipment but also within the team it's ensuring that it's the right fit for the organisation, that it will work across the digital network.

Q. And are there different procurement processes that

relate to hardware and equipment on the one hand and software on the other?
A. Correct.

Q. If we just start with procurement of hardware and equipment, can you just give a general overview of the processes that apply?
A. Sure. So I'll break down hardware, if that's possible, with regards to our user device, so whether that might be a phone or a PC or a laptop. They sit under a government panel that we're allowed to order from, and we will place those orders with the vendors that we currently have relationships with. As mentioned, they are on a government panel. However, as a whole, there's a new procurement process we're looking at across the state where we'll be narrowing down the devices to ensure there's consistency across the whole state and not just the LHD.

Q. So for devices of that kind, are you able procure them directly or do you have to enlist the support of eHealth?
A. Currently we procure them directly using the government panel, ordering panel.

Q. Do you have to seek approval from eHealth before you procure devices such as laptops and mobile phones?
A. Depending on the value of the device. So under $30,000, no.

Q. Are there different processes for different types of equipment?
A. Yes. So now with regards to if we were looking at high-end computer infrastructure, so servers, et cetera, there is a requirement now obviously that they go into the cloud, but if we were to do something local, then there is a special dispensation process that needs to be done through eHealth, and then through the government, to determine why it would be local as opposed to cloud.

Q. So just break that up. There's a requirement to move to cloud-base data storage; is that right?
A. Yea, there's a government mandate across all of New South Wales to do so.

Q. When did that commence?
A. Oh, I would say probably --

Q. Doing the best you can?

A. At least three years ago.

Q. But there may be occasions where you need local servers; is that right?
A. Correct. So depending on what the requirement is.

Q. And when you procure those local servers, is that by way of exception to that policy?
A. Yeah, you need to seek approval as to the reason why it would need to be locally installed. That would then be provided. We would go through eHealth and it would go through NSW State Government.

Q. So you seek that approval from eHealth in the first instance; is that right?
A. Correct.

Q. What about the procurement process, is that done locally or through eHealth?
A. Should we be given approval, it would be done locally.

Q. Are there any other procurement processes that apply to equipment?
A. Not that I'm aware of.

Q. So from those answers, do we understand it that, in your position, all of the procurement of devices and equipment is managed at the local level; is that right?
A. The majority, unless it sits over the value that we're not --

Q. What's that value threshold?
A. $30,000.

Q. So anything over $30,000, what has to happen?
A. We would go through eHealth to seek approval as to whether that could occur.

Q. And apart from giving that approval, does eHealth have any other role in the procurement activity?
A. They would be involved potentially in providing advice for creation of panels as to which vendors would be on or which vendors would not be on. They also may have been - provided advice on the capability of various companies and whether they were able to provide the service or not.

Q. So support to the district in engaging that

procurement; is that right?
A. Yes.

Q. Is there a cost associated when eHealth provides support of that kind?
A. Not directly to the LHD, no.

Q. What about the processes for software? How do they differ?
A. So software is normally related to licensing, and once again, it's similar. There are panels available to choose licensing. However, there are state-based licences, as I've mentioned previously, and with regards to something as large as Microsoft Office, there is a statewide panel and agreement, and we request the services of those licences through eHealth or they automatically charge for the number that we're using.

Q. So just step me through that process a little slower, if you wouldn't mind. So there's a statewide arrangement for certain Microsoft products?
A. Correct.

Q. How do you access that in the district?
A. So currently we would provide automatically the - once an account has been created we just provide access to that. So once you have your "@health" address, you will be given access to it. eHealth then do a once a year charging mechanism based on what they call a "true-up", they look at how many staff you have, how many licences you're using and then that corresponding charge is applied.

Q. Is that charge on a per licence basis within the district?
A. In the majority of cases, yes. Some licences are machine based, some licences are user based.

Q. Is there any bundling of licence products - that is, it comes as a package whether or not it is utilised across the LHD?
A. So Microsoft, if we use them as the example, there's bundles, they refer to it as an - "E" stands for "enterprise" and there's a 1, 3 and 5, and depending on which one you are on is the certain, I guess, levels of access that you can have. The majority of staff sit on an E3 licence.

Q. Are there any other examples where licences are bundled in that way?
A. Not at that volume, however, there are some licences - for example, if I could use an example, there are some tap-on/tap-off software, to enable you to log on. If you have more than 5,000 licences, it may be X price, if it was less than 5,000, it would be a higher price.

Q. Are there any services that eHealth provides to the district that are bundled, in the sense that they include both a service and a licence fee?
A. Yes.

Q. What are they?
A. There are a number, but to give you an example, would be the - what they call mobile device management software, which looks after mobile phones, to ensure they're safe and secure to be on the network. Currently that software is called Intune, which is also a Microsoft product. So within that, there is a cost of a licence, however, eHealth manage that service and provide the support.

Q. And is that charged as one fee - that is, a service fee and a licence fee together?
A. So within our billing system we would see it as one charge per user, yes.

Q. Do you have visibility over which portion of it is the licence fee versus the service fee?
A. No.

Q. Is that something you would like to have visibility of?
A. Yes.

Q. Why?
A. I think it just ensures that you can see the full charge that you are getting. If I could speak freely, the ability to see the charge is relatively recent, in the last two years or so, and it's been a fantastic thing to have. The next component is obviously the breakdown of that charge, and eHealth are working towards that.

Q. When you say "the ability to see the charge is recent", what do you mean?
A. So there was generally a bill provided to the digital services or the digital health team. That's now broken

down into every single component, so there's a charge for Microsoft Office, there's a charge for Intune, there's a charge for Adobe. Individually we can see what every single element is. As I said, we don't quite yet have the visibility of what breaks down those individual charges.

Q. Previously was it the case there'd be a bill with a number on it and not much other information?
A. Correct. So it's well and truly improved and it's been work between eHealth and the LHDs to achieve that.

Q. And is there work ongoing to increase the visibility of the costings in the way that you've described?
A. Correct.

Q. And you gave one example of a service and licence that is bundled together, but are there others?
A. Yes.

Q. And are they arranged in a similar way - that is, you see a single charge rather than one that is itemised by reference to the cost of the service and the cost of the licence?
A. Yes, and that charge could be as a whole of a service or at a user level.

Q. Aside from software and equipment procurement activities, are there other services that eHealth provide to the district?
A. Yes, there are a number of services. One of those services would be cybersecurity.

Q. What do you have in mind when mentioning cybersecurity?
A. So there are certain components of cybersecurity that need to be managed at a state level, and obviously that's eHealth's remit, whereas at a local level we have also cybersecurity requirements and demands that we need to manage. eHealth does look after that state level for us.

Q. Does that include what's described as the privacy security assurance framework?
A. That is a component. However, recently, we have been able to do some components of the PSAF - privacy security assessment framework - locally ourselves.

Q. Let's break it down a little. What is the privacy

security assurance framework?
A. So it's a process to ensure that any software that we're going to be implementing within the state or in the LHD is safe and secure and will protect the LHDs and the information that we hold.

Q. Is that a process that's managed and implemented by eHealth?
A. Initially, yes. However, as mentioned, we have now got some capability to do that locally.

Q. Let's just deal with the standard initial situation first, and then I'll come to the recent development. Was there a cost associated with eHealth's management and implementation of that framework to the LHD?
A. Yes.

