Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Friday, 23 February 2024 at 10.00am

(Day 009)

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

Also present:

Mr Lachlan Gyles SC with Ms Joanna Davidson for NSW Health

THE COMMISSIONER: Good morning.

MR MUSTON: Good morning. We're continuing with Ms Rechbauer.

<CARMEN RECHBAUER, on former affirmation: [10am]

<EXAMINATION BY MR MUSTON CONTINUING:

MR MUSTON: Q. I am told, Ms Rechbauer, that you may want to clarify one of the answers that you gave yesterday? A. Yes. Yesterday, at the end of the session, when you were asking me about the statewide price and the local health district - and a local health district being able to go below the statewide price, and doesn't that make it lower for the state, I was reflecting on that yesterday afternoon after I left.

The reason that we have statewide contracts is to get the best price for the state, which I talked about yesterday. Now, that takes time to work with the supplier community in terms of understanding the disciplines around that. So whilst mathematically, you're right, if there's a statewide price and a local health district can get a lower price, overall, you would, on the surface of it, think that that would be lower for the state.

The reality is that once that behaviour creeps in, as we go to subsequent contracts, the statewide price can go higher because suppliers then know that they can go to individual local health districts with lower prices. So it's actually - in terms of equity across the system over time, it becomes inequitable again.

THE COMMISSIONER: Q. How do we know that? A. From experience. So prior to there being the number of statewide contracts in place, suppliers would offer the same product to different local health districts and even to hospitals within local health districts - some would be paying a much higher price than others because of their ability or lack of ability to be able to negotiate a price, and so that's what the statewide price is about, is to stop that type of behaviour.

MR MUSTON: Q. Can I ask you a few things about that. First, so I understand it correctly, you say there's benefit in centralised negotiation of the contracts,

because the state, as a collective, has a better capacity to bargain with a supplier than would perhaps a smaller LHD?
A. Yeah. That's correct, because it's volume based.

Q. So to the extent that you're talking about inequity between LHDs or potential inequity between LHDs there, it may be that one of them, say a large metro LHD, if they were going it alone, would have a better capacity to bargain than a smaller, more remote LHD?
A. Yes.

Q. So that's the negotiation aspect of it. The second aspect of it that we're talking about is the price, is consideration given to different pricing structures across the different LHDs ever?
A. There's - there are always exceptions to - it depends on what the product is. So - how can I best describe it? In the standing offer of agreement that we have with the suppliers, if they are to go to a local health district with a lower price for a particular product, they're contractually obliged to advise HealthShare so that we can understand what that - how that will impact the system.

So there are circumstances where that would be supported, but on a general basis, it's the statewide price to make sure that there's equity across the system, that everybody's getting the same price and there isn't that - and to reduce the possibility for suppliers to be able to charge more to one hospital and less to another.

Q. Can I ask you some questions about the items that are on the inventory, so the Onelink warehouse items?
A. Yes.

Q. Those items are being delivered by suppliers to the Onelink warehouse only, not to different LHDs?
A. That's right, yes.

Q. So in that case, it's a single, volume-based purchase?
A. That's right.

Q. And you are seeking to - once you have chosen the product that you think is the best product, you are seeking to extract the best price by your market volume?
A. Yes.

Q. Those items then need to be delivered to LHDs?
A. That's right.

Q. The price that each LHD pays for the item is the same?
A. Yes.

Q. Do the LHDs have to pay a delivery cost from the warehouse?
A. It's free into store, that price.

Q. What does that mean, free into store?
A. That means that the price that they pay from the warehouse is the price that they have. However, there is a transport price applied to rural local health districts.

Q. So just unpacking that, if a metropolitan local health district located very close to the Onelink warehouse was buying a box of swabs, they would pay the price of the swabs and what, if anything, for the delivery of those swabs?
A. Yeah, they'd --

Q. What, if anything?
A. Yes.

Q. Would they pay an amount on top of --
A. They wouldn't. It's free into store.

Q. So it's free - for a metropolitan LHD the LHD is not charged any money --
A. Yes.

Q. -- for an item to be delivered from the Onelink warehouse --
A. That's right, yeah.

Q. -- to a hospital within the metro area?
A. Yeah.

Q. A rural or regional LHD that wants to acquire that same box of swabs would have to pay what?
A. It's free into store.

Q. So there's no charge --
A. Actually, the rural local health districts do pay a transport charge under the current warehousing arrangement, and so that - yeah, that's correct. But they

get the same price for the product as the other local health districts.

Q. So they would pay the same price for the box of swabs?
A. Yes.

Q. But in addition to that, they would pay actual freight costs incurred?
A. Yeah, yeah,

Q. To deliver those swabs from the Onelink warehouse to --
A. Yeah, depending on - depending on the product, yes.

Q. When you say "depending on the product", how is it differentiated?
A. Look, that level of detail I'd need to come back to you on. But there is - the rural local health districts do feel somewhat disadvantaged because of that transport cost, and that's recognised. And that is something that we are currently working on for the new contract.

Q. If it be assumed that the rural LHDs are paying more to have the items delivered from the Onelink warehouse to their hospitals, they're paying more, in a practical sense, for the products, aren't they?
A. Yes. But they're still better off because of the statewide price. So even when you take into account the transport costs, because they would have had that anyway, because of where they're located.

Q. You say that. Can I ask, has any economic modelling been done in relation to that?
A. There is modelling done by our --

Q. Who does that?
A. That is done within HealthShare by the category - by the category teams.

Q. What form does that modelling take?
A. Well, yeah, I - I'd need to get that level of detail for you.

Q. Do you know whether there is information available as to precise levels of usage of different items at different hospitals?
A. We know how much is used by each item, and the thing

that you need to keep in mind is that rural local health districts are buying much smaller volumes of products than the metros, so the benefit that they're getting is that the price that they are paying for the particular good is based on the volume of the state, which they would not be able to do on their own, and they would still be charged a transport cost.

Q. Who in your team does this modelling?
A. It's done by the category teams. So there is a number - the products that are done are - so there's approximately half a dozen category managers and teams, and they are the ones responsible for looking at the total contract and the service that accompanies that.

Q. We might have to take that up with them. It's the case that you don't know the details of the modelling that they do --
A. Look, I'd need to --

Q. -- or what the inputs or outputs of that exercise are?
A. I'd need to refer to the experts in procurement on that.

Q. Can I ask you, then - do you still have a copy of your statement in front of you?
A. I do.

Q. Can I ask you to go to paragraph 19 of that statement, which, for the operator, is [MOH.9999.0009.0001] on page .0006?
A. Did you say paragraph 19?

Q. Paragraph 19.
A. Yeah.

Q. I take it that in paragraph 19, that reflects what you and HealthShare aspire to achieve? You're not suggesting that those goals are necessarily achieved in every instance, are you?
A. No. We - as I said yesterday, we're an organisation that is maturing and we work on a continuous improvement, and obviously things change in the marketplace, things change in health, and we need to be responsive to that. So I wouldn't say that in every instance we're perfect.

THE COMMISSIONER: No, I just read the first sentence as

at least partly aspirational.

MR MUSTON: Q. Can I ask you then to go down - do you see three lines from the bottom, where you say "These services help to achieve good patient outcomes"?
A. Yes.

Q. Can I just ask what you mean by "good patient outcomes", where you use that term in that paragraph?
A. So obviously the goal of everybody who works in NSW Health is to ensure that patients receive the best quality care, and our role in that is to ensure that the services that we provide work towards that goal, so whether that be ensuring that, you know, the linen is right, you know, is clean; that food is served --

Q. Can I ask you to focus on the procurement activities.
A. Mmm.

Q. Insofar as HealthShare is involved in procurement, to what extent do you say that it is striving to achieve good patient outcomes, or in what way? What sort of outcomes?
A. That we have the right product at the right price.

Q. Just pause there. When you say "the right product", what is the outcome that you are referring to when you're talking about a patient outcome?
A. So through our processes, our tendering and contract processes, that we have engaged with clinicians appropriately to identify the --

Q. I think we might be at cross-purposes.
A. Okay.

Q. I'm not wanting to ask about the process. You talk about striving to achieve a good patient outcome.
A. Mmm-hmm.

Q. All I want to know is, from the perspective of HealthShare, what is a good patient outcome?
A. That the patient leaves hospital better than when they came in, so whether that be a knee replacement or whether that be a bandage, that that has gone towards their - a healthy outcome.

Q. And in terms of that good patient outcome, when you use that term, are you looking at anything beyond that, in

terms of a patient leaving a hospital better than when they came in, say, for example, longer-term outcomes for that patient?
A. That would be part of the goal. We're there to support clinicians in delivering that. Am I understanding your question correctly?

Q. Yes. Could I ask the witness to be shown exhibit B.016, which is [SCI.0003.0001.0023].

THE COMMISSIONER: It might be 16 is the med tech - sorry, B.016? That's where you are going to? Right.

MR MUSTON: It is.

Q. I can give you a hard copy. There's also a copy that you can see on that screen behind you?
A. Oh, that would be better.

Q. I just want to invite you to read - do you see there a paragraph headed "2.1, "Current NSW Approach problems"?
A. Yes.

Q. Can you invite you to read that paragraph down to 2.1.1.3 to yourself. Once you have considered it, I just want to give you an opportunity to respond to that.
A. Yes, I've read it.

Q. So just understand where that comes from, that's a view being expressed by Paul Dale of the Medical Technology Association of Australia?
A. Yes.

Q. Do you agree with what he's saying there in paragraph 2.1?
A. No. No, I don't.

Q. In relation to 2.1.1.1, his suggestion that an inappropriate weight is placed on the price of solutions instead of using a holistic approach which capturing additional value such as improved patient outcomes and indirect costs to the health system --
A. Yes.

Q. -- how do you respond to that?
A. I think that's an incorrect statement.

Q. In what way?
A. I think patient safety and quality is our overarching goal, so to say that price is - inappropriate weight is placed on price, I would disagree with that. In terms of - yeah, I disagree.

Q. So how is it that you say in its procurement activities - I'm not talking about linen and shared services at the moment, I'm just talking about the procurement activities --
A. Yeah, yeah.

Q. How is it that you say HealthShare is using a holistic approach which captures additional values such as improved patient outcomes and indirect costs to the health system? How is it doing that?
A. Because when we go - when we go out to market, we - it's the process that we use as we go out to market and we need to take into consideration what products are on the market since the last contract, take into account the patient safety aspect, take into account any kind of service provision that might accompany a particular product - I could give you an example, if an example would be helpful.

Q. It would be useful, yes.
A. So hips and knees - we went out in 2018 and were able - so prior to 2018, that was procured locally. Bringing that together into a statewide contract, we were actually able to reduce the number of suppliers and have a more standardised approach to the products that we were purchasing.

That contract came up for renewal in 2022 and at that time, when we went out to tender, we also asked the market what else they might be able to offer, and so a robotic process was identified, which was trialled in Southern New South Wales. So that was something that was - suppliers were actually able to say, "Look, not only do we have these knees and hips, but we've also - what is associated with that is assistive technology in placing them into people." And so that --

THE COMMISSIONER: I think the knees and hips contract is referred to in Mr Dale's statement at 4.3.

THE WITNESS: So that would be a good example of where,

you know - I think is a very good example of where price is not the overarching consideration.

MR MUSTON: Q. When you are considering tenders, I gather what you're telling us is that good patient outcomes, as you understand that term, is something which is factored in to your consideration of which of the tendering parties should be offered the contract?
A. Yes.

Q. How do you assess the patient outcomes which are being potentially associated with the different tendering parties' offerings?
A. So that would be feedback that we receive from contract managers and clinical product managers in the local health districts. So we have - when we have monthly meetings with them, it is about not only the performance of the contract but, you know, all aspects of that, which would include the - you know, what is provided.

Q. Can I ask, with all due respect to contract managers and clinical product managers - they're individuals within the procurement stream?
A. Mmm-hmm.

Q. Is that right?
A. Yes.

Q. To what extent are they, do you think, well qualified to express a view about the likely patient outcomes associated with using a particular product?
A. Well, they receive the feedback from clinicians. That's their role. So clinical product managers are clinicians themselves and have - that's their role in the local health districts, to liaise with the clinicians and get that feedback. When we ask for representatives on the technical evaluation committees, they are clinicians who are using those products, so there's also part of the evaluation process before going out.

Q. So first way that you try and assess the likely patient outcomes of using a particular product is to get feedback from the category managers within your organisation who, in turn, are informed by category managers within the LHDs, who in turn, it's hoped, are informed by clinicians on the ground?
A. That's right.

Q. That's, you would accept, potentially an imperfect process insofar as it depends upon information being passed from one to the other to the other, which is reliable?
A. But we also --

Q. No, just pause with that one. Do you accept that that is an inherently unreliable way of assessing the potential patient outcomes because it depends upon a chain of people passing on information?
A. No, I don't - I don't think it's unreliable.

Q. Do you accept that that requires a chain of people, starting with clinicians, ending perhaps several layers through the procurement pathway at HealthShare, to pass on information about their experience of price?
A. No. I believe our processes are very thorough and that clinicians have good opportunity to be able to provide feedback, and I have confidence not only in HealthShare but also in the teams within the local health districts, that that information is received accurately.

Q. But when you say that you have confidence, that's because you assume it happens; is that right?
A. Because I know it happens.

Q. How do you know that it happens?
A. Because we meet regularly with the local health districts and receive feedback.

Q. Who from within the local health districts are you receiving the feedback from and having the meetings with, I should say?
A. So we meet monthly with the contract managers about the contract, and we meet monthly with the clinical product managers, who give us feedback on the actual products.

Q. Is HealthShare meeting regularly with clinicians on the ground in the LHDs - yes or no?
A. I would say - well, yes, we are, yeah.

Q. Who at HealthShare is doing that?
A. The category managers.

Q. And what's the nature of these meetings? Are they a formal arrangement or informal arrangement?
A. Through the clinical product managers. So that's

where the - that's where the feedback comes.

Q. I think maybe I wasn't clear enough in my question. Are people from HealthShare meeting directly with clinicians in the various LHDs regularly - yes or no?
A. The answer to that question would be yes.

Q. So the meetings that HealthShare is having with clinicians regularly, what's the structure? Is there a regular structure whereby those meetings occur?
A. Well, I think the - the best way to answer that question is that clinicians are there to look after patients, so they have a support system around them to be able to communicate to HealthShare if there are problems with particular products.

Now, we - if there was a particular problem with a product, then we would then meet directly with clinical product managers and clinicians to discuss that particular product. But if you are asking do we meet with them on a monthly or quarterly basis formally about products, then the answer to that question would be no, but we definitely have relationships with numerous clinicians across the state. So there are avenues for that feedback to come directly to HealthShare.

Q. But those avenues would depend upon, to use the example you gave a moment ago, clinicians on the ground telling the relevant procurement people within their LHDs that they perceive there to be problems with a product; is that right?
A. They also have access to HealthShare.

Q. So they could also contact HealthShare --
A. They can yes.

Q. -- if they perceive there to be a problem with a product?
A. And they do, and they do.

Q. Would I be right to say that that's an ad hoc process?
A. It's an as needed process.

Q. I think you told us a moment ago about, as part of this tender evaluation - did you say there was a technical --
A. Evaluation committee.

Q. -- evaluation committee. Who is on that committee?
A. So when we go - prior to going out to tender, we write to all the local health districts and ask them to nominate representatives to sit on our technical evaluation committees.

Q. So is there a representative from every LHD on a technical evaluation committee?
A. In some cases, yes. In some cases, no. It depends on whether clinicians are available to sit on those committees. Sometimes local health districts might be quite happy to be represented by another local health district. But they certainly are all invited.

Q. Do any of the other pillars have representatives on the technical evaluation committees?
A. At times, yes. So the Clinical Excellence Commission may be part of an evaluation committee or we use them as a reference point for the clinical evaluation committee.

Q. What about the ACI? Does the ACI sit?
A. ACI from time to time may be as well.

Q. When you say "from time to time", what --
A. As required. It depends on the contract.

Q. When you say that, what's the trigger for it being required that the ACI participates in one of these committees?
A. So ACI is obviously the Agency for Clinical Innovation, so if it's - if there is a particular product that we require the expertise of the ACI, then we would either reference them or invite them on to the evaluation committee.

Q. How does HealthShare decide whether it requires the assistance of the ACI in any particular instance?
A. It would come through the technical evaluation committee members.

Q. So let me understand that process. The technical evaluation committee is formed and meets?
A. Yes.

Q. And pausing there, that is the - the technical evaluation committee is representatives who happen to be

available from LHDs?
A. Yes.

Q. And I think I might have not asked you who else is on that committee. So you have the LHD representatives and who else?
A. They can then draw - they can then --

Q. Just listen to my question.
A. Sorry, yeah.

Q. The committee involves people who have come from the LHDs?
A. Yes.

Q. After the invitation has been issued?
A. Mmm-hmm.

Q. Is there anyone else who are standing or normal run of the mill members of these committees - someone from HealthShare, for example?
A. Well, HealthShare is on the committee in terms of running the process.

Q. Anyone else who would routinely be these committees?
A. It would depend on the particular product. So, as I said, there are various categories, so it's very much up to - so if you - if the question is in relation to the Agency for Clinical Innovation or the Clinical Excellence Commission, usually, the tender evaluation committee would refer to those - so they may not be members but they could actually provide advice into the technical evaluation committee.

Q. So have I got this right, the technical evaluation committee process, run by HealthShare --
A. Mmm-hmm.

Q. -- sends out invitations to LHDs for representatives to join the committee?
A. Yeah.

Q. LHDs will, sometimes yes, sometimes no, send along representatives who are clinicians?
A. Mostly yes, yeah, yeah.

Q. Subject to availability?

A. Yes.

Q. That group then meets and decides whether it thinks it might be useful to obtain input from either the CEC or the ACI?
A. Yes.

Q. If so, advice is sought from one or both of those organisations?
A. Yes.

Q. But if the technical evaluation committee does not consider it to be something which is needed, then they won't call for the advice of the CEC or the ACI.
A. That would be - that would be right, yeah.

Q. There is no standing arrangement whereby either of those organisations have representatives that sit on technical evaluation committees?
A. Not - no, not all the time.

Q. In relation to the clinicians who are sent by the LHDs, would it be right to assume that the particular experience and qualification of the representative depends very much on what it is that is being purchased?
A. Yes, definitely.