Q. Was it a standard charge or a variable charge?
A. It was a variable charge depending on the complexity of the system that we were implementing.

Q. And was it charged on a per system basis?
A. Yes.

Q. And do you have awareness of how much was charged to the district when eHealth was delivering that framework?
A. Yes, because we sought - we would generally seek a quote prior to going ahead. That quote was within a range, because, as I said, you can uncover a number of different things when you're doing a privacy security assessment framework.

Q. Was there an average range within which those quotes fell?
A. Once again, completely dependent on how complex a system is. If you're putting in a small system, it might be a few thousand dollars, if you're putting in a large system, it could be in the tens of thousands of dollars.

Q. Do you have any awareness of amounts that were actually spent or incurred by the district in eHealth's management of that framework, say over the last financial year?
A. Not at hand. However, I could check if required.

Q. Is it, in general terms, a significant sum of money?
A. As mentioned, it would be, normally, if it's a complex

system, in the tens of thousands of dollars.

Q. And how many systems is this framework being implemented in?
A. It's implemented on a new system basis currently. So if we're putting in a new system, then it's implemented. We haven't put in a large amount of systems in the last probably six months, so there would probably be one or two currently at the moment that, as I said, would be in the tens of thousands of dollars.

Q. Is it applied to systems that were already in existence - that is, retrospectively?
A. It will be, especially if you are looking at changing it, upgrading it, et cetera, or the function or feature set changes.

Q. And you mentioned in your answers earlier that there's been some developments at least within your district about how that framework is to be rolled out?
A. Correct.

Q. What are they?
A. We worked with eHealth, now that we have our own cybersecurity manager on board, who is skilled in this area, to identify systems and if we can manage it at a local level, we will. They have a process where they might randomly pick one or two to ensure that we're following the appropriate processes, however, at the moment, if we conduct the PSAF - the acronym - then we're fine to go ahead with that and install the system.

Q. And is that a process that's been negotiated or is that a process that has been agreed between the district and eHealth?
A. It required a meeting between myself and some of the senior management in eHealth to suggest that this was an opportunity. We worked through how it would work and it's now been agreed and, as I understand it, will be rolled across other LHDs should they wish to do so.

Q. Are there other services that eHealth supplies to the district that, in your view, could be delivered within your local capability?
A. There are components that could be, yes.

Q. So by "components", you mean not the whole service but

at least a portion of them?
A. Correct.

Q. And have there been discussions between your district and eHealth to arrive at a situation where you can deliver those components within your local capability?
A. It's done via negotiation and discussion and where it's appropriate, and that we can both see that there's a benefit, then, yes, that is capable of being done.

Q. What's the benefit to your district in you being able to deliver those, the components of those services, within your local capability?
A. The benefit is we have the capability and the local knowledge to ensure we're providing a, I guess, service to the users at a local level, where at a state level they don't have that visibility, so we can ensure the service is, I guess, in line with what the LHD would require.

If I could give you an example, the Intune software for mobile phones, we know who the people are, we understand what their phone requirements are, it's a little bit easier for us to provide frontline support if we have that capability, where, from a state level, to a degree, they're looking after 150,000 people, and you become a name - sorry, you become a number not a name.

Q. So the benefit there is ensuring that the service is, to the extent necessary, tailored or directed to the local needs within the district; correct?
A. Correct.

Q. Are there other benefits to the district in performing that service within your local capability?
A. The majority is about being able to make it localised and ensure that it is fit for purpose for the LHD.

Q. eHealth charges the LHD for services of the kind we're discussing, does it?
A. Correct.

Q. So is there a cost benefit to the LHD in being able to perform it within its own capability?
A. There can be, depending on the service, yes.

Q. Have you had any examples where you've been able to perform a service that would otherwise be delivered by

eHealth within your local capability?
A. Yes. We recently installed the eRIC solution, which is the electronic record for intensive care. It was a statewide solution. We put a proposal to eHealth that we felt we could implement it at a more - I've just got to choose the word - at an efficient and, I guess, tailored approach for the LHD. eHealth agreed to that. It was shown to work very well and it was efficient. We used our own staff, however, we also used eHealth resources to assist at times where the workload was high.

Q. Was there a cost saving to the LHD in approaching it in that way?
A. I wouldn't clarify it was a cost saving, I would say that we were in control of the cost and we ensured what we felt was the need to ensure our spend was on.

Q. When you say you were "in control of the cost", what do you mean?
A. So we took a component of a budget of that and then we were able to ensure - if we felt that we needed more trainers in the area, we would employ more trainers. If we didn't feel we needed an analyst in that space, we didn't have to employ somebody, so we could arrange how best we felt that it'd fit for our team for the organisation. So efficient, yes. Possibly the same cost.

Q. Are you aware of how much the LHD pays to eHealth for the services it supplies to the district on an annual basis?
A. Yes.

Q. How much, in the last financial year?
A. Approximately $40 million.

Q. $40 million for services?
A. (Witness nods).

Q. And is that an --
A. Sorry, that's licences, services, all bundled together, the total eHealth cost.

Q. I see. So $40 million for the bundled licences and services that we discussed earlier?
A. Yes.

Q. And I take it that you're unable to identify the

portion of the 40 million that results to the services cost that's being charged by eHealth at the moment; is that right?
A. There are some components in there that are purely a service, so let's use, for an example, the service of - they provide a service to provide us the internet. It's purely a service. We pay a set fee for that component. That's within there as a line item.

Q. And how are those amounts charged? How does that actually work in practice?
A. So they utilise - well, it's done through a journal transfer on a monthly basis. The reporting component is using a system called Apptio, which is colloquially known as the "Bill of IT", and we have a monthly meeting with the eHealth finance team to review the charge on a monthly basis to ensure that it meets what we expect it to meet.

Q. Does eHealth roll out programs or initiatives across the state which are mandatory in your LHD from time to time?
A. Yes, they do.

Q. Is the district consulted prior to those programs being rolled out in a general sense?
A. Depends where it's come from. eHealth is responsible to Ministry of Health. So if ministry have requested a particular system and it is mandatory and required, then we're not going to be asked do we agree. We may be asked how best it would be implemented within our organisation, but if it's a mandatory component, it's a mandatory component. Other systems, we have the opportunity as to whether we go ahead or we don't go ahead.

Q. When systems of that kind - that is, mandatory systems or programs - are rolled out via eHealth, is the district given support to implement those changes?
A. Once again, depends on the system. If I can give you a recent example was the radiology system, which is - its acronym is RIS-PACS. There was support provided in the rolling out of that as a statewide system to ensure that the imaging system - so we're referring to, sorry, x-rays and all those radiological images, there was support and budget provided to ensure we had a local team in place.

Q. So support by way of budget supplementation?
A. Correct. As well as some central staff that came in

to help implement.

Q. And what about once it's up and running? What happens then? Is it left to the LHD to manage on an ongoing basis?
A. It's a component of both. So if I could use some terms as - we would take the level zero call, there may be an issue, and if we believe we can solve it locally, we would. If not, we would escalate through to the statewide team and they would look at it.

Q. Speaking in general terms about the current structure of delivery of ICT support, so both procurement and support services provided by eHealth, are there particular advantages that you see from the district level in the current structures?
A. Sorry, could you repeat the question?