Q. So for wound care items, for example, it might be nursing staff who are sent to --
A. Yes.

Q. -- provide clinical input?
A. Yes.

Q. An orthopaedic prosthetic device, it might be an orthopaedic surgeon?
A. Yes.

Q. Would that be right?
A. Yeah, yes.

Q. Do you know, in relation to the evaluations carried out by these committees, how they go about assessing or measuring the patient outcomes that are associated with particular items - that is, the competing items? Perhaps let me give you an example.
A. Mmm.

Q. Just so you can talk me through it by reference to an example. You've got two different sutures. One of them has some antibiotic product and the other one doesn't. There's obviously a price differential. The technical evaluation committee is called to make an assessment about which one is going to be the better one to be purchasing. Do you know how they go about evaluating the patient outcomes that might be attributable to using, say, one over the other?
A. Look, I'd have to - I'd have to take advice from my teams. That level of detail is - I wouldn't be able to accurately answer that.

Q. But insofar as you're aware, there's no formal structure, is there, where particular outcomes are identified and put forward to you, for example, at HealthShare, so that ultimately you can form a view about which of the two products is going to produce the better patient outcomes?
A. That's the discussion that's held in the technical evaluation committee.

Q. So am I right, the technical evaluation committee, internally, decides which product --
A. Yes.

Q. -- will produce the best patient outcomes?
A. Yes. And then they make a recommendation as to which suppliers and which products.

Q. Do you know whether the particular patient outcome that they have relied upon as an important determining factor is something which is identified outside of that committee - that is, is someone told, outside of the committee, who is involved in signing the contract, "This is why we've gone with this product"?
A. So part of the role of the technical evaluation committee is actually to, as a starting point, review how the previous contract and suppliers on that contract have performed and that helps inform them for the next contract. So there would be --

Q. I think my question was, though, to the extent that the technical - I think I said technical advisory - is it technical evaluation committee?
A. That's all right. I know what you mean, technical

evaluation.

Q. To the extent that the technical evaluation committee identifies, for example, a particular patient outcome, which it thinks justifies going with a particular product say, longer life span of a prosthesis or less complications --
A. Yeah.

Q. -- to the extent that they identify a feature like that as the patient outcome which should be given weight in the tender process --
A. Yes.

Q. -- do you know whether they identify that patient outcome to whoever it is up the chain who ultimately makes the decision about whether or not to enter into the contract?
A. That is the role of the category managers both at the local health district and HealthShare to monitor.

Q. Pausing there, it's the role, but does the committee actually communicate that to anyone? Namely, "This is why we have recommended this product - because of this patient outcome"?
A. They receive - so as part - being members of that committee, they receive the feedback of that product over the life of the contract. So that's taken into account in their considerations.

Q. So when it comes to the balancing act of deciding whether or not to enter into a particular contract, do you know how the patient outcome is assessed in the mix of factors that ultimately make up deciding --
A. That's probably --

Q. -- whether or not to sign a contract?
A. That's probably a level of detail that I'd have to refer to our technical teams. You're getting quite technical now.

Q. So let me just ask you at a process level.
A. Sure.

Q. I don't want to ask you about a particular technical item - and it may well be that you don't know the answer, so don't feel pressed to give us one if you don't know it.

A. That's fine. No, I won't.

Q. Is there some formal process whereby particular patient outcomes are given any sort of formal weighting as part of a tender evaluation process relative to other considerations like price, contract performance, et cetera?
A. Again, I'd need to refer to the technical teams, but it would definitely be - it would have - yeah, it would be part of the considerations, I would expect.

Q. I think you said you would expect, but you don't - but the position is you don't know whether they take into account any particular patient outcomes in their assessment of a tender; is that right?
A. I'd need to refer to our - to the experts in our procurement team. I think that, you know, it depends on - would depend very much on the product that we're looking to purchase.

Q. Who makes the ultimate decision about whether or not to sign the contract?
A. So the technical evaluation committee makes the recommendation. That then gets briefed, comes through to me. I sign off on the process.

Q. Pausing there, the brief that comes to you, what information does that brief contain? Does it take a standard form or --
A. The brief - yeah, the brief basically outlines what the contract is, what the process that has been followed, what the recommendation has been. I look to make sure that the process has been followed. I sign off on that. That goes to the chief procurement officer of NSW Health and then he signs off on the recommendation, and if the chief procurement officer has any queries, then it may come back to the tender evaluation committee and then go back up.

Q. So I understand you check the process --
A. Yes.

Q. -- you check the recommendation? Does the brief that comes to you contain any sort of discussion or analysis of the relative pros and cons of the various tendering parties?
A. It wouldn't go - it doesn't go into that level of detail.

Q. So to the extent that the tender evaluation committee has identified particular patient outcomes as being a factor which may justify purchasing a particular item --
A. Yes.

Q. -- that's not information which finds its way into the brief that goes to you?
A. No. What comes to me is the recommendation of the suppliers.

Q. And in terms of what goes from you to the chief procurement officer, do you know whether it's the same information?
A. The chief procurement officer receives the same information.

Q. Thank you. I think we've talked about patient outcomes. Are service levels being offered by particular tendering parties something else which might be taken into account as part of the mix in deciding whether or not to enter into a contract?
A. I'm not quite sure what you're asking me there. In terms of service levels, what --

Q. So, for example, the extent to which a contracting party is able to provide products reliably and promptly and accurately - is that a factor which is taken into account as part of an assessment of a tender?
A. That becomes part - that becomes part of their commitment when they sign the contract.

Q. At what stage in the process is that considered?
A. That would go into the standing offer of agreement, or the head agreement, as we refer to, with the suppliers where all of that is - all those expectations are outlined.

Q. Is an assessment made at any point in the process, prior to that, as to whether or not a particular contractor is likely to be able to meet those performance standards?
A. That - and that forms part of the - that forms part of the considerations of the technical evaluation committee. So when the suppliers put their tenders in, they have had to answer all of those questions that they are, you know, able to provide the products, you know, on time, right price, those types of things. So that forms part of their tender, and then when it comes to the contract, those requirements are then embedded in the contract and they're

contractually obliged to follow that.

Q. So the tender process requires the potential supplier to say they will do something?
A. That's right.

Q. In terms of performance levels?
A. Correct.

Q. I think HealthShare's own KPI about picking that we talked about yesterday - I assume that individual suppliers --
A. Yes.

Q. -- have a similar requirement imposed upon them?
A. Yes.

Q. They say in their response to tender, "Yes, we can comply with that requirement that we get the deliveries right and on time", by a particular percentage of the time, 98 per cent, say?
A. Yeah, whatever, yeah.

Q. Is any assessment made at any stage before the contract is signed as to whether or not --
A. They can do that?

Q. -- it's felt that they can actually achieve what they have told you they can achieve?
A. There would be - there would be - past performance would be. We'd, I would imagine, take that - well, not "imagine", we'd take that into account.

Q. So, just pausing there, if they take past performance into account, there are two contractors tendering for the job, one has a poor past performance record and one has a good past performance record, but the one with the poor past performance record is offering a lower price, may that be a factor which warrants paying a little bit more for the product to ensure the better performance?
A. Price isn't the only consideration, so if - there needs to be - we wouldn't just go for the lower price and accept lower performance; we would want the best price and good performance.

Q. So if an assessment is made that a particular low price - lower-priced contractor may not be able to perform,

that is a basis upon which you might pay a slightly higher price for the same product; is that essentially what you're saying?
A. Mmm-hmm, yeah.

Q. In terms of that assessment of past performance, in what way is the performance of contractors who have been providing a service to HealthShare prior to that tender process assessed?
A. So part of the contract management process, HealthShare meets quarterly with suppliers. There are forums where the suppliers, HealthShare and the local health districts can provide feedback to one another. There's also the procurement teams within the local health districts who meet regularly with suppliers and engage regularly with suppliers. So when we meet with contract managers and clinical product managers on a monthly basis, that feedback about suppliers is given. So there is a continual monitoring of the performance of suppliers throughout the contract period.

Q. We might come back to that. Can I ask the witness to be given exhibit B.023.129 again, that's the [MOH.9999.0010.0001]. We might even be able to get it up on the screen, and that's the easiest way, but if you need a hard copy, do let me know.
A. That's all right. I can read this screen here. It's just that one I have a bit of trouble with.

Q. That's the statement of service again. Could I ask that we go to page .0018. Do you see the heading there "Future Health actions and performance deliverables". Can I just ask, in terms of where the various items that sit within this aspect of the document sit relative to the more granular KPIs in the pages immediately before --
A. Yes.

Q. -- what is the obligation that's imposed upon by HealthShare by these statements? Are these aspirational statements or are they hard requirements - that is to say, the achievement statements and actions that are set out in the table that follows.
A. So they're - I would say that they're aspirational statements.

Q. Perhaps I didn't put the question very well. What are the consequences for failing to meet those aspirations,

from HealthShare's perspective?
A. In terms of our contract management of suppliers; is that what you --

Q. In terms of your arrangements - your arrangement with the secretary under the statement of service?
A. Yes. So our --

Q. If one of these achievement statements is not met, what are the consequences?
A. With the secretary or with suppliers?

Q. With the secretary?
A. Well, we're accountable to the secretary to ensure that we manage our relationships with suppliers and local health districts, forms part of our agreement with the secretary.

Q. But to the extent that a particular item referred to in this "Future Health actions" is not achieved, what are the consequences, if any?
A. So value and act upon feedback - will I use that an example or do you want to pick one out? There's quite a few there.

Q. Why don't we turn over to page 0020, page 19 in the hard copy, we see, "The health system is managed sustainably", for example; do you see that?
A. Yes.

Q. The first item there:

Scale successful solutions: Successful VBHC initiatives are scaled and applied at a local and state level.

THE COMMISSIONER: Is VBHC value based health care.

MR MUSTON: I was about to ask that.

THE COMMISSIONER: That was my guess.

THE WITNESS: You are right, you are spot on.

MR MUSTON: Mine too, but we'd better make sure your guess and mine are the same as the witness's guess.

THE WITNESS: You will know these acronyms better than us, soon. So that's:

> *Complete a refresh of all Procurement category strategies with input from across the system including identification of opportunities to drive better value and eliminate inefficiencies.*

So we need to - as part of our yearly performance reporting, we have to demonstrate that we're able - that we are able to do that.

MR MUSTON: Q. And so to the extent that there's actions listed there, what you need to demonstrate is that you've gone someway down the path towards taking those actions by the date specified?
A. Yeah, and be able to prove that we're doing that, you know, show - it's not just a matter of saying, "Oh, yes, we're meeting that particular aspiration", but also to be able to demonstrate how we've done that. And then, in some cases, we may not have done it - been able to do it to, you know, the level that we aspire to, but we need to be able to demonstrate what we have done and what we plan to do. So it's part of that continually improving our service delivery.

Q. Going back to that term VBHC - the value based health care - what do you understand that to mean in a practical sense?
A. I think fundamentally, value based health care is very much about ensuring that we, as a system, consider as many things as possible when procuring products or services for the system.

Q. When you say "as many things as possible" obviously there's a universe - that covers a universe of things, but --
A. I mean, it does, yes, but you think - there's millions of products that are circling out in the system, so what - you know, for a bandaid, would be very different than a hip or a knee, for instance. So it really depends on the product.

Q. But when you're making that assessment in relation to any particular product, what do you understand the concept of value based health care to require, as an outcome?

A. Well, that it's safe for the - the product is safe for the patient; that it's a quality product; that it's fit for purpose; that it is - obviously price is part of that mix; it may even be, you know, we've got to take into account modern slavery; we've got to take into account small/medium enterprise; we need to take into account local suppliers - so all of that comes into the mix for consideration when we are looking to procure products.

Q. But to the extent that you're looking to procure products in a way which delivers value based health care as an outcome, what is value based health care as an outcome, as you understand it?
A. As I understand it, it's not just about the price. It's taking into consideration all other aspects that go into being able to provide safe products for patients.

Q. Now, in relation to the three items which are 6.1.1.1.17 through to .21, how is it that the actions which are identified in the third column there have a capacity to deliver value based health care or enhance the delivery of value based health care as an outcome, as you understand it?
A. Can you just ask that question again? I'm not quite sure what you're getting at.

Q. Let's look at the first one. Number 17 -- 17.
A. Yeah.

Q.

> *Scale successful solutions: Successful [value based health care] initiatives are scaled and applied at a local and state level".*

Then do you see next to that there is a column that is headed "Actions"?
A. Yes.

Q. I won't read it out to you, but can you explain how those actions are likely to have as their consequence the successful value based health care initiatives being scaled and applied at a local and state level? Perhaps we could roll it back a step. What do those actions actually mean? What do they involve someone doing?
A. So when we're talking - well, take that .17:

Optimise back of house services at key sites, leveraging the principles and learnings from the Task Allocation System pilot, and develop roadmap for broader rollout.

What that's referring to is being able to ensure that the cleaning services that we provide are optimised to ensure that, you know, wards, theatres, are cleaned appropriately that contribute to a good outcome for patients.

Q. So those actions relate to the way in which the cleaning services --
A. Well, it's an example. So the "Scale successful solutions" comes from the, you know, future health framework, and then in that "Actions", we're providing examples of how we contribute to that aspiration.

Q. So the next one, .20?
A. Yes.

Q.

Complete a refresh of all Procurement category strategies with input from across the system including identification of opportunities to drive better value and eliminate inefficiencies.

A. Yeah, that's part of our statewide contracts.

Q. Is that part of this tender evaluation committee process that we've been talking about?
A. Yeah, well, it's the whole - it's the tender process, the contract management process, the delivery of goods. It's the whole chain and how that supports - that then supports good outcomes for patients. So it's not - we're not just going on price.

THE COMMISSIONER: Q. So it's no more complex than value based health care is - cost is an aspect, but you also consider things like, in terms of what you're doing or what you're buying, health outcomes --
A. Mmm, correct.

Q. -- experience of the clinicians and staff, experience of the patients, those sorts of things as well?
A. Yes, exactly. So if we, you know - if you'd like an

example, food, for instance, we have to take into account all the nutritional needs. So we can't just give Vegemite on toast, for instance - that would be, you know --

Q. Cost effective but not really great?
A. -- cost effective but not nutritionally sound. The same with patient transport, you know. You can't just put somebody --

Q. There are plenty of people, I think, WHO like Vegemite on toast.
A. Yes, I had it for breakfast, which is why it came to mind.

Q. It was actually an awful example but I know what you mean.
A. You know what I mean, yeah.

MR MUSTON: Q. Building on that, what you, I think, have told us, both in terms of the delivery of the shared services and your assessment of tenders is a range of factors in addition to price --
A. Yes, yeah.

Q. -- which need to be taken into account?
A. Yes.

Q. And I think you have told us, and again correct me if I am summarising it incorrectly, that when you're engaging in procurement activities, two of those factors that you take into account when deciding whether or not to pursue a particular product over and above price are patient outcomes, which can be derived from the use of that product --
A. Yes.

Q. -- and the performance of the contractor under the contract, the likely performance of the contractor under the contract?
A. Yes.

Q. And they're important from the point of view of patient outcomes because value based health care requires you to deliver the best patient outcomes that you can?
A. Yeah.

Q. And in terms of the performance of the contractor,

they're important because there are - again, correct me if I'm wrong - potentially significant costs to be incurred in chasing up bad contractors --
A. Yes.

Q. -- to the extent that they don't deliver items on time and accurately?
A. Yep, and that - it has a potential impact to patients.

Q. It has a potential impact on the delivery of service to start with?
A. Yes.

Q. The time and cost associated with chasing a recalcitrant supplier --
A. Yes.

Q. -- means that the cost that you're actually, system-wide paying for the particular item is higher than that which is shown on the sticker, as it were?
A. That's right.

Q. And the difference between the sticker price and what you're actually paying is that time which is eaten up --
A. Yes.

Q. -- in dealing with the contractor?
A. Yes.

Q. And so would you agree that it's very important to know whether you're securing the benefits beyond the price - like patient outcomes and performance - for there to be a continual monitoring and assessment of performance?
A. Yeah, yes.

Q. Both of the product, in terms of patient outcomes?
A. Yes.

Q. And of the performance of the actual contractor in terms of those performance benefits that you have factored in to your decision to accept a particular --
A. Yes, yeah.

Q. -- contractor? Let me break them up. In terms of patient outcomes how do you assess or monitor patient outcomes which are generated by the use of a particular product?

A. That feedback would come via the local health districts via their - their engagement with clinicians.

Q. So in relation to that, to the extent that patient outcomes are being measured or assessed, they are patient outcomes which are visible to those clinicians who are seeing patients within the acute setting?
A. Yes.

Q. To the extent that there might be issues associated with patient outcomes which are only revealed within the private - within the primary health setting, so after they've been released from hospital and they are seeing, say, their GP --
A. Mmm.

Q. -- that's something which those in the acute setting don't have any awareness of?
A. I think that would be a question more for the local health districts.

Q. In terms of the performance from a "patient outcomes" point of view, is there any process whereby clinicians at the local health district are asked to monitor particular outcomes which might have been important in the decision-making --
A. Again, I think that's a - that is a question for local health districts. Because the clinicians are part of the local health district, and how the local health districts gather that information, I think that's where that question needs to be directed.

Q. But is there any process whereby the local health districts are told to ask their clinicians to gather particular information about products with a view to assessing whether the patient - expected patient outcomes which are featured in the tender process have actually been secured? Yes or no?
A. Look, I don't know the answer to that question.

Q. Now, in terms of contract management, could I invite you to go to paragraph 49 of your statement, just to make sure that we're all talking about the same thing. You see in paragraph 49 you refer to HealthShare having an ongoing role in contract management? What is that role, as you see it?
A. So that - so once the contract is in place and the

standing offer of agreement has been signed, then HealthShare has an ongoing role in liaising with the - so this is talking about level 2 and level 3, so statewide contracts, so HealthShare has the role of ensuring that the contracts are - that the suppliers are providing products and services in line with the contract. They receive that feedback from contract managers at the various local health districts.

So our role in terms of - we would monitor performance. So when we have the meetings, the contract managers would provide feedback on how the contracts are going. If there is - if a local health district has difficulty with a particular supplier, the procurement teams within the local health district would, in the first place, work with that supplier.

If it becomes more problematic, then that would be referred to HealthShare and then HealthShare would see whether it is just that local health district or whether it is more broad than that, so is it a statewide problem, in which case we would need to engage with the supplier for them to pick up their game.

Sometimes it might be just a - you know, they're having a supply chain glitch. In other cases, it might be more serious than that, and so there are various measures that we can take. And so that is what goes - that is what this paragraph is talking about, that that is the management process that HealthShare undertakes on behalf of NSW Health.

Q. So there would be a difference - the position might be slightly different in relation to suppliers who are delivering directly to the Onelink warehouse, in the sense that HealthShare, presumably, has visibility of what's being delivered to the Onelink warehouse and when?
A. Yeah, yeah.

Q. So HealthShare places orders with the Onelink warehouse?
A. Yeah, yeah.

Q. And HealthShare is able to assess whether or not, in relation to those items, the contractor is performing?
A. Yeah, yeah.

Q. In relation to those contracts where things are being delivered direct to the Onelink warehouse, what is the process that HealthShare undertakes to monitor performance by the contractors?
A. So it's the same as if those suppliers were delivering direct to a local health district or, you know, to a hospital. It's the same process of understanding, you know, how the goods are coming into the warehouse, are they meeting their obligations, and if they're not, it's the same - it's the same process as to whether it's direct to the hospital.

Q. Maybe I have misunderstood the process. The Onelink warehouse, is it HealthShare that maintains a stockpile of goods or is it really just a pass-through, orders placed by LHDs go to the warehouse, and then go to --
A. So we have a supplier - we have an arrangement with the supplier to provide us with, I don't know --

Q. Swabs?
A. Swabs. Those swabs are delivered in bulk to the warehouse.

Q. Just pausing at that step in the process, who decides when and how much needs to be delivered to the warehouse? Is it HealthShare or is it driven by orders placed downstream?
A. No, HealthShare, based on the daily information that it receives in terms of what comes into the warehouse and what goes out.

Q. So on that issue, HealthShare maintains --
A. The stock levels.

Q. -- visibility of a stockpile?
A. Yeah.

Q. And when that stockpile falls below a particular threshold, someone from HealthShare will contact the swab supplier and ask that it be replenished?
A. Yes. Yes.

Q. So in that case, HealthShare knows when it has placed an order?
A. Yes.

Q. It knows when that order has been delivered?

A. Received, yeah.

Q. And it is able to make an assessment of whether or not the contractor has performed in respect of its obligations in relation to that delivery?
A. Yes. That's right.

Q. So that's one scenario. Different scenario I think is the one you were telling us about a moment ago where a statewide or whole of health contract contemplates goods being delivered from a supplier direct to an LHD?
A. Yes.

Q. In that case, order is placed through the iProcurement system?
A. Yes, by the LHD to the supplier.

Q. By the LHD. That sends an order, through that system, to the supplier?
A. Yeah.

Q. The supplier then deals directly with the LHD in terms of the delivery of the goods?
A. Yes.

Q. HealthShare, other than through this process that you spoke of a moment ago, has no direct visibility of performance by that contractor of its obligations in relation to that supplier; is that right?
A. No.

Q. So HealthShare relies on the LHDs to escalate problems in the way that you've just been through with us?
A. Yes. And that's why each LHD has its own procurement team. That's the federated model.

Q. So I think if we go over to paragraph 52, this is still dealing with the level 2 and 3 procurement contracts, is it?
A. Yes.

Q. So in terms of your administration with the terms and conditions, you're ensuring that the supplier maintains its insurances and licences?
A. Yeah.

Q. You don't expect LHDs to --

A. That's --

Q. -- continually make an assessment of that?
A. No, that's our role. That's - we take that on.

Q. And then in relation to b, seeking legal advice before agreeing to material variations, can you just explain what that aspect of the contract administration involves?
A. Mmm-hmm. So sometimes we will enter into a contract with a supplier on a particular item. Now, that supplier may - this is just one example, but the supplier may receive, completely out of their control, a very big price increase, for instance.

So in that case, they would come to HealthShare and say, "Look, this is what's happened. We have a contracted price here, but because of things out of our control, we need to increase the price by X per cent." So sometimes, we may need to get legal advice if we don't agree with that, for instance. So we might - it may be a straightforward case of, "Yes, we are aware of that impost, we've experienced that ourselves", or we might determine that the supplier is not bona fide in terms of what it - you know, of what they're putting forward, and therefore we might need some legal advice as to how we manage that situation.

Q. So the process there, am I right, contemplates situations where a supplier wants to vary the terms of the agreement?
A. Yes.

Q. For some external reason?
A. Yes.

Q. Maybe legitimate, maybe illegitimate?
A. Exactly.

Q. What you're telling us is, at that point you are making an assessment of whether or not you think it is a legitimate or illegitimate reason?
A. Yes.

Q. And seeking legal advice in relation to the variation?
A. Correct.

Q. At that stage, can I ask, does the technical

evaluation committee get reconvened with a view to considering whether whatever change is proposed --
A. No. No, that then becomes purely a contractual issue that HealthShare deals with, that we may need to refer to local health districts; we may need to refer to the ministry in terms of the chief procurement officer; and obviously legal.

Q. So to the extent that the technical evaluation committee might have balanced up price against a whole lot of other considerations like patient outcomes, performance --
A. Yeah.

Q. -- and the like, and made an assessment that, in the balance, pursuing that contract was the right - was something they were minded to recommend --
A. Yeah.

Q. -- no attempt is made to work out whether that recommendation would change if whatever factor it is, say, price, that you're looking at changing through the variation, were on the able at the time?
A. Well, it may be that we might need to, you know, change products or change suppliers, in which case we would go back to clinical product managers in the local health districts and seek advice.

Q. But in working out whether or not you need to change products or suppliers at the time that a variation - the example you gave a price increase you've brought forward - the technical evaluation committee, as I understand it, is not reconvened unless the decision is made not to vary the contract and, in fact, to get a new contract instead?
A. That's right.

Q. So in making that first decision, should we vary the contract or should we not, there's no recourse to the technical evaluation committee --
A. No.

Q. -- to see whether the change that's being proposed would have altered they're recommendation in any way?
A. No.

Q. Putting it simply, if the price increased by $3 per item, no-one takes the step of asking the technical

evaluation committee whether, in making their recommendation, a $3 increase in the price would have made a difference?
A. No.

Q. In paragraph 55, just a little bit further down on the same page, you talk about contract monitoring being undertaken to ensure performance and compliance for "emerging, legacy and strategic suppliers", and the keeping of a report of noncompliance or performance issues. Do you see that?
A. Yes.

Q. So in relation to the Onelink warehouse items, what is that process and what are the records that are kept of noncompliance?
A. So it's the information that we receive daily from the warehouse in terms of what products have been received, what hasn't been received, and where there might be - and if there are any performance, ongoing performance issues. So there's always things that go wrong, you know, one-offs, but it's more about where there's a, you know, systemic problem with a supplier, where we would record that as part of our engagement with that supplier.

Q. So in relation to the Onelink warehouse items, someone from HealthShare maintains, what, a running spreadsheet of performance?
A. Yeah. Yes, so we --

Q. And assesses that against KPIs?
A. Yes. We know at any one time how a supplier is performing against the contract that we've engaged them for.

Q. In relation to the Onelink warehouse items?
A. Yes.

Q. I want now to ask you about the items that are not going through the Onelink warehouse?
A. Yeah.

Q. Where they are being delivered directly to the LHD. In those cases, someone within the LHD will place an order through the system?
A. Mmm-hmm.

Q. Say a nurse unit manager?
A. Mmm-hmm.

Q. Items will arrive in a loading dock at the hospital?
A. Yes.

Q. Make their way up to that nursing unit manager's ward or storeroom?
A. Storeroom.

Q. And someone, perhaps a store person involved in the procurement side of things, will unpack the order. They might find that something has not arrived or has been placed on back order.
A. Yes.

Q. I assume you're familiar with the concept of back order?
A. I am. I'm impressed at your knowledge.

Q. It's growing. It's growing. So that store person, I think if I've understood the way you described the system a moment ago, would liaise with the supplier about that?
A. That's right.

Q. And, hopefully, that store person would resolve the issue?
A. Yeah, in most cases that would be the case.

Q. And if the issue is resolved it wouldn't get escalated to a procurement manager within the LHD probably?
A. It wouldn't?

Q. Would not?
A. Probably not, no.

Q. And would not be escalated to someone within HealthShare?
A. No, no. The supply chain is imperfect so, you know, there's a reasonable tolerance level applied, but it's more when things - when there is continual problems with the supplier that things will escalate.

Q. But as to when that store person or nurse unit manager escalates something, that will depend on a range of very personal factors to that individual, won't it, for example, how irritated they are by the problem?

A. Yes, yeah.

Q. Whether they think it's a big problem?
A. Yeah.

Q. How busy they are?
A. Correct.

Q. So to the extent that they don't think it's a big problem --
A. Yeah.

Q. -- or are very busy and just don't want to have to deal with it because they think they will just solve it themselves --
A. Yeah.

Q. -- the problem and knowledge of the problem lives and dies with them?
A. Yes.

Q. So to the extent that they become sufficiently troubled by an issue - say, it's impacting on the scheduling of procedures or it's resulting in a huge amount of time at LHD level for people to try and either make phone calls liaising with the supplier --
A. Mmm-hmm.

Q. -- or spend time trying to rejig arrangements to enable procedures to continue, they might escalate that to their LHD-based procurement team?
A. Yes.

Q. Somewhere in the chain within the LHD-based procurement team?
A. Yes.

Q. You would expect, wouldn't you, that if they were able to resolve that problem, then it may not come to the attention of HealthShare?
A. It may not, yes. That's true.

Q. And again, that will depend on a range of very human factors - relationship that the procurement person has with the relevant category manager at HealthShare?
A. Yeah.

Q. The extent to which they have time to --
A. Yeah.

Q. -- tell someone about the problem that they feel they have solved?
A. That is their role, as procurement - you know, the procurement team is to ensure that - the procurement team at the local health district is to ensure that suppliers are, you know, delivering their products and services according to the contracts that they have been engaged. So if there is - if it's just a one-off situation, you know - often suppliers will ring before the local health district even becomes aware of it. However, it's more when there are systemic problems with that particular supplier.

Q. There's a huge number of people across the LHDs system-wide --
A. Yeah.

Q. -- who are involved in procurement, probably thousands?
A. Yes, definitely.

Q. And working out whether or not there's a systemic problem might require some assessment to be made of the small problems being experienced by each of those people system-wide?
A. Yes, yes, yeah.

Q. And if I've understood the process correctly, the only way in which a system-wide assessment is being made of performance issues by HealthShare is through a collection of reports and discussions where things have become so problematic that they've made their way up through the chain?
A. Yes, and that's - yeah, that's right, because that's how our federated model works. Each - you know, everybody has their role to play in the good management of, you know, contracts and suppliers.

Q. But under that model, no-one can really be certain, can they, of the adequacy of performance by any particular contractor, outside of the Onelink warehouse arrangement? Let me be a bit more specific by reference to an example. The picking errors that we've talked about - picking errors are an irritation at an LHD level?
A. Yes.

Q. They cost money --
A. Yes.

Q. -- because someone needs to use a little bit of their FTE to fix the problem?
A. Yes.

Q. They can potentially cause service problems, which in turn require FTE to be deployed towards solving those problems?
A. Yes, that's right.

Q. So to the extent that picking errors are happening across the system, no-one is actually measuring, in respect of these deliveries, whether or not a particular KPI - say 98 per cent - is being satisfied or not, are they?
A. In terms of the Onelink warehouse, that is part of our KPIs. But if you are talking about at the local health district, at the hospital level, that would depend very much on the local health district procurement team and how they require that to be reported.

Q. But whilst one local health district might have a good experience of a contractor, another local health district might have a bad experience?
A. That's possible.

Q. And, in fact, every local health district might have an average experience, but not be bothered really to escalate the problem up the chain because it's not quite that bad?
A. That's where the monthly meetings with the contract managers of the local health districts - because that's where they, where those discussions will occur. So a local health district may say, "Look, we're finding this supplier is being completely unreliable"; another local health district might say "Well, we" --

Q. But, pausing there, that local health district conversation between the procurement category managers and HealthShare is only going to reveal these problems if the nurse unit manager or the store person has told them that a problem exists?
A. Yes, and that's part of the role of their job, yes.

Q. Is there any process whereby, in performing that role,

they are asked to gather information about performance in any systemic way?
A. That would be the role of the procurement team. So if they've got - if a number of nurse unit managers, for instance, are reporting the same problem, then the local procurement team would be able to say, "Well, there's a problem there", and that needs to be raised with HealthShare. So it's part of that monitoring of how the contract is being executed.

Q. But you accept, if a number of nurse unit managers are experiencing that problem and not reporting it to their procurement team because it's not that big an issue for them and they are busy, then that's the end of it, in terms of the gathering of that information?
A. That's unlikely.

Q. I will come back to the question I asked a moment ago: is there any process or requirement imposed by HealthShare upon the LHDs whereby the LHDs are to systemically collect performance data in respect of these statewide or whole of health contracts? When I say, "performance data", I mean actual figures, not just anecdotal experience?
A. Yes, I know what - yes, I know exactly what you are asking, and that's probably a detail that I would need to - I'd need to come back to you on. We do gather --

Q. So you don't know whether there is --
A. We do gather information. In terms of your specific question about is there an expectation of local health districts to do that and feed that to HealthShare, I'd need to - I'd need to come back to you on, because I am aware that we have monthly meetings, I'm aware that we provide information to the local health districts as to how contracts are performed, but in terms of what the local health districts bring to those meetings, I would need to come back to you on.

Q. But insofar as you are aware, there is no policy, for example, that requires LHDs to collect the information you would need to work out whether the picking error KPI, under any given whole of health contract, is being met or not met?
A. I - as I said, I'd have to come back to you with that.

Q. You would accept without that information, it is not really possible to make any assessment of the costs

actually being incurred in connection with acquiring the product, when one adds to the cost, cost incurred in acquiring the product, time spent chasing suppliers, for example?
A. That's a pretty hard cost to quantify, try and work that out but, yes, there would be a cost in that, which is part of the reason why we're moving towards more automation and making it easier, you know, for those errors not to occur.

Q. So it is a difficult cost to quantify, but if the contractor is complying with its obligations and delivering what it is supposed to, there is no cost, above --
A. Yes.

Q. -- no additional cost above and beyond the cost of ordering the item --
A. Agree.

Q. -- and paying for the item?
A. Agree.

Q. And so that cost leakage associated with chasing --
A. Yes.

Q. -- suppliers for non-performance --
A. Yes, it's time. It's time.

Q. -- is not being experienced. Where it is being experienced, it is not being measured?
A. Yes.

Q. Is that right?
A. Yes.

THE COMMISSIONER: We might give everyone a break now, Mr Muston, if that's okay. We will adjourn to 11.50.

SHORT ADJOURNMENT.

THE COMMISSIONER: Yes, please continue.

MR MUSTON: Q. I want to move now to procurement activities which are referred to HealthShare, so that is, LHD-based procurement exercises referred to HealthShare, which I think you tell us about in paragraph 61 of your statement.

A. Yeah.

Q. So I understand where they fit in the landscape, that's procurement activities that relate to purchases of over $250,000?
A. Yes.

Q. So that is, over that $250,000 threshold, an LHD is required, as I understand your statement --
A. Yeah, yes.

Q. -- to refer all of the tendering to HealthShare to carry out.
A. Yes.

Q. Is it the case that in some instances, LHDs will refer to HealthShare tendering below that threshold so that HealthShare can provide assistance in relation to that tendering?
A. That's right, yeah.

Q. You then go on and tell us in the following paragraphs about the steps taken by HealthShare in relation to that procurement process. I don't need to take you through that.
A. Yes.

Q. But can I ask you to go to paragraphs 65 and 66?
A. Yeah.

Q. Just remind yourself of those two steps in the process.
A. Mmm-hmm.

Q. That's approach to market and managing, in essence, the tender assessment process?
A. Mmm-hmm.

Q. Can I ask, in relation to either of those steps, is any consideration given by HealthShare to the benefits of standardisation of the items being procured across all of the LHDs?
A. Well, that's part of what we do in the statewide contracts and the tendering process, yes.

Q. But just here, we're not talking about statewide contracts, we're talking about a contract that has been -

or a need that has been identified within an LHD?
A. Mmm.

Q. The LHD is going out to tender for a particular item?
A. Oh, you're talking for under 250,000 now?

Q. No, so over $250,000 --
A. Yes.

Q. LHD has identified a need for an item worth more than $250,000?
A. Oh, yes, I'm with you now, yes. HealthShare's managing that process for them, yes.

Q. HealthShare is managing the process?
A. Yeah.

Q. The process goes through its preliminaries that you've told us about in paragraphs 62 to 64?
A. Yeah.

Q. Then I just want to take you particularly to those two steps that you've identified in paragraphs 65 and 66?
A. Yeah, yeah.

Q. I'm just asking you whether, at either of those stages, is any consideration given to the benefits or potential benefits that could be secured by standardisation of the item in question across LHDs?
A. Okay. So if I understand the question correctly, we're working with one LHD?

Q. Yes.
A. On a particular contract, and what you'd like to know is, when we look at that contract, do we look at standardising that across to other LHDs? Do we look for opportunities?

Q. No. So I think you've told us in paragraph 43 - and you don't need to go to it - that sometimes, when HealthShare is presented with a $250,000 plus contract to tender, it considers whether or not that might provide an opportunity to generate a new statewide or whole of health contract for that item?
A. Mmm-hmm, yes. That's right, yeah.

Q. So that's one way we can go.

A. Yeah.

Q. What I'm wondering is whether, when you're presented with the $250,000 plus purchase required by a particular LHD, and HealthShare is managing that tender process for the LHD, does HealthShare take a step back and ask itself in relation to the product that's being procured, "What are other LHDs doing in terms of this product" --
A. Yes.

Q. -- is there an ability to standardise the product across LHDs through this process?
A. Yes, we do.

Q. How do you do that?
A. So we have what's called the local health district tendering team, so there's a team that specifically works with local health districts. So those teams would have oversight of what a number of local health districts are doing. If I could give you an example --

Q. Yes.
A. -- so renal services was something that was picked up by our local tendering team, in terms of they could see that a number of local health districts were actually going to the same suppliers, and so a recommendation was made to take that to a statewide level and standardise.

Q. So we've been given some evidence of a particular issue that arises in relation to arterial lines?
A. Okay.

Q. When patients are transferred from one LHD to another, from one - sometimes even from one facility to another?
A. Oh, yes, yeah.