Q. Yes. Considering it globally - that is, the current arrangements in relation to ICT procurement and the delivery of central services in the space by eHealth - are there any particular advantages from your point of view in the current structures to your operations within the LHD?
A. Yes, there are.

Q. What are they?
A. So I believe you get standardisation across the state, which is useful in many instances; you get a greater cost saving capability - obviously ordering for 150,000 staff versus 18, 19,000 staff, will give you greater cost savings and efficiencies.

Q. Any disadvantages?
A. As mentioned previously, you miss out on the localisation capability. So where you were saying in the bundle that we might purchase, it might fit a large percentage of the state, but it doesn't fit everybody, and so there may be components in there where it would be useful to be able to modify certain things, but for the greater good, it works.

Q. When you say "modify certain things" - that is, not to take up certain products in the bundle; is that what you have in mind?
A. Not to take up certain components or you may require more than what was included because you have an extra component that you need that your LHD may do that other LHDs don't do in the state.

Q. So does that arrangement sometimes involve the LHD having to pay for something that they don't use?
A. That's possible.

Q. But do I understand your answer to be, in the wash, the benefits outweigh the negatives. Is that your view?
A. That is correct.

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

THE COMMISSIONER: Yes, Mr Gyles?

MR GYLES: Just one question for Mr Dickinson.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. You are a member of the HGEN committee?
A. I am.

Q. And one of the topics or areas that that committee deals with is wi-fi; is that correct?
A. Correct.

Q. Is there a standardisation of wi-fi across the state at present or is that something that the HGEN committee is looking into?
A. There is a standard that should be met, yes. Noting that that has only been in place for a period of time, I would say, let's say, I can't remember the exact date, but let's say two, three years. Obviously large amounts of wi-fi was put in before that standard existed.

Q. I see. And is the HGEN committee that you're part of doing anything to seek to bring about a complete or a more complete standardisation of wi-fi across the state?
A. Correct. So the intention of HGEN is twofold. One is a procurement component, and the second piece is to ensure a level of wi-fi and connectivity, if I can just say that in general, because it includes wired as well, to a standard across the whole state to ensure that no matter where you are in the state, we can provide you a service.

Q. And if there is a standardised and - if there's a standardised wi-fi, that is, the wi-fi connectivity and strength in the different locations is able to be achieved,

that would assist in respect to presumably some of the services that run off the wi-fi?
A. Yes.

Q. And duress alarms, which is a topic that we've spent a little bit of time with over the last couple of days, that is something that would benefit from a standardisation of wi-fi; is that correct?
A. There would be a benefit, yes.

MR GYLES: Thank you. Thank you, Commissioner.

THE COMMISSIONER: Thank you very much, sir, for your time. It's greatly appreciated. You are free to go.

THE WITNESS: No problem. Thank you very much.

<THE WITNESS WITHDREW

MR MUSTON: Thank you, Commissioner. I think that brings us to the next witness, who is Carmen Rechbauer.

<CARMEN RECHBAUER, affirmed: [2.39pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. My name is Carmen Rechbauer.

Q. And you are the chief executive of HealthShare?
A. That's right.

Q. You prepared a statement dated 12 February 2024 in relation to this Commission, which I think is exhibit B.011?
A. Yes, that's right.

Q. Is the content of that statement true and correct?
A. Yes.

Q. Do you have a copy of it with you?
A. I do.

MR MUSTON: For the benefit of the machine it's [MOH.9999.0009.0001].

Q. Could I invite you to go directly to paragraph 6 of that statement, which is on page 2?
A. Yes.

Q. You tell us there about the genesis of HealthShare as an organisation. You, I think, were involved with the Health Support Services prior to HealthShare coming into existence; is that correct?
A. Yes.

Q. Is it right to say that you were involved with the Health Support Services from January 2005?
A. From August 2005.

Q. So the role that you held initially within Health Support Services was the director of shared business services; is that correct?
A. I think it was called manager of shared business services.

MR MUSTON: Perhaps could, to short-circuit this, we bring up [MOH.0001.0437.0001].

Q. Hopefully that will come up in a moment for you. Can we just zoom in on the section that is headed "Recent experience". Could you just perhaps take us through the experience you have had that is disclosed there? So you started as the executive director of the South Eastern Sydney Area Health Service?
A. That's right, yes.

Q. Then moved to the Health Support Services. We're told there in January 2005, but I think you said a moment ago --
A. It should be August, yeah.

Q. August 2005?
A. Yeah.

Q. Does that correctly identify the role that you held at that time?
A. Yes.

Q. What did that role involve?
A. I was employed to transition food and linen services from the local health districts to what was then known as Health Support.

Q. So that was a process whereby food and linen services were being centralised as a shared service?
A. Yes. Yes, that's correct.

Q. Did that process or that transition process continue until you left Health Support Services in February 2017, or was it something that was done a bit quicker?
A. Well, I didn't leave Health Support Services, they became HealthShare. So the organisation that I was originally employed in in August 2005 was called Health Support. It then changed to Health Support Services, and then it became HealthShare NSW.

Q. Do you remember when it became HealthShare NSW? Was that about the time you took on the executive director role?
A. Roughly, yes.

Q. So just going back to paragraph 6, HealthShare had as its genesis a report that was prepared in 2011, I think you tell us?
A. Mmm-hmm.

Q. And the process that ultimately led to the creation of HealthShare was completed by somewhere around March 2017; is that your recollection?
A. It would have been - to be HealthShare, I think it was a little bit earlier than that. I - yeah, I - not a hundred per cent sure. It's essentially been the same organisation with different names since 2005.

THE COMMISSIONER: It was recommended to be HealthShare in that 2011 report.

MR MUSTON: It was.

THE COMMISSIONER: So 2017 would be a fairly leisurely pace.

MR MUSTON: Well, that was why I asked.

Q. Moving beyond that, we can be confident, can we, that you have held the position of executive director clinical support services at HealthShare since March 2017?
A. And I became chief executive in December 2018.

Q. So can I take you back to the text of paragraph 6 of

your statement. Do you see at the end of that paragraph you have said that HealthShare was tasked with developing a stronger customer focus and contestability of pricing?
A. Yes.

Q. Can you explain to us what that means in the context of the role being played by HealthShare, or at least the role that it was at that time anticipated that HealthShare would take?
A. So the role of HealthShare was to provide - to provide shared services to health entities in NSW Health, and under our determination of functions, we were to deliver a number of different services to provide economies of scale through our - through the service provision that we provided. So that depended on which business line as to how centralised those services were.

Q. So just coming back to paragraph 6, the economies of scale that you're referring to, is that what you had in mind when you referred to "contestability of pricing"?
A. Yes, that's right.

Q. And in terms of developing a stronger customer focus, to what extent was it anticipated or do you understand it to have been anticipated that the creation of HealthShare would have had that effect?
A. There was a - when HealthShare was first established, it was a mandatory process, and then, as the organisation evolved, it was felt that they needed to take - that HealthShare needed to take a more customer-focused approach to its relationship with health entities in NSW Health, and that has since evolved into a more partnership approach.

Q. So when there's a reference - the reference in paragraph 6 to "a customer" is a reference to the LHDs, do we take it?
A. Yes.

Q. What was it about the customer focus, as it were, before the creation of HealthShare, that was lacking in strength? What was wrong with the existing system that required strengthening, as you understand it?
A. I don't think it's - I don't think there was anything particularly wrong with the existing system; it was more a case of the evolution of the shared service model that existed within NSW Health, that the focus on customer

service came about as local health districts had their own boards and the system was much more devolved than it was prior to - prior to that time, and so there was an expectation that HealthShare needed to be more in tune with the individual needs of the local health districts.