Q. -- there's an incompatibility between the arterial lines which are used at one LHD and the arterial lines which are used at another?
A. Mmm.

Q. Are you aware of that issue?
A. I'm not aware of that particular issue, but yes, that would be an opportunity.

Q. And I assume that what that means, and I'm not - I must say, I'm not familiar with an arterial line or even

what it looks like, but I assume one end of it goes into the patient?
A. You and me both.

Q. The other end gets plugged into a machine somewhere?
A. If you say so.

Q. As I gather from the evidence that we've received, the bit that plugs in to the machine doesn't plug into the machines at one LHD but it does plug into the machines at another one?
A. And that would be a good example of an opportunity to standardise, and the benefits that that could have for people moving around the system. Not only patients but staff.

Q. Potential benefits for patients, in that they don't have to have an arterial line taken out and put back in?
A. Mmm-hmm, yeah.

Q. Potential economic benefits in that you don't have to throw away that arterial line that you've taken out because the plug is the wrong shape?
A. Yeah.

Q. And potential benefits for practitioners because they don't have to go through the process of replacing it and using, no doubt, their --
A. Yeah.

Q. -- limited time to do it? In terms of that sort of issue, what is the process that HealthShare goes through in respect of tenders that are referred to HealthShare in an attempt to make sure that it's not compounding a problem like that?
A. So that would form part of our discussions with local health districts, or we might - and we might make a recommendation to the chief procurement officer.

Q. Just pausing there, the discussions with local health districts, is there a process whereby, when a $250,000-plus tender is referred to HealthShare, there is consultation with all other LHDs about the item?
A. Yes. So what HealthShare would do would be to consult with other local health districts to get an understanding of what they're doing and --

Q. Who within HealthShare does that?
A. That would be the category managers. So, you know, let's say the medical consumable category team. And they would make a recommendation that this is the product that, you know, might be suitable for standardisation, and then there needs to be very, very detailed consultation with clinicians across the state.

Q. So let's assume we're in this process, the $250,000-plus contract for a new piece of monitoring equipment at, say, RPA Hospital has been referred to HealthShare. There has been some discussion with other LHDs which has revealed this issue, namely, the potential need to standardise the product across the board. The very lengthy and detailed process that you've just referred to, how does that happen and within what time frame?
A. So there are a number of forums that are managed either by the Ministry of Health, ACI, CEC - so they would - HealthShare would refer that particular product. Let's say - well, it happened with the - can I give you an example?

Q. Please do.
A. Pharmaceuticals is a good example. So there was an identification - it was identified that pharmaceuticals could be rationalised. The Clinical Excellence Commission stepped in and developed the state formulary in consultation with the clinicians across the state. So they, like us, would go to each of the local health districts, ask for representatives, and then discussions would take place.

Q. Pausing there, though, the formulary and pharmaceuticals are a consumable and not a capital item?
A. Mmm.

Q. I'm just at the moment focusing on - perhaps I haven't been clear about that - capital items, where there's an expensive acquisition of a capital item, like a piece of monitoring equipment or a --
A. Yeah. It would be a similar process. It would - HealthShare would then - so, look, there are so many different advisory groups, committees, task forces, depending on what that device is, there would be a group of clinicians who provide advice on that on a statewide level. That would be referred to one of those groups to see if there is an opportunity to standardise that particular

product.

Q. So the reference that you gave then to so many different committees and groups and task forces, is there a process whereby the views or voices of those wide array of groups actually get collated somewhere and provided to HealthShare?
A. Well, when I say there's a lot of groups, you know, obviously there's many specialties in health, so clinicians are, you know, grouped together for particular products and activities that they do, so it wouldn't be just about procurement; it would be a whole range of things to do with their particular discipline.

Q. Yes.
A. But that would be, say, a place that HealthShare would go to to say, "Look, we have, you know, identified that this is possibly a piece of equipment that we could standardise across the state. What would that look like?"

Q. But is there any formal process whereby tenders referred to HealthShare have to be distributed to all of these groups and have the feedback of these groups provided?
A. I'd say that it would be more on a case-by-case basis.

Q. Can I move on to paragraph 67 of your statement. You tell us there that after the contract is awarded - so we're talking about the more than $250,000 contract that HealthShare has managed the tendering process in relation to --
A. Yeah.

Q. -- HealthShare then administers the contract through the processing of purchase orders raised by the LHD, SHN or agency. Can I just ask, what is the role that HealthShare has in the ongoing contract management of those contracts?
A. For contracts - so these are contracts that are over 250,000 that HealthShare has supported the local health district in terms of developing that contract, and then the local health district is responsible for managing that contract. The role that HealthShare would play in that would be that if the local health districts need some, you know, advice or support, the local health district would contact HealthShare. Otherwise, that local health district would manage that contract, by their procurement teams.

Q. Again, so there's no doubt, HealthShare does not, itself, make any attempt to monitor the performance of those - under those contracts?
A. That's not - in those situations, the role of the local - it's the role of the local health districts to manage their contracts, not - HealthShare's role is not to monitor.

Q. So again, just so we're sure, whoever might have the role, the fact is that HealthShare does not monitor performance of those contracts after they've been entered into?
A. No, no - oh --

Q. Unless assistance is called for by an LHD in relation to some issue that arises?
A. Yes. So - just to be very clear, if contracts are valued over $150,000, they must be loaded into the PROcure system, which then has, you know, information about those contracts. So there is visibility of what is on contract over $150,000.

Q. But in terms of --
A. But that --

Q. -- whether or not that contract is being performed by the supplier, that's --
A. But that doesn't have supplier performance in it. PROcure doesn't hold information about supply performance.

Q. Can I come to the shared services, so food and linen and payroll and those services?
A. Yes.

Q. Moving away from the procurement for a minute --
A. Thank God.

Q. -- and into the shared services. In respect of those services, is there any benchmarking done to work out whether the shared service that's being delivered by HealthShare is delivering better or equivalent value to an LHD to what it could secure if it was supplied by the market?
A. Yes. There is.

Q. How is that done?
A. So it's done - it's done in a few different ways. So

we market - we market test. Would you like an example.

Q. Yes, that would be useful.
A. I'll give you two examples. First example is the linen services. So HealthShare manages the linen services for the whole of the state. We went through a market testing process where we actually tested the market in various regions around New South Wales to test the market and the result of that was that NSW Health was best serviced by HealthShare, so that --

Q. So when you went through that market testing, was that going to the regions and determining what a local linen provider might be able to provide a local hospital --
A. Yes.

Q. -- in terms of price?
A. Understanding for the local health district what they could provide. It wasn't just for particular hospitals but for the local health district. So that process resulted in the linen services remaining with HealthShare.

Q. Just before you move on, in relation to linen, has any market testing been done of prices that might be secured by entering into a statewide contract for linen services with a private linen entity?
A. No, we haven't gone - we haven't done a statewide approach. What we - we decided - it was decided that NSW Health wouldn't benefit from having a private provider providing linen on a statewide basis.

Q. Why was that?
A. Because those - that has been - in other states, that has not resulted in a very good outcome. And so we recognise that there is a place for the private sector to support HealthShare, and so we, at that time, tested the market on a regional basis to see whether there were some opportunities, and at that time - at that time, it was decided to remain in-house.

The other example is warehousing. So we --

Q. Just before we move on from the linen, when you say "at that time", when was this testing done?
A. So that would have been probably nine years ago now.

Q. Is it done with any regularity, that sort of testing?

A. So at the moment it's more - we do market testing more as a point in time depending on the business. I think - so obviously COVID interrupted our natural flow for a few years, but I think there's definitely an opportunity for us to do more regular market testing, but, in addition to that, we do work with a lot of private providers in our various business lines, including linen.

Q. So in terms of food, I think you told us yesterday that food is not being supplied to Western and perhaps Far Western LHDs as a shared service?
A. No, that's right.

Q. That's because it was not economical for HealthShare to do that?
A. No, there's no economies of scale. There's no benefit for those local health districts.

Q. No benefits to whom? To the local health district or to HealthShare?
A. No, to the local health districts. They wouldn't - we don't provide - we provide - they can order off the contracts that we establish, the food contracts. They might come to us for advice on food safety, for instance. They may even come to us for advice on - you know, to benchmark with what we're doing in other local health districts. But they are responsible for delivering those services themselves.

Q. So is that an exception that has been made to the direction in respect of shared services, food-shared services, in relation to those LHDs?
A. Yes.

Q. Who sought that variation from the direction - HealthShare or the LHD?
A. That was I think, well, it would have been - when HealthShare did its due diligence, so when the food services transitioned, went through the transition process from the local health districts to HealthShare, we did a due diligence on each of the local health districts, and HealthShare's recommendation was that those - HealthShare and the local health district agreed that there wasn't much value to be gained by HealthShare providing those services, but that they could piggyback off our food contract.

Q. Can I ask you to go to paragraph 28 of your statement,

which is on page 9.
A. Yes.

Q. You tell us there about the --
A. Sorry, paragraph 28?

Q. Paragraph 28. It should be broken up into three subparagraphs, a, b and c?
A. Sorry, I went to page 28. Okay, yes. Three intra-health funding models.

Q. So these are the three means by which, if I've understood it correctly, HealthShare is reimbursed by LHDs for the services that are being provided?
A. Yes.

Q. Now, in relation to b, just starting with that one, volume based service model - I think that's relatively self-explanatory?
A. Yes.

Q. Correct me if I've misunderstood it. If an LHD, say, purchases 10 boxes of swabs, they are charged the price for 10 boxes of swabs?
A. Mmm, yeah.

Q. Likewise, linen and food --
A. Yeah.

Q. -- is it correct to say that they are a volume based service, so if a particular LHD orders 1,000 pillowcases a month, they pay a per pillowcase price?
A. Yes.

Q. How is the price of the shared services items calculated? So, for example, whatever the per pillowcase price is, how does HealthShare arrive at that price?
A. Oh, that's quite a detailed accounting question. There's quite a lot --

Q. What are the factors that go into it?
A. Well, there's modelling involved in that. Look, that's a level of detail I think you'd need to - I'd need to refer to one of our finance team.

Q. Does that modelling or the basis upon which those charges are calculated get shared with the LHDs?

A. Yeah, the LHDs receive a pricing booklet every financial year, with an outline of the services and how that works.

Q. So just in relation to that, the pricing booklet tells them what it costs per, say, pillowcase?
A. Mmm-hmm.

Q. But does it actually tell them anything about how that cost has been arrived at by HealthShare?
A. Possibly not.

Q. Now --
A. Not that it couldn't be. It's just --

Q. Do you think it would be of benefit to the system if it was revealed to LHDs - the basis upon which these prices for volume based services, that they're required to purchase through HealthShare, are actually quantified?
A. So we have regular meetings with the local health district.

Q. Sorry, the question I asked was; do you think it would be of benefit to the system if the manner in which the prices for volume based services that LHDs are directed to acquire from HealthShare are quantified?
A. Yeah.

Q. In relation to the fixed price service model - so that's 28a - are you able to tell us how those prices are quantified?
A. So it would probably be easier if I explain that via an example. Would that be okay?

Q. I think an example that I'm curious - it might be a good one, I won't identify the number because I understand there's a confidentiality claim made in relation to that, which we will deal with at some point, but, for example, the price per employee for what are described as core workforce services. Do you know how that price is arrived at?
A. Sorry, what is that?

Q. The core workforce services, which is described as operational HR advice, transactional HR services, industrial advice, recruitment support, performance development, workforce reporting, work health and safety,

safety packaging for customers with staff who are eligible for salary packaging. As a lump sum item, there's a single figure per head which is charged to the LHD for each of its employees?
A. Well, those services that you're just talking about there, we don't provide those services to the local health districts. Those services are provided to pillar agencies. That's what that would refer to.

Q. So that's --
A. So that would be like ACI, CEC, Bureau of Health Information. We provide workforce or people and culture services, and so there would be a figure arrived at, and then we would say, "All right, per employee, it will be X amount of dollars." So if they have 100 employees, it's that cost times 100 employees.

Q. So how is that cost, that you multiply by 100, determined? What --
A. By the number of staff that we have, in that - so the pillar would say, "We would like to have this scope of services", and then we would work out how many - so the pillar would say, "All right, we have 1 00 employees. We need this scope of services." And then we would work out how many staff we would need to support that, the level of what the pillar would want, and then that is an aggregated figure that's then, say - say 100 employees, whatever, say we've got 20 employees to look after 100, wouldn't be that many, probably 5, 6, divided by the cost of those employees and then that becomes the charge to the pillar.

Q. Let me come up with perhaps a more widespread example. A visiting medical officer payment?
A. A what?

Q. A visiting medical officer payment?
A. Yes.

Q. As I understand the HealthShare statewide pricing guide, there's a fixed price per VMO payment that's charged?
A. Mmm-hmm.

Q. Would it be fair for me to assume that each LHD makes a number of VMO payments --
A. That would be right, yes.

Q. -- in any given period?
A. And we would have a team of people who process those payments.

Q. And how does HealthShare go about deciding what the price per payment charged to LHDs will be?
A. So it's usually - a lot of the services that we --

Q. In that case?
A. Well, in that case, that would be labour to administer those payments, and so --

Q. But in what respect? Is some assessment made of how long it takes someone to process a payment, or is it --
A. Yeah. So there would be - there are KPI - there would be KPIs applied to that particular team as to, you know, the number of VMO payments they pay, and then that would be built up into a pricing schedule.

So let's say there are, as a very crude example, 10 people looking after VMO payments across the state, then their salaries would then be divided out and that - and charged to the local health districts. That's crude.

Q. Is that sort of information shared with the LHDs, in terms of --
A. Not to that - no, not to that --

Q. -- the way in which the prices --
A. Not to that level.

Q. Just let me finish the question.
A. Sorry.

Q. Is that sort of information shared with the LHDs in terms of the way in which the prices are calculated?
A. Not to that level of detail, no.

Q. What's the rationale for charging LHDs for these fixed-price items? What's the - you might not know, but what's the rationale for HealthShare charging an LHD for dealing with processing VMO payments, for example?
A. So the shared service model - so, if I can just go back to prior to the - so those transactional services you're talking about are offered out from our shared service, what we call our shared service centre. So prior to --

Q. Just pausing there, when you say "offered out", the LHDs are directed to use them?
A. Well, yes. So provided to the local health districts. Now, prior to those services being done centrally by HealthShare, there were processing teams in each of the local health districts. So by aggregating that into the shared service centre, fewer number of people were required to provide those services to the local health districts. So the benefit to the system is that it's cheaper to bring that together in a centralised model. The next --

Q. But, just asking you to pause there, there's no reason why that benefit would be lost if the system centrally funded that service in a way that didn't then send a bill to each individual LHD for it?
A. That would be a lot of transactions occurring, where - and the other benefit from --

Q. Well --
A. Can I just --

Q. You said, "that would be a lot of transactions". I'm just asking, there's no reason why the service could not be provided centrally in the way in which it is, without individual LHDs being sent a bill for that service?
A. So the --

Q. Couldn't it?
A. So the opportunities that exist in that shared service environment, so that was what I was trying to explain, was that they are now - they are centralised. There is now an opportunity to automate a lot of those processes, which then would deliver benefits to the local health districts in terms of reduced costs.

Q. But coming back to my question, there's no reason why those benefits couldn't have been secured in a way that did not involve the LHDs being sent a bill from HealthShare for the provision of those centralised shared services? And I'm not talking about food and linen; I'm talking about things like managing a payment system?
A. I'm not sure what you're getting at.

Q. So HealthShare could be funded to manage the payment system, system-wide, as it does?
A. Yes.

Q. That funding doesn't need to come individually from LHDs; it could come from the ministry?
A. Theoretically.

Q. So HealthShare could be given an amount of money that it has to work with in order to deliver that service?
A. So --

Q. Just yes or no? Could be?
A. It's not a yes or no answer, I'm afraid.

Q. Well, HealthShare could be given money from the ministry to manage those centralised services across the system, couldn't it? It's possible?
A. That - if that were the case, then those services would need to be standardised for that to work in that case.

Q. Well, why?
A. Pardon?

Q. Why?
A. For it to be - for it to be efficient.

Q. Let's take payroll services, for example.
A. Yes.

Q. Is there any reason why HealthShare could not be funded by the ministry to deliver payroll services across the system?
A. It could.

Q. And in terms of benefits that might be - financial benefits that might be secured by, say, standardisation, as I think you've referred to a moment ago --
A. Yeah.

Q. -- those sorts of efficiencies would be incentivised if it was HealthShare having to produce from within its own budgetary envelope an outcome in terms of the delivery of those services, wouldn't it?
A. Yeah, but you're --

THE COMMISSIONER: Q. I think what Mr Muston is putting to you, Ms Rechbauer, is not - he's certainly not gone there yet, he's not suggesting what he's putting as

a possibility is necessarily the best system?
A. No.

Q. He's just putting it to you that it's possible it could be done a different way?
A. Look, it is possible, but it would ignore the federated system in which we work. Because each local health district is - has a role to play in staff being paid. So the reason that HealthShare - the reason that HealthShare charges the local health districts for its services is that we're charging them for a component of the transactional process. I'm not explaining that very well, am I? I'm sorry.

MR MUSTON: Q. So when any individual working within a system receives that pay, that's a centralised process at the moment?
A. The transactional side, yes, that's right.

Q. And so to the extent that there's an entry made, perhaps at an LHD level, that says, "Midwife Jones has worked the following shifts", HealthShare then goes away and takes that information, processes it and produces a payment into the bank account of Midwife Jones?
A. Yeah, mmm.

Q. There's no reason, is there, why each LHD has to pay a fee to HealthShare for delivering that service?
A. You would lose the benefit of seeking efficiencies across the state if you were to lump it all together.

Q. What efficiencies would be lost in relation to payroll management?
A. So there would be - so, look, there are a number of steps in the payroll process that result in a person getting paid. So whilst HealthShare pays - whilst HealthShare pays staff at the end of the day, there are slight variations between each of the local health districts about what they do and what HealthShare does. And so that's where the charging comes into it because it's a - we've delivered this service at this price. And so it provides the opportunity for the system to further standardise, because we can see what local - you know, what works in various local health districts and what could be scaled. It's been an evolutionary process.

Q. All I'm really asking is whether the efficiencies to

be driven through that standardisation could be achieved if HealthShare was centrally funded to deliver that service?
A. That's a model.

Q. And HealthShare itself would be incentivised in those circumstances to deliver the most efficient and standardised system that it could?
A. The services that we deliver to the local health districts require the local health districts to work with HealthShare to achieve those efficiencies, so it's not a one - it's not a one-way efficiency. There's two sides to it. One that - in the services we provide, there are requirements for the local health districts to do certain things and for HealthShare to do certain things.

THE COMMISSIONER: Q. Do you mean that by having to pay, the LHDs are incentivised to be more efficient themselves?
A. Exactly. Exactly. Yes. Otherwise it just becomes, you know, you end up going to the lowest common denominator and that was the reason for shared services.

MR MUSTON: Q. On that issue, I understand all LHDs are required to use a single system called "HealthRoster"; is that right?
A. Yes, yeah.

Q. That's a standardised system?
A. Yes.

Q. And so the charges that are being levied to the LHDs for those payroll services don't drive any particular further standardisation within the LHDs, do they?
A. But there may be inefficiencies in the local health districts as to how those processes are entered into the system, which creates extra work for HealthShare once it gets to the shared service centre, and then they get - they are charged accordingly.

Q. But the charges are on a per head of staff basis, levied on a per head of staff basis, aren't they, the payroll charges?
A. But there are - if we are required to - if a local health district wants us to do more than another local health district, then they need to pay for that.

Q. But that may be because they've got more staff?
A. No, no, it is not a matter of staff; it's a matter of

scope of what they're requiring HealthShare to do.

Q. So there's no reason, is there, why the basic service couldn't be funded through a budget given to HealthShare?
A. Potentially. That would be another model.

Q. And then any additional service that might be required could be charged on a volume basis or a pass-through basis of the type you refer to in paragraph 28b and c?
A. That's possible as well.

Q. And that would strongly incentivise LHDs sticking in a standard way with the basic model?
A. And that's where HealthShare wants to move to with the local health districts. That's our next tranche of standardisation. You might recall --

Q. My understanding of the payroll system and the payments relating to it might be wrong but at the moment, LHDs are not paying nothing for the standard system, are they?
A. No, they're paying for the services that we provide.

Q. So they pay an amount for the standard system to HealthShare?
A. Mmm.

Q. And then to the extent they want more services or more variations to it, they pay more?
A. Mmm.

Q. Could I ask you to go to paragraph 112 of your statement, it is on page .0030 in the top right-hand corner.
A. 112?

Q. 112. It is at page 30, and it is at the bottom of the page.
A. Oh, yeah, "Cross agency collaboration"?

Q. The one immediately beneath it, the "In business-as-usual activities"?
A. Oh, 113? Maybe I've got --

Q. It is 112 in mine?
A. Okay, I've got it, "In business-as-usual activities", yeah.

Q. Just to make sure we're using the same document the paragraph commencing "In business-as-usual activities" --
A. I've got that.

Q. -- is that paragraph 112 in your document?
A. No. I've got 113, but that's okay.

Q. Could we have a look at the document that you've got?

THE COMMISSIONER: My 112 starts "In business-as-usual" as it is up on the screen.

MR MUSTON: That's comforting to me, but could I ask you to --

THE COMMISSIONER: You might have an earlier draft of your statement.

THE WITNESS: Yeah, I may have printed out an earlier version.

MR MUSTON: Perhaps the witness could be given - just to make sure we're not at cross-purposes about anything.

THE COMMISSIONER: Q. That hasn't happened - when you have been directed to paragraphs before, it's all been correct?
A. It's all been okay. So, yeah, I'm not quite sure what's happened there. But I've got here, "In business-as-usual activities".

MR MUSTON: Q. Perhaps if you look at the one on the screen would be the easiest thing.
A. All right.

Q. -- to save the court officer the trouble of getting another copy. You see that paragraph there now. Can I ask you, is that a feature of HealthShare's current procurement arrangements, what you've described there - that is, a lack of visibility about what's on hand at any particular moment in any particular hospital?
A. At the moment, and that's what the DeliverEASE program is about.

Q. So at the moment, HealthShare does not have visibility of what's on hand in relation - in any particular hospital

at any particular moment?
A. Not in all hospitals, no. In some, we do, because of DeliverEASE.

Q. So as part of HealthShare's procurement operations, is it anticipated that after DeliverEASE is introduced, it will be potentially moving stock from one hospital or one LHD in order to fill orders?
A. That would be a possibility. That is something that we would be able to do, and that came out --

Q. It is a possibility, but is it something which is currently being planned?
A. Well, what's - what we want to achieve out of DeliverEASE is that we have the visibility of stock across the system so if required, it could be - it is possible.

Q. So, for example, we've heard some evidence in the Commission about stock in some small facilities only being available in largish quantities?
A. Right.

Q. And that stock is used in small quantities in those facilities --
A. Right.

Q. -- such that a box of 50 might need to be purchased. In the period of time before it goes off, you might only be able to realistically use two of them.
A. Right.

Q. And so 48 of them end up getting tossed.
A. Okay.

Q. Is there any consideration being given as part of this DeliverEASE system - by HealthShare, I should say - to introducing some sort of process whereby stock and its potential expiry is being monitored and being shifted around in the system to avoid that wastage?
A. Well, that - that would be a benefit that DeliverEASE would - could offer. It could --

Q. So, breaking that up, it definitely sounds like it would be a benefit --
A. Yes.

Q. -- that is, if wastage was being reduced?

A. Mmm-hmm.

Q. I understand that it's something that DeliverEASE could offer. What I am wanting to know is, is that something which HealthShare is currently working towards delivering through the DeliverEASE process?
A. So the stock is still managed by the local health districts, so it would be a local health district decision to be able to move stock around, but the DeliverEASE would provide the information for the local health district to make that decision if they wanted to.

Q. I think that means the answer to my question is no; HealthShare is not currently looking at implementing a system whereby it monitors stock around the state and seeks to fulfil orders using stock that's already out there in the system in order to reduce wastage through stock going out of date?
A. I would say that would be an aspiration.

Q. Is HealthShare aware of that being a problem around the state - items which are going out of date because they're only able to be purchased in larger quantities than is needed?
A. Yes, we --

Q. How is that being brought to HealthShare's attention?
A. Well, again, that's down through the procurement - the local health district procurement community.

Q. Other than through the aspirations for the DeliverEASE system, is HealthShare - has it taken any active steps to do anything about that problem after it was brought to its attention?
A. So it depends on - it would depend on the particular - that would be something that we would need to discuss with the suppliers. If that feedback is about the Onelink warehouse and the products that come out of the Onelink warehouse, then that would be certainly something that HealthShare would be seeking to - would be looking to address.

Q. When you say HealthShare "would be looking to address", do you know whether - of any instances where HealthShare has addressed that issue?
A. I would say that - look, I think those types of issues arise from time to time and as they do, then HealthShare

works with the local health districts and suppliers to rectify those situations.

THE COMMISSIONER: Q. Sorry, does that mean you're aware of that happening or you think that's what would happen?
A. No, I'm aware that that happens. There are - you know, just within - like anything, there are always improvements that need to be made.

So an example would be that we're currently going out to contract for our warehousing services and based on the experience that we've had over the past few years, we're looking at some different models to address some of the challenges that local health districts have had with the current contract. But - and we also deal with things on an ad hoc basis.

MR MUSTON: Could the witness be shown exhibit B.023.15, which is [MOH.0001.0013.0001].

THE WITNESS: Which paragraph?

MR MUSTON: Q. We might use the one that's up on the screen. That might be the easiest way, if that's convenient to you?
A. I see, yes, this one, yes the audit office report.

Q. The auditor-general's report?
A. Yes.

Q. For the benefit of the record, that's the auditor-general's report, performance audit of HealthShare dated 31 October 2019. Could I ask that we roll down to page 3 in the hard copy. I'm sorry, my numbers are not lined up with the ones in the top right-hand corner. Do you see there a heading:

HealthShare's contract management practices are limited by inadequate performance monitoring?

A. Yes.

Q. And the first paragraph there that refers to - well, I invite you to read just to yourself everything under that heading.
A. Yes.

Q. Can we jump forward to page 19 in the bottom right-hand corner. Again do you see at the very foot of that page:

HealthShare's contract management practices are limited by inadequate and inconsistent performance monitoring.

A. Yes.

Q. Then there's a reference again to the same issue raised?
A. Yeah.

Q. Namely, HealthShare is indicating that it didn't have the capacity to closely manage individual contract performance?
A. Yeah.

Q. And even if it did, it does not have the information to do so?
A. Yeah.

Q. Do you see there there is a reference to HealthShare working on solutions to deliver that information?
A. Yeah.

Q. What are those solutions and to what extent have they been delivered since the report was issued in 2019?
A. All right. So you'd like to know what we have done in terms of - so the headline is "Contract management practices are limited by inadequate and inconsistent performance monitoring" - what have we done about that?

Q. Yes.
A. Okay.

Q. It says there HealthShare is - I assume "it" in that second sentence is HealthShare"?
A. Yes.

Q. Where it says, "It is working on solutions to deliver that information"?
A. Yes.

Q. So what has been done to deliver that information?

A. Okay. So in terms of - so in - at the time that this report was done, contracts weren't being loaded consistently into the PROcure system, so HealthShare has done a lot of work in conjunction with the local health districts to --

Q. Pausing there, HealthShare knew what the terms of the contracts were, obviously enough; is that right - in the case of whole of local health and statewide contracts?
A. I'm not understanding your question there.

Q. So you indicated that one of the things that's been done is - that was not happening at that time was that contracts were not loaded up into the system?
A. There were some contracts loaded up into the system but not as many as should be, which is what the audit office report picked up.

Q. But when it was indicated there that HealthShare did not have the capacity to closely manage individual contract performance, an absence of knowledge around the contracts wasn't a problem for HealthShare at that time, because HealthShare knew what the contracts were; is that right?
A. Mmm-hmm. Mmm-hmm.

Q. So what were the capacity issues that were causing HealthShare to be unable to manage contract performance at that time?
A. So the challenge at that particular time was a resourcing challenge. And then --

Q. So resourcing challenge in what respect? Resourcing challenge within HealthShare?
A. Across the system. So that was --

Q. What resources, further resources, were required?
A. So we - so from a HealthShare perspective - so the audit office report focused on contract management and what - and HealthShare, at the time, was challenged with the number of contracts that they were required to oversee. So part of - what resulted from the audit office report was really a - really was one of the factors that led to the overarching procurement reform program, and so what's happened since the audit and now is that roles and responsibilities for oversighting contract management have been much clearer; HealthShare has proactively ensured that contracts over $150,000 are loaded into PROcure, and in

terms of the performance monitoring of the contract management, there have been regular meetings, regular meetings with suppliers, and with local health districts, in terms of that overall contract management performance.

Q. So coming back to some evidence you gave us earlier about the store person or nurse unit manager who experiences non-performance at a possibly small level on a given day --
A. Yeah.

Q. -- doesn't tell anyone else about it?
A. Yeah.

Q. Maybe that happens regularly but they don't tell anyone about it because it doesn't inconvenience them enough --
A. Yeah, yeah.

Q. -- a real problem gets escalated to someone within procurement within the LHD?
A. Yeah, yeah,

Q. As part of the dialogue, that person within the LHD might raise that with --
A. That's right.

Q. -- a category manager at HealthShare, but again, depends on whether they think they can deal with it themselves: that arrangement was no different in October of 2019, was it? That was the way it worked back then?
A. You're right. What you're describing is a very manual process, which has been tightened up, I guess, in terms of, you know, how that performance cascades through the system, and the next step to that is actually automating that. That's where that whole DeliverEASE and SmartChain come into play, that we're not totally reliant on, as you describe, people reporting things. So --

Q. When you said a moment ago that the system's been tightened up --
A. Yeah.

Q. -- in what way has it been tightened up?
A. So where it says here "inconsistent performance monitoring", right what the audit report picked up there is that our engagement with suppliers at the time -

HealthShare was focusing on more of the high-value suppliers or the high-risk categories of products, rather than putting a system in place whereby we had a consistent engagement with contractors around their performance. So that's what I mean by it's been tightened up.

THE COMMISSIONER: Q. There's a couple of examples given on the next page that might assist you about the patient transport services contract and the contracts for clinical IV administration?
A. Yeah.

Q. When you say that things have been "tightened", is it in relation to what were identified as the deficiencies here?
A. Yes. So, for instance, take the patient transport services, we've got a number of private providers who we meet with regularly. We benchmark their services against our services. We work out how they can support us most efficiently. You know, what should HealthShare concentrate on when it comes to patient transport and what should we give to our private providers. So there's far more discipline and rigour in our processes today than there was back in 2019. And the next step from that is obviously, you know, where can automation assist us.

MR MUSTON: Q. So while we're on that page, page 20, I think, if we scroll down, do you see the heading "HealthShare does not always collect or validate performance data"?
A. Yes.

Q. Do you see the criticism that's made there in that first paragraph of the then practices of HealthShare?
A. Yes.

Q. Do you see the second paragraph:

In the HealthShare initiated contracts that were reviewed, HealthShare contract managers did not always collect or validate performance data, significantly increasing the risk that poor supplier performance was not identified or managed.

A. Yes.

Q. So has that situation changed?
A. Yes.

Q. How is the performance data being collected and validated in respect of, say medical consumables?
A. So that's where our category teams have been so - the category teams have been, I guess, more specialised as they've got more, you know - we've got six, I think we're about to go - about to create another category team. So there's greater specialisation of people in those teams.

We have systems in place where we record, when we've met with suppliers, what the issues have been, what their performance has been like, what actions have been taken, who we've consulted.

Q. Pausing you there, your ability to talk to them, or your category managers' ability to talk to them about what their performance is like is informed by the ad hoc or episodic reporting of problems from LHDs that we've talked about?
A. And from the - from what data we do have. So, you know, there is some data that we receive, and certainly as we move down the DeliverEASE and SmartChain process, that data will become - you know, that - the information that is derived from that data will further strengthen where we are today.

Q. There is a number of recommendations made by the auditor-general in the report. Is there any internal HealthShare reporting or documentation of the actions taken in response to those recommendations?
A. We had to report to the - we had to respond to that audit office report, yes.

THE COMMISSIONER: I think it's an appendix. There is a response, 29 October 2019, from the then health secretary.

MR MUSTON: I think, though, if we go to page 5 of the auditor-general's report, there are some recommendations which go beyond the date of the report.

THE COMMISSIONER: Yes, sure.

MR MUSTON: I think we can probably take that up elsewhere. I don't have any other questions for this

witness, Commissioner.

THE COMMISSIONER: Mr Gyles?

MR GYLES: Just one matter, if I might, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Ms Rechbauer, is it correct to say that one of the consequences of the auditor-general's report was the implementation of a new operating model?
A. Yes.

Q. And where there are difficulties identified in terms of data information - that is, a lack of data information - once the operating model comes into effect through the component parts, such as DeliverEASE, SmartChain and enabling traceability, there will be a greater access to data information --
A. Most definitely.

Q. -- than there was at the time the auditor-general's report was brought out?
A. Without a doubt.

Q. To the extent that there are resourcing issues identified in the auditor-general's report, because of the automation and greater level of information that's available, there will be less need for resources - that is, human resources - as compared to the benefits to be obtained from the new technology?
A. Yes. The resources will also be redirected. So there's, you know, lots of manual processes still occurring, so as automation increases, then resources will be used to analyse the data and provide information to the system to improve. That's the goal.

Q. And in terms of managing individual contracts, is it fair to say that the category manager plays, obviously, a pretty prominent role in that?
A. Plays a very big role, yes.

Q. And I think you have said you are adding a new category in?
A. That's right.

Q. So there is an additional headcount there?

A. Yes.

Q. And resourcing to that area?
A. Yes.

Q. And they all, going forward, will have access to a greater level of information?
A. Yes, that's right.

Q. So, in a way, once that all comes in, ideally, that will have a material impact on the sorts of issues that were being raised by the auditor-general?
A. Yes, that's right. So the audit report focused very much on contract management. Our response to the audit report is actually to look at our whole procurement and supply chain ecosystem across NSW Health to support improved reporting as per the recommendations of the audit report.

MR GYLES: Thank you, Ms Rechbauer. Thank you, Commissioner.

THE COMMISSIONER: Nothing came out of that?

MR MUSTON: I don't have any further questions.

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

THE WITNESS: My pleasure, thank you.

THE COMMISSIONER: You are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

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

LUNCHEON ADJOURNMENT

<ZORAN BOLEVICH, affirmed: [2.04pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?

A. My name is Zoran Bolevich.

Q. Dr Bolevich, what's your current role?
A. I am the chief executive of eHealth NSW and also the chief information officer for NSW Health.

Q. You have prepared a statement to assist us in relation to this Inquiry?
A. Yes.

MR MUSTON: I think that statement is exhibit B.006, which is [MOH.0001.0433.0001] for the benefit of the operator.

Q. Do you have a copy of that statement with you?
A. I have it in front of me, thank you.

Q. Your statement helpfully sets out a lot about your organisation and the work you do. I won't take you through that again. At the moment, I'd like to focus on the shared services which are provided by eHealth?
A. Mmm-hmm.

Q. Can I take you immediately to paragraph 51 of your statement.
A. Paragraph 51?

Q. Fifty-one, 5-1.
A. Yes.

Q. You tell us in that paragraph that LHD and SHNs are directed to obtain certain services from eHealth - that's the shared services that we're talking about.
A. Yes. So shared services are part of the NSW Health structure and under the documents outlined here in the statement are designated to provide certain types of services across the health system to all the various entities of NSW Health.

Q. I will just ask you to pause there. If you go over to the next page, page 26 -- -
A. Yes.

Q. Do you see amongst the shared services covered by the direction is, in iii at the very top, the information and communication technology services --
A. Correct.

Q. -- which are being provided by eHealth?
A. Yes.

Q. "Information and communication technology services" sounds like a pretty broad description. What are the actual services that are being provided by eHealth? Perhaps starting in general terms?
A. I will try. eHealth NSW provides the entire span of ICT and digital services, from planning and investment management, things like developing business cases and maintaining architectures and standards for ICT in NSW Health.

We also project manage and coordinate implementation of new systems and digital capabilities across NSW Health, so we have a very significant project management part of our services. And then, once those systems are in place, are in use in our various organisations, we also provide support for users of those systems, of those digital platforms, right across NSW Health. It's the entire span of the ICT value chain, as we call it.