Q. Can I ask you to go forward to paragraph 18 of your statement, which is on page 5, at the very bottom of page 5.
A. Yeah.

Q. You tell us there a little bit about what HealthShare does. If you go over to the next page, do you see you've identified particular items, a to i, as particular functions of HealthShare?
A. Mmm-hmm.

Q. Could I get you to just walk us through what they involve? So starting with the first one, "financial services such as accounts payable, accounts receivable and general ledger", what is it that HealthShare provides to the LHDs in that respect?
A. So they're known as our transactional services, so that's the more traditional model of the shared service organisation. So it - those functions were originally in each of the local health districts, so there would have been 17 different ways of processing accounts payable, receivable and general ledger.

Q. Just pausing there, is that accounts payable by the LHD or to the LHD?
A. Yeah, for the LHDs, on behalf of the LHDs to suppliers, yeah.

Q. Sorry, I interrupted you. I think you told us there were 17 different systems?
A. Yes. So those functions were sitting in 17 different local health districts or area health services, I think they were at the time, and they were centralised, if you like, to HealthShare.

Q. So did that involve the introduction of a centralised platform, computer-based platform --
A. Yes.

Q. -- through which all of those services would operate?
A. Yes.

Q. Now, is that something that HealthShare does in collaboration with eHealth or is it just HealthShare?
A. So at the time when we were Health Support Services, the IT function sat under a chief executive, and then when HealthShare was established, eHealth became a separate entity to HealthShare. So eHealth is the IT shared service organisation and HealthShare provides the actual services. But the platform is managed by eHealth.

Q. So just quickly in relation to that one, what are the services in addition to the platform that are being provided by HealthShare?
A. So in terms of our shared service centres, it's financial - our financial services; it's payroll services; and procurement, transactional services. So the payment of invoices and the payment to the 160,000-odd staff in NSW Health in terms of their pay.

Q. That covers b, I assume, the employee and payroll services referred to there?
A. Yes. Yes, so we have what's called "shared service centres" where we have people working, carrying out those functions.

Q. Item c we might come back to, I think we understand what that involves. Then d - perhaps to run through them, I'll tell you what I understand them to mean and you tell me if I'm wrong.
A. Mmm-hmm.

Q. The food and patient support services including cleaning involves providing as a centralised service the food that is provided to patients within hospitals?
A. So we manage the - we manage the whole process, if you like, from end-to-end, whether that be purchasing from suppliers or making products in our production kitchens right through to delivery to the hospitals and delivering food to patients.

Q. And cleaning services is - you provide the cleaners; is that the way it works?
A. Cleaning services are largely we provide them into the rural local health districts, and we also provide cleaning services to Royal North Shore Hospital.

Q. Linen services I think is self-explanatory -

HealthShare provides --
A. So we have laundries, we have approximately eight laundries across the state, and we deliver all the linen that's required in the hospitals.

Q. Could you very quickly explain what f refers to, the "assistive technology and related services"?
A. So that is Enable, so it's disability services. So we have a warehouse with wheelchairs and products for, you know - what do you call it? I've just gone blank, sorry. You know, wheelchairs to help people be mobile in their own homes. So we provide those types of services.

Q. Patient transport services I think is self-explanatory; the make ready services in partnership with NSW Ambulance I think you've explained elsewhere in your statement; and PPE obviously is self-explanatory.

Can I ask you, to what extent are the services referred to in a to i required to be used by LHDs?
A. So financial - the shared services as in, you know, the finance, procurement and payroll, we provide those services across the state.

In the procurement and warehousing and distribution, we manage the statewide contracts and we provide the warehousing and logistics for a number of fast-moving consumables.

Food and patient support services is in just about every hospital. The only areas that we don't provide those services are in Far West New South Wales and some of the Western New South Wales hospitals because the economies of scale aren't there because of the distances, so we don't - there's no value add there.

Q. What happens in those instances?
A. The local health district manages those services locally. The linen services we provide the linen services in all but Far West, for the same reason as we don't provide food, the economies aren't there.

In terms of Enable, we provide that - provide those services to - across New South Wales. With patient transport services, we're largely in the metropolitan areas. With the make ready service, again, that's largely in what they call the super stations in the metropolitan

area. And then, oh, the personal protective equipment is largely a function of the - of our role during COVID.

Q. I think you tell us that in relation to a number of these items or these services there's a direction that LHDs must use the shared service?
A. That's right.

Q. To the extent that the LHDs use the services, either because they have to or because they choose to, they pay HealthShare for them as a customer, I think you've told us?
A. Correct.

Q. I think you tell us in paragraph 6 that the initial intention was that HealthShare was to enter into service level agreements with local health districts?
A. Mmm-hmm.

Q. Did that ever happen?
A. Yes, we did. We had - initially we had service agreements with the local health districts.

Q. But that's ceased, I think you tell us?
A. Yes.

Q. And you now enter into an agreement, or HealthShare enters into an agreement, with the secretary?
A. We have a statement of service, yes.

Q. You've told us about that in paragraph 13, if I could take you forward to that. So paragraphs 13 and 14 set out the current arrangement; is that right?
A. That's right, yes.

Q. And the statement of service, which you refer to in paragraph 13, sets out some key performance indicators, which --
A. Mmm-hmm.

Q. -- are those that are required to be performed by HealthShare?
A. Mmm-hmm, yes.

Q. And in paragraph 14 you tell us about, at the foot of that paragraph, some KPIs concerning procurement and addressing accountability, service delivery and funding. Am I right in understanding that those KPIs are those which

apply to the LHDs?
A. Yes. So we have - there are - we have KPIs in our statement of service with the secretary.

Q. Pausing there, that's things that HealthShare has to do, so HealthShare, under that agreement, is required to perform to a particular level?
A. Yes.

Q. Or is --
A. Yes, so --

Q. -- asked to perform to a particular level?
A. Yes. So some of those KPIs are reasonably generic in terms of we need to meet certain --

Q. I'll come back to them in a minute.
A. Yeah, okay.

Q. So just to divide the two up, paragraph 14, the KPIs again, so there can be no doubt about it, are KPIs which describe the level to which the LHDs have to perform?
A. They're also in our statement of agreement.

Q. The LHDs' KPIs are in your statement of agreement?
A. The KPIs - so in our statement of agreement, as I said, there are some generic KPIs. There are also KPIs that are specific to each of our business lines, and it is those KPIs that we work towards in delivering our services to the local health districts.

Q. Is it right that those KPIs that you are working towards delivering are wholly contained within the statement of service between the secretary of NSW Health and HealthShare?
A. That's correct.

MR MUSTON: Could I ask the witness to be shown exhibit B.023.129, which is [MOH.9999.0010.0001]. Do we have a hard copy of that, perhaps, just to make it a bit easier?

Q. While that's being found for you, looking at the cover, that's the statement of service for the period 2023 to 2024?
A. Mmm-hmm.

Q. I think if we turn over to page 0002, it appears to have been executed on 8 February 2024.
A. Mmm.

Q. That's a fair way into its term. Is there a reason why it wasn't executed until so late in the piece?
A. So the statement of service is negotiated with the Ministry of Health in around April/May of each financial year, in preparation for the following year. And then there is effectively agreement that HealthShare operates towards that statement of service from 1 July.