Q. I think in paragraph 53, at the foot of page 26 there, you set out, going across to page 27, the categories of services being provided. Does that cover the field in terms of the services?
A. It does, and just again, a very high-level overview. It goes from things like ICT infrastructure, things like, for instance, wide area network that connects our 225 hospitals and 300-plus community health centres, to hosting systems and platforms, either in the data centre or in the cloud; and then supporting and maintaining and enhancing various types of business systems, corporate systems like workforce, finance, payroll, procurement; and then, probably most importantly, clinical systems like electronic medical record systems.

Q. So in terms of the IT or information and communication technology services that LHDs might acquire, are there any services which are acquired by LHDs outside of those provided by eHealth - that is to say, are LHDs purchasing information and communication services from other suppliers?
A. Yes. Yes, they do.

Q. Do you have any examples of that - not all of them, obviously?

A. For example, the local devices, you know, for instance, laptops, desktops, workstations on wheels, you know, mobile devices used by clinicians, those sorts of things, are procured locally, and sometimes support mechanisms for them can also be supplemented by services from the private market.

Q. From the perspective of the individual who runs eHealth, do you see that as a good thing or a bad thing?
A. I see it as a good thing.

Q. Why is that?
A. Because it does enable us to, I guess, provide for local needs and local specific requirements and contexts of our local health districts and various other agencies but we still do it in the context of statewide standards and architectures. So it is not an isolated activity, as it were, but actually happens in the broader context.

Having said that, the environment is changing and I'm sure we'll come to that as we move on through the discussion.

Q. Can I ask you to go back to paragraph 15 on page 3 of your statement.
A. Fifteen?

Q. Fifteen, 1-5.
A. Yes.

Q. In that paragraph you tell us that the shared services operate on a cost recovery model?
A. Yes.

Q. Just so I'm sure we're all talking about the same thing, the various services that you detailed in paragraph 53 --
A. Yes.

Q. -- to the extent they're provided to the LHDs, are provided on the basis that the LHDs are charged by eHealth for them?
A. Except for rollout of new systems which tend to be capitally funded so that's - when I talked about sort of big project management machine that we have, we do that in partnership with our LHDs because a lot of implementation activity happens locally, but that tends to be funded

through capital expenditure.

The user charges will typically apply to those sorts of services that relate to capabilities, technologies, et cetera, that are already in place, what we call "business as usual" type technologies and services. They are the ones that sort of are used on a day-to-day basis across the health system that are primarily subject to user charges.

Q. So is the distinction, if eHealth rolls out a new system across LHDs - for example, the single digital patient record that we'll come to --
A. Correct, yes.

Q. -- there's a component of that rollout which is funded by eHealth on the basis that it's not being recovered from the LHDs?
A. Well, it's funded by the government, by treasury, by ministry, through a process of capital expenditure approval and those sorts of processes, but yes, in principle, projects are funded as specific time limited endeavours, if you want.

Q. But the important point is, in relation to the rollout --
A. Yes.

Q. -- of those projects, individual LHDs are not being sent a bill by eHealth --
A. No.

Q. -- for rollout costs?
A. No, no.

Q. But in relation to the business as usual, as you described --
A. Can I say, though, they often contribute over and above to what, you know, project budgets necessarily have factored in to it, because we do engage with our - you know, in particular, clinicians and other users across the system a lot, and their input into those processes is important.

Q. So your point there is, whilst LHDs are not being sent a bill by eHealth for that rollout --
A. Correct.

Q. -- people within the LHD are individually working --
A. Yeah.

Q. -- on the rollout project and their time is money?
A. Absolutely. Yeah. Sometimes, supplemented - it's a bit complicated - by project funds, but often not in totality.

Q. So the supplementation might be, for example, supplementation for additional staff?
A. Correct.

Q. Within an LHD to assist with a rollout?
A. Correct, correct.

Q. In relation to the "business as usual" type activities, though, eHealth is sending a bill to LHDs for the provision of those services?
A. We are, and I can probably use that word now because we call it "Bill of IT", we've recently, over the last couple of years, changed the way that we administer our user charges.

Q. Pausing there, how were they once administered --
A. It was relatively simplistic cost allocation model. So you take kind of the total cost of eHealth chargeable services, and then there were some relatively simple allocation metrics - number of FTEs, number of clinical FTEs, those sorts of things.

Q. And then that resulted in, what, a single number being given to LHDs?
A. Pretty much, largely sort of fixed cost driven type arrangement. I mean, there was still some science behind it but certainly not as detailed and, I would say, advanced as what we now have.

Q. So in terms of what you now have, can I ask, first, how do you go about quantifying the various charges that eHealth levies for the provision of its services?
A. Yeah. So there are two components to our charging model now. It's becoming truly what we call a consumption based model, and the idea is that there are two components to volume, if you want the - how services are utilised in LHDs and other agencies. Mind you, it's not just LHDs, we support all other agencies of health. And then there is

a price component.

So the price component is really determined by the cost that eHealth incurs, either through charges by various sorts of vendors and third parties, and/or by cost of our own staff and - et cetera. So for each service, there is a price determined and then --

Q. How is that price determined --
A. That is determined --

Q. So it's a combination of the cost of any licences and the like to eHealth?
A. Correct. It's pretty granular.

Q. Plus what?
A. It's pretty granular and each service is analysed for various sorts of cost drivers, et cetera, et cetera.

Q. So can I ask this in relation to that?
A. Yes.

Q. The granular assessment or granular calculation of the charge --
A. Yes.

Q. -- is that granularity shared with the LHDs?
A. Increasingly so. Phase 1 of our Bill of IT process has been really to establish that clear determination: here's the price, here's the service catalogue of 250-odd services that we provide. For each service, here's the price, and here is the key metric - FTE, number of users, number of accounts, whatever the technology demands.

Then there is an assessment of the utilisation, the volume, if you want, of those services that LHD is forecast or estimated to use, and obviously multiplication of those two factors provides us a service charge for the year for each LHD or each agency. Volume times price.

Q. Is that calculated in advance or is it calculated afterwards?
A. It is calculated in advance based on historical figures, and then it is provided to LHDs now on a monthly basis. We've created - we use some pretty advanced technology that's been specifically developed for IT billing that helps us produce those dashboards, and LHD

colleagues - typically a combination of directors of finance and CIOs - have access to those dashboards. They receive an update every month. They can log on and that's where they can see all that granular detail or, by service line, which services the LHD has been consuming and how much of those services. And then, once a quarter, our team has a discussion with LHDs about, I guess, understanding the bill, discussing elements of it, and probably most importantly, as we mature, we are now at a point where we're working together in partnership to see how we can actually find opportunities for efficiencies and cost savings in there.

Q. On that issue of efficiencies, it would be possible, as an alternative model, for eHealth to be funded by the ministry to deliver all of the shared services, as opposed to the funding being given to the LHDs and then recovered by eHealth - just, first of all, structurally, that would be a possibility?
A. Conceptually, yes. Now, I would probably be stepping outside my realm of expertise here and I would suggest you canvass some of these ideas with our activity based funding and finance experts in the ministry but the benefit of what we're doing --

Q. Just pause, I'll ask you the next question, which is: do you see a benefit which is secured by the current cost recovery model which would not be secured through that central funding model?
A. Yes, insofar that it enables local health districts and other agencies to, first of all, have visibility of how they're utilising IT services, which gives them an opportunity to apply themselves to various sorts of areas for improvement, saving, et cetera, et cetera. So it's a good discipline, to start with.

Secondly, it is my understanding, although I'm not an expert, that this also enables LHDs and ministry as the system manager to have a really good grasp of what are the elements of, for instance, ICT and digital that feed in to the provision of clinical care.

That, again - I'm not an expert - is an important component in what I understand to be the activity based funding model. So conceptually what you're suggesting, I think could work, but there are some technical nuances to it that I think would have to be explored from the

perspective of broader funding models for health.

Q. Can I ask this: are you aware that some CIOs within the LHDs believe that their own teams have the capacity to perform some of the services which are being performed currently by eHealth?
A. Yes, and we discuss that regularly.

Q. What's the forum in which those discussions take place?
A. We have a forum which we call CIO executive leadership group, or CIOELG for shorter - we like our acronyms. We meet about every six weeks on average. It's usually a full-day meeting, with packed agendas, where we discuss all manner of things from, you know, new technology standards that we need to be developing statewide to various sorts of programs that are going on, to these sorts of issues around where is perhaps the lack of clarity around service provision; what are some elements that could be done locally that - or in a more consolidated way? So that's one of the forums where some of these issues can get raised.

Q. So if a CIO from one of the LHDs comes to you and says, "eHealth is charging me for this service that my own in-house technology team can perform adequately", how is that dealt with by you?
A. We would want to understand the concern or the concept better and see where those overlaps might exist. Obviously we are trying to avoid those situations wherever possible. What is, I think --

Q. Why is that?
A. Well, what's really important to understand here is we do try and work as a network, as a health system, if you want, as one organisation, and I guess at the end of the day, it is the end user of those IT and digital capabilities that we place at the centre. So we see it as our shared responsibility between the eHealth team and local IT teams to provide the best possible experience to the users on the ground.

So the question is how do we best leverage what is available locally and what's available in eHealth, without duplicating?

Q. Are those the issues that you are referring to in

paragraph 63 of your statement, which is at the bottom of page 28?
A. Yes.

Q. Particularly that last sentence - they are the problems that you see are being abated by centralisation?
A. Yes. Yeah, that's correct. It's one of the, I guess, advantages of standardising and consolidating certain ICT capabilities.

Q. In terms of those overlaps and inefficiencies, do you know how they were measured or whether they were measured or tested in any empirical way?
A. Well, what we have done - I'm not sure whether that will meet your definition of "empirical", but there have been a number of initiatives over the years, I can think of one or two off the top of my mind, where we worked with the local team to do sort of journey mapping, if you want, and kind of worked backwards from the need of the local user, let's say, a frontline clinician, and then kind of worked backwards from that and start mapping, okay, what are the elements of that service provision that are done locally; what's working; what's not working; how does that then flow into eHealth; what are we doing about it; are there some opportunities to streamline those journeys and those workflows? That kind of work has occurred.

And there has been also some external validation, various sorts of reviews and things like that, where we had input and suggestions provided, "Look, this is kind of industry good practice. Consider this." So in that sense, we have had some empirical evidence.

Q. Can I ask you to go down to paragraph 68?
A. Yes.

Q. You say you're unaware of instances where individual entities have been able to secure better pricing on an equivalent item?
A. Mmm.

Q. To the extent that - well, first question: have you had discussions with LHDs where they have indicated that they could do anything more cost-effectively than eHealth is currently doing it for them?
A. Well, I think the point we were trying to make here was specifically in relation to procurement outcomes, and

really, what we're trying to point out here is that we have developed over the years, I think, a pretty effective ICT procurement mechanism whereby, in collaboration with LHDs we are able to be really clear on what are the needs and requirements for LHDs and for the wider health system and then through competitive procurement processes achieve really good economies of scale and really competitive price points.

So that's what we are trying to articulate here, that certainly we feel that the effectiveness of this - of that procurement process to date has been good, strong, and I certainly am not aware of an example where on a like-for-like basis, market is giving a better deal to an individual entity as opposed to us as a system. That's what we were trying to point out there.

Q. Can I ask you to go back to paragraph 29 where you tell us about a range of statewide ICT and digital projects and reforms that have been completed?
A. Yes.

Q. These are the projects that are amongst those managed by eHealth?
A. Correct.

Q. Did that management involve any planning or assessment of the costs associated with the reform and its rollouts in the LHDs?
A. Yes, yes.

Q. How is that assessed?
A. Well, normally, that process starts even at the business case phase, so when we're developing business cases for some of these, especially larger investments, larger programs, there's an assessment of what we expect would be costs associated with acquiring technology, through procurement, what are then the costs of designing, configuring, you know, adopting it for the needs of New South Wales, and then ultimately what are the costs involved with implementation, change management, training. These are very complex systems that are being introduced.

So to the extent that we are able to, we model those types of costs at the business case phase and then, as we go through the process, it becomes increasingly clear, first for the procurement process, whether we've got those

assumptions right and then, as we start planning implementations, we also go back and recheck those assumptions.

Q. So in terms of the modelling that you do, I think you've already told us that an assessment is made of the likely resources involved in the rollout?
A. Yes.

Q. So people to deliver the training?
A. Correct.

Q. People to upload the system on to people's machines and the like?
A. Correct, yes.

Q. And so you, as part of your business case, make an attempt to quantify that?
A. Correct, correct.

Q. That's communicated to the ministry?
A. Yes, correct.

Q. And I think - I gather from what you told us a moment ago, that sometimes results in supplementation at the district level?
A. Yes.

Q. And no doubt informs --
A. Yes.

Q. -- eHealth's budget for the particular period?
A. The process for, in particular, larger projects for having those business cases approved, et cetera, is quite involved, and goes beyond health itself. There is a whole of government framework which health is bound by, which is administered by our colleagues in the department of customer service, there's a whole investment assurance framework, there are gateways to go through. It's a pretty complex business.

Q. Can I bring you back to the modelling?
A. Yes.

Q. Is equivalent modelling done of the likely human - ongoing human resources needed in LHDs to operate --
A. It is, some of that modelling is done.

Q. Is that communicated to the ministry for the purpose of informing the ministry about --
A. It is, yes.

Q. -- what it might be costing LHDs to operate these systems?
A. Yes, it is.

Q. How is that communicated?
A. Well, obviously the business cases have the sort of capital component and then the ongoing recurrent expenditure component where we are trying to capture some of those elements that you're describing.

Q. Can I ask you a specific question? Does eHealth have any role to play in relation to duress alarms at hospitals and facilities?
A. Not in any direct sort of a way, but we have been part of discussions with LHDs and with our colleagues in health infrastructure, who have a role to play in that space, when new capital builds - you know, new hospitals have been built. We have been having discussions especially in recent months and years about opportunities potentially in the future to have greater standardisation of those technologies, and the reason why we think that the time is good to be considering that is - I don't know whether you'll ask me about it later on or not but I'll mention it now - we have been doing some really good work with LHD colleagues around standardising local hospital networks.

Q. That's the wi-fi?
A. That's the health grade enterprise, "HGEN" project, which we have described in here, which is trying to modernise and standardise local networking in hospitals. This is very important for things like duress alarms.

So as we move through the HGEN process and start seeing greater standardisation and modernisation of all those wi-fi and other local networking equipment and services, that opens up opportunities for us to look, okay, what are other services that are sitting on top of those networks - duress alarms, building management systems, telephony and so on. So that's why we are starting those considerations and looking at what we might be able to do in the future.

Q. Could I take you to paragraph 85 of your statement, which is on page 32.
A. Yes.

Q. Can I invite you to just read that and perhaps just explain to us in practical terms what the disadvantage that you are identifying there is, by reference maybe to an example, that might make it easier for us to understand?
A. Well, there have been situations where, you know, we've made certain commitments as a system to, for example, move some of the local infrastructure into the government data centre, you know, and we make certain investments and commitments of resources and time and technology into those processes.

But it tends to take, then, a long time to align everybody's local priorities, and there's almost a feeling sometimes of a bit of an optioniality of some of these things. So we make an assumption that everybody's committed to the journey, but it takes then a long time to actually get everybody to participate, which is one of those situations we've come across.

Sometimes, it also relates to the adoption of certain clinical systems, and so there are certain local circumstances that sometimes prevent LHDs to participate, or participate in a timely fashion in these sorts of initiatives and statewide initiatives. It's not surprising, I guess, in a large complex system, but it is something that we continue to work on to make sure that when these commitments are made, that we're actually all in lockstep and moving forward.

Q. Moving forward to paragraph 88 on the next page, it identifies another disadvantage some of the complexity around the current procurement and service delivery arrangements?
A. Yes. Mmm.

Q. Are you commenting there on the actual policies themselves, when you refer to "complexity" or the actual practical steps required to implement them or both?
A. Well, there are two elements to that comment. One, again, just acknowledging it is a complex system with lots of stakeholders and we try and make sure that we involve people in these processes and that we get the best possible understanding of requirements, specifications, et cetera,

et cetera, and that can take time.

But then there is another element to it, which we are commenting on here, which is that the procurement frameworks themselves are quite complex and at times burdensome and seem to have an ever-growing list of requirements, you know, cybersecurity is a really good example. It's really become big in our world, right, and we are seeing, for instance, more cybersecurity - more onus on cybersecurity, for instance, in procurement processes.

Then there are some other detailed elements, the various procurement frameworks which are not always making our process easy.

Q. So has eHealth taken any steps or done anything in an attempt to deal with the complexity of all of these various pieces?
A. We are very engaged with colleagues in the sort of whole of government space, because a lot of these procurement frameworks for ICT are actually all of government frameworks, and NSW Health is required to apply them and use them.

Q. Can I ask you to pause there. To assist eHealth's staff in applying and using those policies, do they have to sit and read through all of them and understand them or ares there some steps --
A. Absolutely.

Q. Every single one of them?
A. Yes.

Q. So has eHealth taken any step to assist them in understanding all of those policies and how they work together?
A. Oh, in terms of local procurement stuff?

Q. Local.
A. Yes, so obviously for those procurements that are procurements for statewide capabilities or for one of these projects that I was talking about, eHealth will be taking the lead role in procurement anyway.

For those procurements where we are now acting, if you want, as an ICT category manager, under the new procurement policy, in other words, where LHDs are coming to us for

procurements over $150,000, yes. So what we are trying to do there is to kind of provide, if you want, an advisory service approach to those procurements and assist LHD colleagues with navigating that pretty complex set of requirements.

Q. Have you prepared any resources to assist in that - providing that service? Have you got a --
A. We rely on our own procurement team inside - in health for that.

Q. You refer at the end of that paragraph to a potentially lengthy, costly and time consuming process that lacks agility and responsiveness. Do you have an example of an instance where a lack of agility and responsiveness has potentially been a problem, that you can call to mind?
A. Sorry, which paragraph was that?

Q. Paragraph 88, you see the last sentence there. I'm particularly interested in your comment that the processes lack agility and responsiveness.
A. Yeah.

Q. What I'm wondering is whether you can call to mind any particular example where you think that has actually been a problem in a practical sense rather than just an irritation?
A. Yes, I would have to think of a good example. I guess maybe by way of the opposite, what we have seen, for instance, during the COVID years, as we refer to them in health, we've seen an incredible acceleration and ability for us to move in a very agile and responsive fashion, because we had that sort of singular focus on responding to the pandemic, and there was also a little bit more - I won't say that processes - the procuring processes were less stringent, but there was - there was a real appetite to streamline and cut through some of the bureaucracy and get to the outcome faster. That is not the normal modus operandi because there are so many of these requirements that we have to step through. So that's what we're commenting on here.