From memory, that statement of service was held up because of budgetary issues, so there was a bit of a delay in health receiving its budget, but for all intents and purposes, HealthShare has been working on this statement of service from 1 July 2023.

THE COMMISSIONER: That might have been the election that caused that.

THE WITNESS: Yes.

MR MUSTON: Okay.

Q. Perhaps if we could go forward to page 11, which is .0012. Is that where we find the KPIs that we have just been talking about?
A. Yes.

Q. So if we look at them from the top, that first KPI that relates to food services - so, in fact, all of them - "Patients and carers have a positive experience and outcomes that matter", that first block, that's performance which is an obligation or seeking to meet a particular requirement of patients not of LHDs as customers?
A. That's right, yes. Well, yeah.

Q. Recognising that LHDs with happy patients get benefit, there's no doubt about that?
A. I think it would be fair to say that everybody who works in NSW Health, irrespective of where they sit, our number one obligation is to patients.

Q. So in terms of the experience of patients and the extent to which HealthShare complies or meets its KPIs, how

is that measured?
A. So in terms of patient satisfaction, it's - we've had - we do surveys, and the bureau of health investigation - the Bureau of Health Information, sorry, also includes questions about food services in their post-patient surveys, and then that information is given to HealthShare, as it is to the local health districts, so we have a very good - we have a good view of how patients have found their experience.

THE COMMISSIONER: Q. It's probably not very important for this Inquiry, but the 68 per cent target, is that historic? How is that reached?
A. Look, it's historic. Delivering food services - it doesn't matter whether you're in the hospital system or in the private sector - is pretty tricky.

Q. I was wondering what you'd get from a two hat restaurant, whether you'd get 68 per cent --
A. Yes, it is pretty tricky. Yeah, it's pretty tricky. So putting it in perspective, we serve 24 million meals a year, and you know, we have - many of our patients are extremely vulnerable, from a nutrition point of view, so there's a heavy involvement of clinical dieticians in our menus and - so that obviously has an impact on, you know, how people perceive their experiences with food in hospitals.

MR MUSTON: Q. I think we can move on from food. The second category headed "4 Our staff are engaged and well supported", is that amongst those generic KPIs that you referred to a moment ago?
A. Yes. So all health entities are required to perform against those expectations, and that's measured on a yearly basis by the "People Matters" employee survey.

Q. So the staff that are referred to in those KPIs are the staff directly employed by HealthShare?
A. Correct. We have approximately 8,000 staff across NSW Health hospitals.

Q. And not other staff employed elsewhere within the health system that might be interacting with HealthShare - so, for example, not LHD staff?
A. No. No.

Q. If we move, then, to the item headed "6", on the next

page, "The health system is managed sustainably", and the first of the KPIs under the heading, " Financial KPI":

> *Expenditure Matched to Budget - General Fund - Variance ...*

Do you see that?
A. Mmm-hmm.

Q. Just so I understand what that means, that is HealthShare is given an annual budget and there's an expectation that, within the parameters identified in that first row there, it brings its operations in - within a financial year within that budget?
A. Correct.

Q. So if you're 5 per cent - or 0.5 per cent or more over budget, that's treated as unfavourable, whereas if you're on budget, then you are treated as performing?
A. Yes.

Q. So that's purely on financial efficiency, in terms of what's being measured?
A. Correct.

Q. It operates to incentivise the streamlining of the costs of delivering the services as much as possible?
A. Yes.

Q. Would it be right to say that that KPI and the financial KPIs are not relevant to the costs of goods that are being passed through to the LHDs?
A. I'm not quite sure what you mean.

Q. So perhaps I'll jump forward a step. To the extent that HealthShare is involved in facilitating the purchase by LHDs of, say, medical consumables?
A. Yeah, that doesn't come within our budget.

Q. Those items don't come within it?
A. No.

Q. So, rather, those budgetary items that are the subject of the financial KPI are the costs - would include the costs of HealthShare staff delivering and maintaining that service?
A. Yes, yes.

Q. But not the actual goods themselves?
A. Yeah. The majority of our costs are staff related.

Q. And would it be right that there's no measure or factoring in to those financial KPIs of costs which might be incurred by the LHDs in connection with, say, procurement activities? So for example, costs incurred by an LHD in chasing up a supplier who has failed to deliver an item?
A. That's not included here.

Q. To the extent those costs are incurred by an LHD that's something which would be caught by, no doubt, an equivalent KPI in their service agreement?
A. Yes. Yes, that's right.

Q. But to the extent it's being done by the LHD --
A. That's right.

Q. -- that's not having any impact on HealthShare's ability to comply with that KPI?
A. Yes.

Q. If we turn over the page, I think the top two there on page 13 again are pretty generic - happy customers, by which - again, there's the reference there to "customer", a reference to the LHD?
A. Yes.

Q. How is that measured?
A. By surveys. So we actually ask the local health districts to provide us feedback on our various services.

Q. How often does that get done?
A. At least yearly.

Q. When was it last done?
A. Well, it would be - it would have been last year, last calendar year, I'd say, yeah.

Q. Would it be fair to assume that there was an equivalent KPI to that first one, the customer satisfaction KPI, in the 2022/2023 statement of service?
A. Yes.

Q. And can you recall whether the result of your last

survey showed HealthShare to be performing, underperforming or not performing, referable to the baseline?
A. Generally, HealthShare performs quite well to that KPI, yes.

Q. So coming down to the next one, "Procurement and Supply Chain KPI"?
A. Mmm-hmm.

Q. Can you explain to us, particularly the first one, "Annual Procurement Savings Target Achieved", what does that refer to, as best you understand it?
A. So we have what's called a savings leadership steering committee that is chaired by the chief finance officer and chief procurement officer of NSW Health. HealthShare is a participant as are a number of local health districts and other statewide services. HealthShare is given a savings target each year to achieve in terms of the products that we procure on a statewide basis. So, for instance, in 2023/24, that target is about $96 million.

Q. So if I can ask you to pause there, the savings are not savings which are sought to be found within HealthShare's own operations?
A. Those savings are specifically for procurement.

Q. And so --
A. For the state.

Q. So achieving those savings requires, to the extent that you have, HealthShare has, control over it, requires HealthShare to drive change within its purchasers - so within its customers?
A. In its procurement activities on behalf of NSW Health entities, yes.

Q. So in broad terms, to achieve that, HealthShare requires the LHDs to modify their purchasing behaviour in a way which produces the savings which --
A. Yes.

Q. -- are required?
A. It's a partnership, yes.

THE COMMISSIONER: I need to give people a break, because we've been going an hour. Is now a convenient time?

MR MUSTON: Now is a convenient time.

THE COMMISSIONER: We will take a break until 3.20.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, please go on.

MR MUSTON: Q. I think we were just working through some of these KPIs. If I can take you back to page 13 under the heading "Procurement and Supply Chain KPI", we've heard quite a lot about reducing free text order catalogue compliance. I think we understand what that relates to. Can I ask, is that something which the introduction or expansion of the master catalogue has gone some way towards achieving - that is, a reduction in free text orders?
A. Yes.

Q. Just while we're on the free text ordering, is it the case that free text orders attract an additional charge for the LHDs when they're placed - that is, over and above the charge that would ordinarily apply to an order made on the catalogue?
A. That would be our preference. At the moment, not.

Q. So at the moment, if an LHD places a free text order, is it the case that there's no additional administration charge associated with fulfilling that order?
A. At the moment, not.

Q. Again, I think the next few are relatively self-explanatory. Can I take you to the - the next one is. Can I take you to "Percentage pick accuracy for orders". What does that actually relate to?
A. So that would relate to our warehouse activities. When an order is placed, then the warehouse staff pick the orders, they take the products off the shelf. So the expectation would be that what is ordered is delivered accurately, and so it's - that's the KPI, to how accurate that is.

Q. So it would be right to say that that's - as we've been through the KPIs from the top, that's the first one that really is a KPI which measures HealthShare's performance in relation to what it delivers to LHDs?
A. Yes. That's a daily KPI that, you know, if LHD people order from the warehouse, they would expect to get what

they've ordered, in full, on time and accurately.

Q. And if they don't, then there's a risk of that KPI not being achieved?
A. Yes.

Q. The next one, "Labour cost per purchase order raised", what does that relate to, in a practical sense?
A. Look, that level of detail I would really need to come back to you on.

Q. Would you give the same answer in relation to the next two - "Cost per [purchase order] raised"?
A. Yes.

Q. And likewise, "Labour cost per [purchase order] raised per FTE"?
A. Yes, yes.

Q. Would it be fair to say in relation to those ones that, whatever they mean, it doesn't, at least on its face, appear to relate to the performance of HealthShare when viewed from the perspective of the customer - that is, viewed from the perspective of the LHD?
A. Yeah. Yeah, that they are confident that we're as efficient as we can be, yes.

Q. But as to how efficient HealthShare might be, that's not really a - that's not a KPI, the performance of which directly relates to the service that the customer is receiving?
A. Mmm, yeah.

Q. I think if we move down to the next one "Employee and Financial Shared Services", the first of those items probably does fit into the category of something which regulates the quality of the service delivered to customers?
A. Mmm-hmm.

Q. So that's a KPI which is owed to your customers, in effect?
A. Yeah.

Q. But the balance again - as does the second; would you agree with that?
A. Yes.

Q. The third, does that fit into the same category? I assume that those urgent requisitions are coming from LHDs?
A. Yes.

Q. But what flows from that, then, fall into this category that we're not exactly sure what they mean?
A. Well, not that I'm not sure, it's just that, you know, at my level, that isn't a KPI that I would be - that's a business line KPI, and I'd need to get back to you as to - to make sure that I was able to answer your question accurately.

Q. Can we move all the way over to page 14, you see at the foot of the page a heading "Patient Services and Planning KPI"?
A. Sorry, which one?

Q. "Patient Services and Planning KPI" at the foot of that page there?
A. Yes.

Q. Do you see the second one:

Food Services:
Percentage of default meals where HSNSW provides meal ordering.

A. Yes.

Q. What does that relate to?
A. A default meal; is that the question?

Q. Yes.
A. So a default meal is where a patient hasn't ordered; they've just been given a meal.

Q. So just talk us through the process. Who does the ordering, the patient or the LHD?
A. The patient orders the food from our food service staff, but in some cases, patients are unable to order for a variety of reasons, and in that case, they are given what is called a default meal - a meal that they haven't ordered, but they still receive a meal.

Q. And so in terms of that KPI, who's responsible in a

practical sense for making sure that --
A. There's a dual responsibility between HealthShare and the local health district. So HealthShare's responsibility is that we are able to get around to patients - that we get to the patients for them to have the ability to order, and it's the - however, the local health district can often intervene in that process, in terms of placing patients on those default meals, as we call them.

Q. I think the balance, if we go over the page to pages 15 and 16, are either self-evident from the text of them or, alternatively, fall into similar categories to those that we've discussed. Are there any that you feel the Commission should have particular regard to in understanding the work of HealthShare, or is there nothing that --
A. No, I think they're all quite self-explanatory. They're quite detailed and as I - you know, as I alluded to earlier on, they are specific to each of our business lines.

Q. Can I just ask you to focus for present purposes on HealthShare's role in procurement and supply chain activities.
A. Yes.

Q. Paragraph 31 of your statement, if you could have a look at that?
A. Yes.

Q. You step through a range of the services that HealthShare undertakes in connection with its procurement activities. Could I just ask in relation to them, item b:

> *Administration of statewide (whole-of-Government and whole-of-NSW Health) contracts --*

Et cetera, et cetera, do you see that?
A. Yes.

Q. What's involved in that administration process? What are you referring to in particular?
A. So it's the - it's the tendering process for goods and services that we procure on behalf of NSW Health, largely in --

Q. Just asking you to pause there. Item a is the tendering, and I think we understand that HealthShare has a role in ensuring that the tendering process is performed in accordance with state government procurement policies?
A. Yes.

Q. Once a tender has gone out and a contract has been entered into --
A. Yes, yeah.

Q. -- it then seems, from b, that there's a process of administration of that contract?
A. Yes, yeah.

Q. What does that involve from HealthShare's perspective?
A. No, you're correct, yeah. It's the contract management process. So once the tender is awarded and we enter into a contract with a supplier, then HealthShare has a role in managing that contract on behalf of the local health district. So that's - we refer to the administration, but it encompasses those things that are outlined in the statement in terms of our relationship with suppliers.

Q. So when you use the term "contract management", do I take it that you're referring to catalogue management, warehousing and distribution of goods available under the contracts?
A. So in terms of - there's the contract management component and then there's the warehousing and logistics component.

Q. Let's separate them out. What do you mean or what are you referring to when you talk about the contract management component?
A. So that's actually managing the suppliers, that they comply with the - what we call the standing offer or the head agreement of the contract and how they perform that contract. Yeah, that's the contract management component.

Q. And then I think the warehousing and distribution we understand. But there's the Onelink warehouse, which is operated by HealthShare?
A. That's right. Well, Onelink warehouse is - yeah, we - the Onelink warehouse is a private provider, but HealthShare manages that contract on behalf of NSW Health.

Q. So HealthShare has entered into a contract with the Onelink warehouse privateer. They run that; consistent with the terms of that contract, they run the warehouse?
A. Yes.

Q. And in relation, again - so to understand where it fits into the scheme of things --
A. Yeah.

Q. -- a number of suppliers under statewide and whole of health contracts will deliver their goods to the Onelink warehouse?
A. Yes.

Q. And they're items which are remembered to in some policies we've seen as inventory items --
A. Yes.

Q. -- is that correct?
A. That's right.

Q. So when the LHD places an order for, say, a bandage, which is in the inventory, that order goes to the Onelink warehouse and delivery is - someone picks it, to use a term we've already seen, it goes into a little truck --
A. Yeah.

Q. -- and gets driven out to the LHD?
A. Or a big truck.

Q. It depends how many there are. It gets taken to wherever it needs to be in the hospital?
A. Yeah, that's right.

Q. So that's the Onelink warehouse component of it. But there's also separate statewide contracts which don't involve goods passing through the warehouse; is that right?
A. Yes.

Q. So there are contracts whereby an LHD can take advantage of the contract and make a purchase --
A. Yes.

Q. -- the goods will come direct from the supplier to the LHD?
A. Yeah.

Q. And in relation to those arrangements, there's no warehousing or distribution work being done by HealthShare; is that right?
A. That's our only warehouse, that's correct.