Both eHealth and our LHD colleagues would always, of course, want us to get to the outcome faster, and to be able to respond to their requirements. Sometimes, because of the complexity of these processes and the many

requirements we have to examine and be compliant with, it does take a long time. So that might be the - I can give you one example of a very prolonged process but we probably don't have too many regrets about it and that, in fact, is the single digital patient record. It was a very extensive, comprehensive, long procurement process, but it's not the one that I would criticise for it.

The reason why I say that is because we actually decided to make that process very, very inclusive. As part of that process we had at one stage about 350 staff participating, and most of them clinicians, participating in the evaluation process, and there was more than one product to evaluate. And as you can imagine, constructing an exercise like that is not trivial.

But we felt that we had to do it because that's how you arrive at a really, really good outcome. So sometimes it is actually appropriate to take time to do your procurement process properly.

But there might be some pieces of technology or processes that are perhaps not as complex and are less risky and we could cut through that much more quickly, yet there is a template to follow and we have to stick with it.

Q. So just sticking with the single digital patient record for the moment, that's a project that you've described in paragraph 31a of your statement.
A. Yes.

Q. Just again, I'll summarise my understanding of it, again in a very high-level way. Tell me if I'm roughly on the right track. So the idea is, at the moment, there are, across different LHDs, a range of different electronic medical record systems in operation?
A. Correct.

Q. Which have in their origin, as their origin, procurement exercises performed by different perhaps local area health services at some point in history; correct?
A. Yes, and even some statewide exercises which were, I guess, of their time.

Q. A consequence of those exercises, whatever they might have been, is a system where different LHDs and different hospitals could collect patient information electronically?

A. Correct.

Q. They are not able to talk to one another electronically, in the sense that a patient's records are stored at one hospital; if the patient presents at another hospital in a different LHD, those records might not be readily accessible?
A. Broadly speaking, yes.

Q. The idea of the reform is to introduce a network-wide single digital patient record --
A. Correct.

Q. -- which is accessible anywhere within the system where a patient might present?
A. Correct, correct.

Q. And there's a range of different components to that system which no doubt will operate in different parts of the system's operations, whether it be imaging records which need to be accessible across the system?
A. Yes, yes, correct.

Q. Or the readouts from bedside point of care machines that get picked up by the system?
A. Correct. Correct, yes.

Q. So the idea is that all of these different pieces of patient information, which might be collected electronically within a hospital setting, are then recorded to the single digital patient record?
A. Correct.

Q. And able to be viewed anywhere in the system where that patient might require treatment?
A. Correct, correct. Plus, it is a very powerful internal communication and what we call work flow, clinical work flow management tool, because electronic medical records enable clinicians to order tests, receive results, make observations, record progress notes, capture patient history and a lot more. So you could really call it the work horse of a clinical institution.

Q. So in terms of the work flow, am I right in my understanding that the system will, once completed, have the capacity to prompt a clinician in relation to a particular course of - a potential course of treatment,

depending on, for example, the recordings of a patient that have been made in the system?
A. Yes. And even our incumbent EMRs have some of those capabilities. Obviously we expect that with the new platform we would go a step or two further, but yes, that's typically what you can do with electronic medical records.

Q. So would an example of that, say, be the sepsis pathway?
A. Sepsis pathway is one.

Q. Just pausing in relation to that one, if a patient presents and has particular observations made which, under the sepsis pathway, should alert a practitioner to the possibility that the person has sepsis, there will be some sort of a prompt on the system to say, "These two observations have been made. Have you considered whether or not this patient should be on the sepsis pathway"?
A. Correct.

Q. Something like that?
A. Correct. Yes, in principle. If I may, maybe another example, NSW Health has a very well-established method called "Between the Flags", which was developed by our Clinical Excellence Commission here in New South Wales and has been used for many years successfully on paper, but we now have a digital version in the EMRs and that is very helpful because it helps our clinicians to detect early potentially deteriorating patients, so if they're outside of the parameters, outside of the flags, so to say, they can then intervene and prevent the patient from deteriorating.

Q. So that, once the system is completed, ideally provides a single source of information within the acute care setting?
A. Correct.

Q. Current arrangements, putting to one side the different systems in different LHDs - current arrangements have patient information split across a number of different platforms?
A. (Witness nods).

Q. The acute care setting, so the EMR or, in future, the single digital patient record?
A. Yes.

Q. Within a primary care setting, there'll be patient records kept by the patient's GP?
A. Correct.

Q. Possibly within an aged care facility or some other NDIS type facility, for example, there might be patient records kept?
A. (Witness nods).

Q. Those are records that, at the moment, are not able to be viewed as a single point source of information in relation to the patient, are they?
A. There are some ways or methods in which summarised patient information can be viewed across different levels of care that you are describing, principally the federal My Health Record plays that role.

Q. So the federal My Health Record, and maybe if I can jump to the next point you were going to make, to the extent that a patient is discharged from a hospital, if the system works, there should be a discharge summary which goes to --
A. Correct.

Q. -- the GP?
A. Correct.

Q. The quality of the information, of course, there, depends upon what has been written into the discharge summary?
A. Correct.

Q. Whether or not it gets to the right person or to a person who is providing treatment in the future depends upon the person identifying who the GP is at the time of their admission and then in future visiting the same GP?
A. Correct, correct.

Q. It would be beneficial, wouldn't it, from a health point of view, for there to be a single point source of information in relation to a patient's medical records - that is, a single point of information which shows the treatment delivered and the observations made of the patient both in an acute setting and, say, in a primary care setting?
A. That certainly is the Holy Grail of digital health and

something that nationally, and even internationally, we're all striving towards. It often gets, then, bundled into this concept of interoperability in digital health, or lack of it, which is in other words ability of all of these different disparate systems to seamlessly share patient information.

A lot of work is currently going in to developing standards that will hopefully enable a more streamlined sharing of information between different systems, so even if we don't get to the Nirvana that you are describing, at least then we can ensure that those individual systems - primary care, hospital care, aged care - have an ability to seamlessly and safely and securely share certain defined core datasets in the interests of the patient.

Q. So whether it reaches the Nirvana stage or just a slightly greater sharing of information, any level of information sharing or the accessibility of a single point of common information about a patient will enhance --
A. Undoubtedly.

Q. -- continuity of care?
A. Undoubtedly.

Q. And it will reduce wastage through duplication?
A. Undoubtedly.

Q. And it will enable a better assessment of outcomes when considering the value of the health care delivered?
A. Yes, yes.

Q. Does the single digital patient record project, as it's currently conceptualised, contemplate any bridging of these information gaps, in particular between the acute care setting and the primary care setting?
A. Yes, yes, it does.

Q. In what way does it conceptualise that?
A. Well, first of all, the platform that we've chosen and that we will be configuring and implementing here in New South Wales has quite robust and pretty advanced integration capabilities, which will enable us to do the interoperability better, let's put it that way.

It also has a number of other interesting features, like there is a portal for providers - for instance, GPs -

to be able to come in to the system and see a view of the patient. There is a portal for patients themselves - there is a very competent patient app, which comes with the system as well. So those are some of the ways in which we think SDPR will advance the cause.

Q. Just pausing there, that assists in the transition of patient information from the acute care setting to the primary care setting?
A. Correct.

Q. Either because, if these components become operational --
A. Correct.

Q. -- a GP can get into the system and see information --
A. That's it.

Q. -- or, alternatively, the patient can get into the system and see information which they can share with their GP?
A. Correct, yes.

Q. It doesn't currently contemplate the other side of it, which is the sharing of information between the GP and the hospital?
A. It does - obviously that would require us to develop those interoperability mechanisms with primary health care software tools and work with industry who support, develop those types of systems.

Q. In relation to that, can I ask you --
A. And this is where the adoption of standards I mentioned earlier is a very important enabler.

Q. In relation to that, can I ask you, are there a number of major suppliers of medical record technology in the primary health care setting?
A. Yes.

Q. That is to say, are there multiple suppliers across the system or is there a small handful who would supply everyone?
A. There is a multiplicity of suppliers but it's fair to say that there's probably three or four companies that have the largest market share. So we know who those market leaders are, as it were.

Q. As part of the single digital patient record project, is any work being done to try to get at least those market leaders in a position where information is capable of being shared between the primary health care setting and the acute care setting - that is, in that direction?
A. Not directly as yet, would be my answer, but we have commenced conversations with colleagues in the primary health care sector, just recently had a really important conversation with primary health networks here in New South Wales to see how we can collaborate with them and have them involved in this very program.

Q. Can I ask you to go to paragraph 105 of your statement, which is on page 35.
A. Yes.

Q. I think you set out there some of these discussions. What I really want to ask you about is the very last two lines. Do you see?
A. Yes.

Q. You perceive there to be a need to review and modernise legislation and policy frameworks to enable that information sharing to occur?
A. Yes, that's correct.

Q. What is the modernisation of legislation and policy framework that you have in mind?
A. All Australian jurisdictions have ever so slightly different health information, privacy legislation and regulation, and here in New South Wales, of course, we have our own version of that.

What we are referring to here specifically is a set of, I guess, policies and potentially legislative instruments that would facilitate that sharing of information between primary health care and hospitals. So at the moment, my understanding is that, for instance, GPs accessing our hospital electronic medical record is something that requires a number of steps and special dispensations and things like that for special circumstances. Whereas in other jurisdictions, for instance, in Queensland, they have changed their regulatory framework so as to enable GPs to have a much easier access, for instance, to the hospital digital records.

So that's an example of what we're talking about. And we believe that, obviously, with the advent of single digital patient record, now is a perfect time for us to actually pause and have a look at what we've got and how those frameworks that are now 15, 20 years old, how do they actually perform in today's environment which is becoming increasingly digital.

Q. Can I move to another topic. We've been told by a number of people that artificial intelligence is going to revolutionise health care, amongst other things. It's not explicitly mentioned in your - or the opportunities that you identify at the end of the statement, but do you perceive there to be any opportunities presented by artificial intelligence?
A. Very much so, and to try and grasp those opportunities, NSW Health has just recently established an AI task force, which I have the pleasure of co-chairing together with my very good colleague Jean-Frederic Levesque, who is the chief executive of ACI. We had our inaugural meeting just recently, the Minister for Health very kindly came to open it for us.

The idea there is for us as a system, again, across LHDs, ministry, pillars, to work together to figure out what are some of the enablers for a safe, purposeful, effective, equitable adoption of these technologies into our health system. Not to create red tape and bureaucracy around it but actually to create a sensible and useful framework which will enable our clinical teams, research teams, et cetera, et cetera, to innovate in a safe and hopefully scalable way, you know, some of those local innovations. If we are successful in what we are trying to do, hopefully we can identify early those ones that are the most promising and high-value innovations, and then we can scale them across the system.

So those are some of the ideas that we will be exploring and we want to develop some framework for safe adoption of AI in health as well.

Q. The last thing I want to ask you some questions about is eHealth's involvement in the procurement reforms --
A. Of course.

Q. -- that are under way. You tell us a little bit about them, I think, in paragraph 23b of your statement.

A. Yes.

Q. At b and c in particular are two that I would like to just ask you some questions about.
A. Yes.

Q. Now, in terms of the second of those systems, the SmartChain, are you familiar with the system which is used in at least two of the metropolitan LHDs called "h-trak"?
A. I am familiar with it, yes. Not in detail, but I know what you are referring to.

Q. At a very general level, does its functionality overlap with what you understand to be some of the functionality of the SmartChain traceability system?
A. To some extent. One, I would say - one component of it does, yes, or one component of SmartChain overlaps with h-trak, yes.

Q. There may be a very good reason for not doing so, but do you know whether consideration was given to scaling up the h-trak as opposed to replacing it with the SmartChain?
A. My understanding is that h-trak has been introduced in a number of LHDs in a sort of locally specific way. So what we have at the moment is a number of different implementations of h-trak, with, so I understand, not much commonality or standardisation between them. So therefore, I guess, conceptually, if one were to contemplate scaling that, you would have to go through a process of standardising and, you know, changing the way those local implementations are currently working.

That doesn't seem like a particularly rational proposition when we actually already own an enterprise product which is our Oracle ERP, which has these capabilities out of the box, ready to go. So I guess we are using capability and technology that we already have in the health system to try and tackle the problem and deliver the outcome that hospitals need.

MR MUSTON: I have no further questions for this witness - oh, hang on, I might. No, I've got no further questions for this witness.

THE COMMISSIONER: Mr Gyles?

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

Commissioner. Thank you.

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

THE WITNESS: Thank you, Commissioner.

<THE WITNESS WITHDREW

MR MUSTON: The next witness is Michael Gendy.

THE COMMISSIONER: We might have a short break, then, and come back.

MR MUSTON: I will let you know that Mr Gendy is next and when we are back arrangements can be made to have him in the chair.

THE COMMISSIONER: We will have a break until 10 past 3.

MR MUSTON: Okay.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

MR MUSTON: I call Michael Gendy.

<MICHAEL GENDY, sworn: [3.10pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. Michael Gendy.

Q. And you are the chief procurement officer for NSW Health?
A. That's correct.

Q. You've held that role since January 2018?
A. Correct.

Q. You've prepared a statement to assist the Commission dated 31 January 2024?
A. Yes.

Q. It is exhibit B.005 [MOH.0001.0434.0001]. Do you have a copy of that statement with you?
A. I do.

Q. Could I ask you to go directly to paragraph 4 of that statement.
A. Yes.

Q. You tell us there that one of your responsibilities is to oversee what you've described as the NSW Health procurement policy and procedures, along with related systems, structures and frameworks, for procurement activities?
A. Yes.

Q. That's the policies, frameworks and legislation that you have sought to summarise in paragraphs 32 to 57 of your statement; is that right?
A. Yes, correct.

Q. I think you return to them, in terms of their application, in paragraphs 70 to 79.
A. Yes.

Q. Would it be fair to say that those policies are very complex?
A. They are.

Q. And it would be difficult for someone on the ground, in an LHD, wanting to acquire something, to understand how they all fit together?
A. It's fair to say that, yes.

Q. There are thousands of people within the system who have responsibilities at various levels for procurement within NSW Health?
A. Yes.

Q. Do you consider that it's realistic for it to be expected that those individuals who are tasked with procurement responsibilities will have a sufficiently mature understanding of all of those policies to enable them to perform their procurement functions in accordance with them?
A. The expectation is that the procurement leads or the procurement officers at the district should be fairly familiar with the NSW Health procurement policy and

procedures, and they are essentially the touch point and contact for any local staff or nurse unit manager, perhaps, who doesn't really need to be at that level of understanding of the policy.

Q. Are you aware that a number of LHDs have produced their own local policies and frameworks in an attempt to synthesise the requirements of the various policies you've identified so as to enable staff on the ground to understand and apply them?
A. I'm aware that there are local procedures within every district, and they vary by district, and they are in line with the district's financial delegations so as to ensure accountability and responsibility, obviously for taxpayer money.

Q. So the delegations deal with the financial point at which a decision needs to be passed up the chain?
A. Yes.

Q. But in terms of what that decision is and whether or not the making of that decision complies with the various policies, frameworks and pieces of legislation you've identified, are you aware that the LHDs - some LHDs have produced, as it were, "health procurement policies and framework for dummies" manual?
A. Yes, so to be clear, there is only one NSW Health procurement policy. What the districts, again, would have produced is a manual at a local level or a flow chart, so to speak, to enable the staff who are not meant to really be involved in procurement at that extent to really understand, as you highlighted, you know, a manual for the individual at a ward, so that they understand how to actually go about procuring a good or service within the district.

Q. Do you see any benefit in potentially simplifying or streamlining all of those policies in a way that makes them a little bit more digestible to a procurement person on the ground?
A. We certainly have - we certainly have strived and we continue to strive to simplify it as much as possible. The challenge is always trying to incorporate a lot of the statewide government policies and directions within our framework to ensure that we are compliant, as a cluster or a portfolio, with all those directions and frameworks that are set by central government. So whilst we try and

endeavour to simplify that, it is still very difficult to get it down to a simple couple of pages. We have certainly attempted that, and what we then - what we try and do is to have a simple way of allowing individuals to jump on a procurement portal, and through that procurement portal they are able to at least get an understanding of: right, what do I want to buy today, this is how I go about it, and these are the different touch points throughout the system.

Q. So is it right to say that in relation to a lot of the requirements of this complex array of policies, they are factored in to the portal in a way that means one doesn't need to understand them because the portal works in a way that, by necessity, applies them as one passes through the pathway of that portal?
A. Correct, to a degree. Ultimately, complex procurements which would not occur at a ward level would require deeper understanding of the policy, and this is where the procurement staff or the procurement contact leads at a district level would be very familiar with that.

Q. So is it right that at least at a ward level and a day-to-day procurement level, the reforms that you tell us a lot about in your statement have sought to cut through some of the complexity that sits around these policies?
A. That is definitely the aim, yes.

Q. And the areas in which you've had trouble simplifying the policies in a way that produces, I think, what you described as a two-pager, is more in that area of high-level, high-value procurement that would ordinarily be carried out by someone within a procurement team, either at the LHD level or possibly at HealthShare?
A. Correct.

Q. We've been told as part of the evidence we've been given this week about a range of different channels through which procurement, at a ward level or at an operational level, can occur.
A. Yes.

Q. There's the PCard you've heard about?
A. Yes.

Q. There's the S1 form?
A. Yes.

Q. There's the iProcurement portal?
A. Yes.

Q. There's the DeliverEASE system, which, as we understand it, interacts automatically with the iProcurement portal?
A. Yes.

Q. Are there any other means by which someone in an operational role within a hospital might need to procure something, or any other ways in which they would go about procuring something?
A. Not that I'm aware of, but if I can expand a bit on those points.

Q. Yes, please.
A. So there really is one centralised platform, an enterprise platform, being Oracle. That's really the foundation, if you think about it, the foundation of where purchase orders and requisitions are raised against.

DeliverEASE is a solution that is actually enabling a level of efficiency across the supply chain and inventory management. And I think you mentioned the S1 form. My understanding is that that's a manual form where you're seeking to procure items that are out of trust funds. Again, we don't - because it is not necessarily related to taxpayer funds, but they do come to me for exemptions, where I can see them, but that's a very sort of - I see very minimal of those. In fact, I've only seen one come through in my six years.