Q. So the rest, I think, are very self-explanatory. In relation to e, though, just to make sure we've understood it correctly, when you refer there to "fleet management", you're referring to vehicles; is that correct?
A. Sorry, can you say that again?

Q. When you refer in e, so paragraph 31e, to "fleet management", that's vehicles?
A. Vehicles, yes.

Q. So in paragraph 32 you tell us again in a little bit more detail again about some of HealthShare's responsibilities. Do you see there in the middle you refer to your intention to ensure that both metropolitan and regional/rural LHDs get the best value from suppliers?
A. That's correct.

Q. Can I just ask you to tell us what you mean when you use the word "value" in that context? Are you talking about the best price or are there other considerations?
A. No, there are a number of considerations. So patient safety and quality would probably be number one. Obviously price comes into it. But as does - from our, you know, engagement with clinicians, they provide us with advice as to what is actually required in a particular product, so that comes into it. So there's a number of components that need to be taken into account and not just - not just price. So that all wraps up into what we would describe as value.

Q. So that's value, certainly value in terms - I understand that's value in terms of the product selection.
A. Mmm-hmm.

Q. Where there's a distinction that you draw between metropolitan and regional and rural LHDs and ensuring that both get value from the suppliers --
A. Mmm.

Q. -- is there anything that you want to tell us about the distinction between those two and the way in which you

see one getting value over the other as being something that is sought to be avoided?
A. Our role is to get the best value for NSW Health, which means that all health entities have access to the same product quality, price. That's our role.

Q. Perhaps if I can take you directly to the example you give us at the end of that paragraph.
A. Yes.

Q. So do you want to have a look at that?
A. Yes.

Q. Could you just explain to us exactly what it is that - explain to us the situation that you're describing in that example?
A. Okay. So if we negotiate a price for a particular product, it's on a statewide basis. So irrespective of whether that product is purchased by a small hospital in Western New South Wales or Far West, or by a large Sydney metropolitan hospital, it's the same price, so that there is equity, not just to the local health district but to patients, so that patients have access; it doesn't matter where they live in New South Wales.

What can happen from time to time is that a supplier may go to a local health district, usually in the metropolitan area, and offer, in this case where we've given an example, free of charge capital equipment. In our view, that would not be - that's not equitable across the state because --

Q. Just so I can understand what you mean, because the metropolitan LHD is getting it and the rural and regional LHD is not?
A. Yes, that's right. Or maybe one metropolitan local health district gets that deal but the others don't. And so our role - that's what we were established to do - is ensure that there's equity. So that's where we step in.

Q. But is any assessment made of the system-wide benefits or detriments of accepting that, in that case, free piece of capital equipment in the metropolitan LHD?
A. If that - when things like that are offered to a local health district, they usually refer that to HealthShare, to advise them that they've been offered that, and then --

Q. Can I just ask you to pause there?
A. Yeah.

Q. Is there a process where they're required to advise you of that or is it more of an ad hoc arrangement?
A. No, they are required to under the principles of equity across the state. If it's a statewide contract and they're being offered something in addition to what's been negotiated in the contract, they are required to let HealthShare know.

Q. So, sorry, you referred to the principles of equity. Where do we find that requirement? Is it in a policy somewhere?
A. It's part of our - it's part of our instrument of function. That's what we were established to do, to ensure that we provided services that were equitable across NSW Health.

Q. But from the point of view of the person within the LHD who has been offered the - in this case the free capital equipment --
A. Yes.

Q. -- do you know whether they have an obligation imposed upon them by any policy to refer --
A. Yes, they have.

Q. -- that to HealthShare?
A. Yes.

Q. Where would they find that?
A. They would - so each local health district has their own procurement team, and so they would be required to escalate that up through their management.

Q. But by what?
A. Pardon?

Q. By what? What would require them to do that?
A. To advise that they've been - to advise that they've been offered from a supplier something that is not part of the statewide agreement, the standing offer of agreement, as we refer to it.

Q. So again maybe I'm not being clear. I can understand that, as a matter of good practice, it would be desirable,

that someone who is offered a piece of free capital equipment refer that up the chain within their LHD and ideally from the LHD to HealthShare. What I'm trying to understand is whether or not there is any policy which exists that the person who has received the offer is bound by, that requires them to do that?
A. It's part of the - it would be part of the procurement framework that we operate under.

Q. But where does the person who has received the offer find that obligation or that framework?

THE COMMISSIONER: You're asking if there's some express instruction?

MR MUSTON: Yes.

THE COMMISSIONER: -- as to whether you have to.

Q. Is there?
A. So yes, if there's a - part of the NSW Health procurement framework is that HealthShare is responsible for managing statewide contracts. Generally, that is over $250,000. As part of that, the local health districts are required to procure those products under the standing offer of agreement.

Q. That might be more by implication, then, but I think Mr Muston is asking is there something more definitive and express about the particular scenario you are describing when a supplier might go directly and offer --
A. Yeah.

Q. -- as you say, free of charge capital equipment?
A. That's probably a detail I'd have to go back and check.

MR MUSTON: Q. Let me ask it a different way. You are aware that from time to time offers - suppliers make offers to, for example, metropolitan LHDs to do something a bit better than what is on offer in the --
A. Yeah, yes.

Q. -- statewide contract? You are aware that from time to time, that is brought to the attention of HealthShare?
A. Yes.

Q. Can you be confident that or do you have any confidence that whenever that happens, it is brought to the attention of HealthShare? Or let me withdraw that and rephrase it.
A. Yes.

Q. Can you be confident that every time that happens, HealthShare becomes aware of it?
A. I would be confident to say that the majority of times, HealthShare would become aware of it.

Q. So to the extent that HealthShare becomes aware of an offer like this that has been made to a metropolitan LHD, what steps are taken by HealthShare to ascertain whether it would be advantageous, system-wide, to accept that offer?
A. So part of our standard offer of agreement with the suppliers, there is a requirement there that if they offer a lower price to a particular local health district, then that price would then be taken up by the state.

Q. So is any assessment made at that point of whether - let me take it back one step. I gather that what you are telling us is one of the benefits - or that the benefits of these contracts need to be assessed not on an individual LHD basis but on a system-wide basis; is that correct?
A. Mmm-hmm.

Q. So one needs to see, to use your example, if a price that's offered for a particular good across the board is potentially going to be better, system-wide, than a very low price that's being offered in a metropolitan LHD, if the cost is a very high price - if that means a very high price in a rural LHD?
A. Or another LHD.

Q. And so in order to work out whether or not, system-wide, what is being offered is good, one needs to look at the whole system?
A. Correct.

Q. So when someone comes to a metropolitan LHD and offers a very good price, well under the state contract price, for a particular item, is any assessment made of whether, if it were taken up in that LHD, it would nevertheless be to the benefit of the system?
A. The contractual arrangement that we have with the

suppliers is that if they offer that price to a particular LHD, then it has to be applied across the state.

Q. Well, let me ask you by reference to this example. If someone came to a metropolitan LHD and said, "We're willing to sell you a piece of equipment for a lower price than the statewide contract price, but we won't sell it to a remote LHD for the same price because it is not economically viable for us", does anyone from HealthShare ask the supplier whether they would happily sell it to the metropolitan LHD for the low price but, nevertheless, maintain the state contract price for all other LHDs?
A. That's not the way we operate.

Q. Even though, system-wide, that would produce a saving within the system, would it not?
A. The supplier would need to - the supplier would need to be able to offer that price more broadly.

Q. But that would potentially be giving away a financial benefit, wouldn't it, to the system?
A. It is a good question.

Q. Let me try and put an example around some simple arithmetic --
A. Yes, I know - yes, I do, I understand what you are getting at.

Q. Let's say a remote LHD goes to a particular supplier, if they were doing it alone, to buy a piece of equipment, and the supplier says, "$20 million for the piece of equipment". A metropolitan LHD goes, going it alone, to the particular supplier, they probably buy more of them, they are closer to the ports, the supplier says, "Well, for you, we can do it for $5 million".
A. Yes.

Q. But as a system, as I understand it, you go forward and negotiate system-wide?
A. Yes.

Q. And let's say, hypothetically, you reach an agreement with the supplier whereby they say, "We'll supply everyone in your system, $10 million. That's the price, $10 million", so the people out there in the remote area are getting it for a better price than they could if they were going it alone; the local LHD in the metro area is

probably paying more than they would, but system-wide, that's something that, under the contract, has been accommodated?
A. Yes.

Q. That contract is locked in and they are obliged to pay - to charge that price system-wide.
A. Mmm.

Q. If, after the contract's been locked in, a supplier comes forward and says to the metropolitan LHD, "We can do it for you for cheaper", where is the problem with that, so long as they are still bound to supply it to the remote LHD for that $10 million price in our example?
A. But it wouldn't - if you consider that there needs to be equity across the system, and the supplier can supply it to one LHD, then HealthShare would - HealthShare would want to understand from the supplier why they could do it for that local health district and not more broadly.

So it may be that a contract is in place and a supplier subsequently can do a better price. In that case, we would go out for a supplementary tender to see what else might be out there at a better price. So that - that's how it works. That's how we operate.

Q. You say "That's how we operate", but as I understand the answer you gave earlier, if the supplier offered the metropolitan LHD the cheaper price, the response is, "Not unless you can give that price to everyone within the system"?
A. Our experience is that if a supplier can provide that price to a local health district or to a hospital, that often comes at the cost to another district or another hospital. So we would have to be satisfied that it wasn't - that it didn't create inequity across the system.

Q. But once you've got your statewide contract price locked in, everyone within the system gets it for that price?
A. Yes.

Q. If a particular LHD or a particular hospital is offered a reduced price or a discounted price, could you explain how it is that enabling them to take up that discounted price would introduce inequity into the system?
A. Because other local health districts aren't able to

get that same price.

Q. Can I ask this, then: in terms of an assessment of system-wide, what might be to the greatest financial benefit of health, is any modelling done as to whether allowing the metropolitan LHDs that might purchase certain items of equipment in higher quantities, closer to ports and people who do the maintenance - enabling them to get them cheaper as opposed to the regional LHDs which might pay more for them - is any modelling done as to whether that would actually produce a better financial outcome system-wide than the single state price that applies across the board?
A. We are always testing the market for products that are available and seeking to understand where we can get the best value for the system as a whole.

Q. I'm just trying to understand how that fits with --

THE COMMISSIONER: The example you have given, Mr Muston, of a statewide contract where a supplier is offering every LHD a price of $10 million for machine X but then goes to a metropolitan LHD and says, "You can have it for $9 million", maybe results in inequity - I don't know whether that's a proper description - but your scenario certainly would result in a saving. It might be an unusual hypothetical, though. I don't know how often it might happen.

MR MUSTON: Maybe.

THE COMMISSIONER: But as a matter of maths, I think you are right, it would end up with a saving overall.

THE WITNESS: But we would need to make sure that that wasn't at the detriment to other hospitals or local health districts.

THE COMMISSIONER: Q. Well, they would still have their contract from the statewide contract. So they would still have that, albeit they wouldn't be offered the special deal that a particular LHD might be. That's the difference, I think?
A. Mmm.

MR MUSTON: Q. Perhaps if we take it back even one step further: do you know whether any modelling is done, at the

time that these statewide contracts are being assessed, as to whether allowing a metropolitan LHD to acquire items for the cheaper price, even if it comes at the expense of regional LHDs that might have to pay a higher price, might, nevertheless, produce a better economic outcome across the system?
A. That would definitely be part of our processes in establishing statewide prices. But our experience with suppliers is that they - in order to - in order to achieve the equity that we're looking for in NSW Health, we seek to get a price that is consistent across the state.

Q. That's one way of achieving a form of equity?
A. Yes.

Q. What I want to suggest - and you can correct me if I'm wrong, but another way of achieving equity is to identify what the most cost-effective way of acquiring an item is system-wide?
A. Mmm.

Q. And then distributing the money between the LHDs in a way that ensures everyone can still get what they need, but it actually is less money that needs to be distributed in order to acquire all those items?
A. Yes. And our role is to understand from the suppliers why they are able to do that for that particular local health district versus other local health districts. So that would need to be taken into account.

It may very well be, in some cases, where a supplier may have a range of goods that are perhaps close to their use-by date and they offer a local health district a lower price to be able to - that would be a legitimate reason that a local health district could get that lower price. So that does occur. But on an ongoing basis, that would be quite unusual.

Q. So it is the case that on occasion there are offers made to LHDs for a lower price than the statewide price and exceptions are made to the rule that that price needs to be rolled out across the system?
A. On occasions.

Q. What's the process by which those occasions are assessed?
A. The local health district has to go - has to seek

permission from the chief procurement officer for NSW Health and the chief procurement officer would ask HealthShare to provide advice.

MR GYLES: Commissioner, before my learned friend moves on could I note something, which I haven't objected to, but there is an assumption embedded in all of those questions which is that once one starts taking individual LHDs out of a statewide contract, that the price for the remaining LHDs will remain the same. Now, that may be a safe assumption, it may not be.

THE COMMISSIONER: It is a hypothetical, I think.

MR GYLES: I'm just noting that for the record.

MR MUSTON: I did think I had made that clear.

Q. My question was not, obviously, in relation to a hypothetical 5, 10 or 20 million dollar item, or any item including the one in the example, but what I'm trying to explore with you is whether, when these opportunities for LHDs are brought to the attention of HealthShare, there is any assessment made of whether, system-wide, it would be beneficial to enable the LHD to avail itself of that opportunity?
A. And that's where we'd have the discussion with the supplier to understand what the offer is.

Q. Just to make sure I understand it, having had that discussion, is an assessment made of whether enabling the particular LHD to take up the offer that might have been made will, system-wide, provide financial benefits?
A. I'd have to --

Q. By which I mean, by allowing that LHD to get it cheaper than any other LHD?
A. That's probably a level of detail where I'd need to get a little bit more advice.

Q. But you are not aware of whether or not that assessment is or isn't made in these instances; is that right?
A. There would - if a supplier goes to a local health district and offers a lower price, that is most definitely discussed with HealthShare and, if necessary, with the

chief procurement officer. Any further detail, I'd need to take some advice on that.

THE COMMISSIONER: Q. If HealthShare becomes aware of it?
A. Yes.

MR MUSTON: I note the time, Commissioner. I've got a while to go.

THE COMMISSIONER: All right. We will adjourn, then, until 10am tomorrow. Thank you.

AT 4PM THE COMMISSION WAS ADJOURNED TO FRIDAY, 23 FEBRUARY 2024 AT 10AM

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