So the challenge is trying to make sure that everything integrates with a single platform that we have, being Oracle.

Q. I think the other one, I'm reminded, is a SARA, S-A-R-A, request, which seems to be, if you can't work out which of those other platforms to use, you put it into SARA and hope something comes back?
A. SARA is - whilst it's a platform used for requesting to procure an item, it's not necessarily a - it's not necessarily a platform that actually makes payments or - it is really all the payments and requisitions are coming through the Oracle platform, and iProcurement, which you referred to Mr Muston, is essentially the ordering platform itself, so to speak, that has the catalogue for all the

items that are part of this large extensive catalogue we have for health.

Q. So how does an individual working within the system, who needs to acquire something, actually know which of the various processes they should be using?
A. Depending on where they work and what department they work. So if we take an example of a nurse unit manager who is responsible for, you know, their - basically a ward and they are responsible for that area within the hospital, they would, as part of their induction, I would imagine, be, you know, made familiar with what the ordering platform is, how do I go about raising a requisition, what are the different challenges, and it's fair to say there is a level of knowledge that is transferred there.

The other method is, we are developing some modules within the procurement academy that we launched about 18 months ago, and some of those modules are really tailoring procurement for non-procurement folk. So again, whilst our modules are really targeting procurement capability and capability uplift at a district level for those procurement staff, but it's also important to ensure that, as you mentioned, someone who doesn't really - who's not a procurement expert, how do they go about procuring items within their position.

Q. So the procurement academy, this is some online educational material that's being prepared to assist in letting people who are non-procurement folk know which platform they should be using to buy what?
A. Yeah, it's not online material; it's actually a face-to-face delivery or it can be virtual depending on the location. Obviously, we're looking always to save costs and be efficient.

But these are modules that have been - procurement modules and training that have been specifically developed and tailored for health, so they're developed within my own branch, in conjunction with the Chartered Institute of Procurement & Supply Chain, so we wanted to make sure that we're leveraging industry best practice as part of that when it comes to negotiating and contract management, so these are modules that have been designed and tailored for NSW Health procurement staff.

Q. Could I ask you to turn to paragraph 64 on page 21 of

your statement.
A. Yes.

Q. You tell us there about the four work streams that are part of the procurement reforms. Would it be right to say that the first one you tell us about there in subparagraph a is part of this process of synthesising or simplifying the policies that we've been talking about?
A. That's correct.

Q. Turning over to b, the medicines formulary, I think we understand how that works, in terms of it being a list of particular medications which have been identified as appropriate for use within New South Wales public hospitals, in an attempt to reduce down what was once a large and varying list of medications used across the system.
A. (Witness nods).

Q. But you use the phrase:

> *... develop a holistic framework governing the procurement and usage of pharmaceuticals to support optimum clinical governance and better value health care leading to improved patient outcomes.*

A. Yes.

Q. Is that just a longer-winded version of what I just said?
A. Yes. But I'll add - what I'll add there is, the medicines formulary started off, and as everything that we do in health has to be about patient outcomes, and it's obviously had the clinical - the objective to have a better clinical outcome for the patients and make sure that there's consistency in prescribing, making sure that obviously we don't have a multitude of variability around different items and medications - and again, I'm not a clinician, not an expert, but if you look at where we were and where we are now, moving from over 6,700 medications or medicines on the list down to about just over 2000 or so, and we're still covering the range of prescribing and ability to provide those medications as required, it just shows you that there was probably a lot of benefit in going down that path to standardise that.

The second piece to that would be, now that we have a list, a consistent list, so to speak, in simple terms, of what these medications are that we're going to be prescribing and we have and are in the system, and our requirements, how can we now leverage that knowledge and now overlay that with our procurement strategy to enable a greater level of commercial efficiency across that? So it's a two-pronged approach.

Q. The next one you tell us about is the DeliverEASE?
A. Yes.

Q. Which I think you've told us a little bit about already. That's a platform or a mechanism by which the ordering process through the iProcurement system is automated?
A. Yes.

Q. We've been told by people who are using it that it involves scanning of items using a barcode and scanner or an iPad?
A. Yes. So there is a barcode on the shelf, for every row of items or section of items, and when the procurements - sorry, when the staff member within the hospital or the ward notices that the items have gone down below their minimum levels, they can then scan that code through the STARR app and input how much more they require. So it saves them having to manually go back to their desk and actually type in and raise a requisition for every single item on that shelf.

Q. So the ordering process is simplified because they see they need an item?
A. Yes.

Q. They scan the item using the STARR app? They put in the number of the item that they want to buy and then the procurement automatically happens thereafter?
A. Absolutely, and DeliverEASE has a hard and - I guess a hard or a physical component to it and a software component. So the physical component is getting the storeroom right in the first place, so actually making sure that there's a level of organisation without - within the storeroom, to enable anyone who walks in, irrespective of which facility they work in, to locate whatever item they need.

Q. So it's a standardisation in a physical sense of storerooms?
A. Yes.

Q. Across the system?
A. Yes.

Q. So if a nurse needs to go and get a particular sized bandage, he or she would know that they - whichever hospital they happened to be in or whichever ward, if they go into the storeroom, it's going to be in roughly the same location?
A. Correct. So that's the physical piece and that's very important, before you go down the path of any software or automation, that you have to get the physical nature of that storeroom organised.

The second piece is the software, which is the smarts behind the ordering - the inventory management. This is where how could you actually automate that ordering process, and where we are right now is really the first phase, which is - and sorry if I'm adding a little bit further to your question.

Q. No, no.
A. So the first phase involves, okay, we've got the physicality sorted out. The second piece is how can we automate that? Automation occurs in two ways. The first one is ensuring that you have the right stock levels on the shelf, and this is where the min/max comes in, minimum and maximum levels.

Q. Pausing there, who decides in respect of any particular item what the min and max should be for that item in any given ward?
A. So this is - the project team works directly with the LHDs to ensure, at a ward level, what should you really be having on that shelf and -- -

Q. Can I ask you to pause there?
A. Yes.

Q. So a ward that might have a very high turnover, maybe a busy metropolitan emergency department, might need a large number of bandaids on stock because they might go through a large number of them.
A. Yes.

Q. The equivalent department in a small regional centre might need much smaller quantities, because if they had a large quantity, they would end up holding on to them until they went off?
A. Absolutely.

Q. So there is tailoring, is there, of the min/max levels in each of those settings?
A. Correct. There's customisation around those min/max levels, depending on the ward. Not every ward is going to - as you said, not every ward is the same.

Q. Before we move on from that, is there - in terms of part of that process, has that generated any consideration of the volumes in which items are supplied? Perhaps to give a practical example, we've been told that a particular item which is available in a box of 50 is delivered to a small regional outpatients or LHD emergency department, where they're lucky to use two of that box before they go off. But as they understand the system, you need to buy the box, because that's all you can do, and so they repeatedly buy a box, use two, throw 48 away, buy a new box, ad infinitum. Is that something which is being looked at through this process?
A. Absolutely. The aim of DeliverEASE is to eliminate waste, and waste is something that obviously we shouldn't have anywhere, and part of the exploration phase of DeliverEASE was we identified a lot of stock that was on the shelf that was actually expired because of, one, individuals not being able to locate it in the first place; but the other was historically, as an orderer or a nurse unit manager, or whoever is placing the order, "I feel comfortable always having six boxes of something, even though I may not necessarily go through the six boxes in three months, but that's just how I - you know, I've always done it that way and that's how we're doing it."

But the reality is DeliverEASE will eliminate that waste by really targeting what that ward, an individual customised ward, requires to enable it to continue until the next ordering cycle, without having expiration date issues based on that. So the Onelink warehouse can break down products. There is no reason why a ward or an individual feels that they have to procure an item that will take them 12 months to go through. That shouldn't be the case.

Q. In the example that we've been given - and I can't, I must say, remember what the item was, but that probably wouldn't matter, although you might know them all - there's a possibility, is there, that the person who's ordering the box of 50, perhaps just is not on top of the functionality of the system which would enable them to order two, if that's all they feel they need.
A. Correct. I would imagine that in this particular example, DeliverEASE has not been rolled out to that facility, and possibly there's a lack of knowledge back to Onelink, and this is where I guess, from a contact perspective, the procurement lead for that district would be aware to say, "Actually, if I'm aware of this, I will contact Onelink and say, 'Can you please ensure that next time we place an order for this, we don't get a box of 50, we only get a box of 2'?"

Q. But your point is with the DeliverEASE system, once it's in and operational, the item gets scanned, "How many do you need?" You press "2".
A. Yes.

Q. And that's all that's going to arrive?
A. Correct, correct.

Q. I think I diverted you. So the first step in DeliverEASE was setting up the storerooms?
A. Yes.

Q. The second step was setting up the STARR app platform that enables a scanning of the items to assist in the ordering?
A. Yes.

Q. And there's this process of customisation of the min/max in each particular storeroom to make sure it suits the needs?
A. Yes.

Q. We've heard a lot over the last week about nurses, store staff and procurement, operational staff, counting items in storerooms. Is it anticipated that the DeliverEASE reform will reduce the need for that manual counting?
A. Yes.

Q. How is it going to do that?
A. In two stages. So the first stage will be - at the moment we're gathering the data to build up a picture and a history for every ward. The first stage of evolution for the deliveries is what is called a "proposed order", an order proposal, where the - after a period of time of data gathering the system and the algorithm will be able to say, "Right, based on historical usage, and the next time you're going to get delivery, you will need X amount of items", because it's already got that history of reordering within over, let's say, let's call it, a 12-month period. So it has developed a pattern, so to speak, to understand, that well, every time - and within that period of time, you know, within the month of November/ December, you ordered X amount, and you go through that amount every day, you will need this and --

Q. Just pausing there, that information is being gathered based on current ordering practices?
A. Yes.

Q. So as the procurement store officer goes into that storeroom, counts what's there, enters into DeliverEASE, how many more they need to get to the max, that data is being harvested to produce a predictive system that says "It's December, you normally use 100 of these during December, it's been a while since you ordered them, and so we anticipate if things are going to plan, that you should be placing another order"?
A. Correct.

Q. To work out whether or not that predictive system is - or the prediction is right, someone will still at the moment need to go in and count to see what's in the storeroom to make sure that there hasn't been a surge, or that there hasn't been a slow month or --
A. Correct. And the reasons for the cycle counts that - you would have heard that term over the course of the week. The reasons behind these cycle counts is because that's the only way to understand what stock is on the shelf.

As clinicians/nurses, are taking stock from that room, the only way for the system to be dynamic and transparent enough is every time you would take out a bandage, you would have to scan. Now, they're not - that's not really practical in our environment, and the environment/setting that they are in, and hence why there's an algorithm that

sits in the background that would require a data feed over a period of time to build the intel to say, "I think this is what you need, and if you agree, press 'Okay', and that's all you have to do."

Q. So one efficiency there is you don't need to punch in the number that you need; you can just say that looks right?
A. Yes.

Q. The second efficiency is, would I be right, it might reduce the frequency of physical counting if people within the wards become comfortable that this predictive ordering is pretty right, but there needs to be probably a stocktake done at a wider interval than is currently happening?
A. Correct. You still will need to have those stocktakes to make sure that the system has the right data.

Q. You mentioned the scanning in, scanning out. Is that a future - is that something that you have in mind as a future development to the DeliverEASE process?
A. No, because again, the practicality behind scanning every single item that goes - that's being consumed, and then reliance on those individuals to actually scan them, so the scanner is still a manual, physical item that you have to apply. So if individuals don't scan items that they're taking out of the room, then there's no point in having a scanner there. So we realise, we're practical enough to understand that that's not really a practical solution, hence why we've got that intel and smarts in the background.

Q. To the extent that that is a practical solution - so, for example, you are undoubtedly familiar with the h-trak system?
A. I am.

Q. And what we've been told is that where that h-trak is being used in theatres, for example, there is a physical scanning of every single item that is used in every procedure from the swabs down to the - up to the prosthetic device?
A. Yes.

Q. In that instance, is the DeliverEASE system able to accommodate a push/pull model based on the scans?
A. The items in theatres are quite high value, and

obviously apart from the smaller swabs and bandages that you may have mentioned, but the reality is that h-trak is also there as a transparency and costing solution. So it does offer, in its off the shelf configuration, a costing of a procedure - so how much does a knee replacement or hip replacement, or whatever the procedure may be, what was the cost of that? So it enables the district to sort of understand holistically where that - where they are, and potentially understand from a funding perspective, well, this is where our efficiency lies at that level.

It does also, obviously, track implantables, so prostheses and other items that are used in the procedure. But the volume that is involved in that scanning is not as high as it would be in a typical ward storeroom, so there is quite a - those items in the ward stock room are very fast-moving items, and again, at the pace that staff would be working on, it would be an interruption in that work flow, particularly, say, in an ED environment.

Q. So the question, though, is accepting that that may be right --
A. Yes.

Q. -- where it is being done, in theatres - we're coming, I think, to the next of the reforms, the SmartChain reform --
A. Yes.

Q. -- that will involve scanning of the type which is currently used in the h-trak system of consumables and - anything that's used in the operation; is that right?
A. So the SmartChain solution, or SmartChain, is - again it's a solution, but it is a project name, it's a solution name; it's not a different system per se. SmartChain is not a replacement for h-trak. h-trak is a patented software that is owned by a vendor and it's a stand-alone system. It's not integrated within our enterprise system.

The solution that is tabled as SmartChain, what that is going to do is to essentially look at what are all the features and solutions that we need at a theatre level, at a ward level, holistically across the entire supply chain, and essentially connect all that together.

So to answer your question around scanning in and out within theatres, that will continue, that can continue, so

the software will allow that to happen.

Q. That is, the software that underlies the SmartChain solution will continue to allow that scanning to happen?
A. Correct. Correct. So we --

Q. So my question in relation to that is: to the extent that the scanning will be a feature of at least some part of future operations under the reforms --
A. Yes.

Q. -- is it contemplated that that scanning process could be used to do away with or greatly reduce the need for physical counting in storerooms, at least where that scanning is happening, for example, in theatres?
A. It's possible, but it's not part of the solution at the moment.

Q. Okay. Could I ask you to go to paragraph 94 of your statement.
A. Yes.

Q. You identify there some of the key challenges in delivering the procurement reform program, including resourcing?
A. Yes.

Q. In terms of facing those challenges, have you looked at the way that procurement and supply chain systems are run in other settings, so, for example, the private hospital settings?
A. I haven't personally looked at private hospital settings, but certainly through my experience, over two decades-worth of experience and knowing, at a supply chain level and a procurement level, the holistic end-to-end supply chain models that are out there, that is informing a lot of the input into this, but also liaising with other colleagues in the industry, the supply chain industry, to understand, at the end of the day, the supply chain is pretty consistent across whatever setting you have. Obviously it's varying in complexity based on whether it's a hospital or whether you are in the hospital industry, so there are risks that have to be managed in those various settings, but ultimately, what we are aiming to do here is to eliminate a lot of the manual input and inefficiencies that may exist simply because historically we've never really had one holistic, end-to-end supply chain ecosystem

and --

Q. Have you, or has anyone within health to your knowledge, looked at the procurement systems and logistics systems which are operated within private hospital networks to see whether they could be adapted for use in the public hospital setting?
A. I'm not aware of that.

Q. Has anyone, insofar as you are aware of, looked at equivalent supply chain and logistics type operations in perhaps different but vaguely analogous settings like aged care facilities and the like?
A. I'm not personally aware of that.

Q. And as part of the process of considering how to - or whether and how to roll out the reforms, is consideration being given to any - to contracting them out to a third party, for example, an Amazon or someone like that?
A. Sorry, just to clarify your question, are you saying to actually contract or put out the entire supply chain process to a third party?

Q. Yes.
A. We have looked at - and when I say "we", as in my colleagues in HealthShare and eHealth, who are obviously driving a lot of that project implementation, visited Amazon warehouse to sort of see at an enterprise level and a system level what that looks like, and some of the smarts, and obviously there's a level of sophistication around order picking and packing and obviously with, you know, an organisation like Amazon.

So there has been some leveraging of that knowledge to try and understand what is industry doing out there that we, one, can leverage, but also understanding that there's an inherent risk by simply putting out our entire supply chain to an organisation and really kind of saying, "Here you go. You can manage this for us." Obviously it's very different if an order is missed for - you know, if you don't get an Amazon order today and you get it the next day, it's not an issue, but for us if items are running low for a certain reason, it's important that there's a greater level of involvement and ownership of that supply chain ecosystem.

Q. Could I ask you to turn back to paragraph 93, so

that's just the page before that one.
A. Sure.

Q. You tell us a little bit about what you perceive to be some of the benefits of the procurement reform. I'm just wondering, particularly in relation to a, 93a, how is it that you perceived the reform program is going to produce that as an outcome? Perhaps I should take it in two steps. What do you regard value based care to be, where you use that term in 93a(i)?
A. Value based health care for me is all about patient outcomes and the primary focus of that is the outcomes that we can achieve for our patients. Everything that we do is all for our patients.

Whilst the word "value" is there, I think we need to - we need to make sure that we don't associate "value" plural with price. It's - value encompasses, you know, the efforts of staff but also the value that the patient has in the end after their surgery as well, which is related to their outcome. So that's, for me, what value based health care is. It's really all about patient outcomes and how we can approve that outcome for the patient.

Q. So how is it that the reform procedure, as you envisage it, is going to assist in delivering better patient outcomes?
A. From a procurement perspective, the - all the systems that we're working on and these improvements across Oracle, and, you know, to be specific, the SmartChain solution is an example, what that will enable us to do is to ensure that we are maximising the commercial value of what we're procuring, which can then translate into, obviously, operating within the same envelope, cost envelope, so to speak, but actually getting more items and getting greater commercial value for those items.

How that is going to be achieved is by saying, well, ensuring that every district is procuring the items at the correct price and ensuring equity and availability for those items across the entire system. You know, some of the things that we've discovered through the reform program for SmartChain and also master catalogue, which you may have heard of across the week - some facilities, some districts, are paying a different price for the same item that another district is paying for --

Q. So, cutting to the chase, is the point that you're making there that by generating economic efficiencies in procurement, that will free up money?
A. Yes.

Q. Which can be used to deliver - assist in delivering clinical services?
A. Yes.

Q. And thereby drive better patient outcomes?
A. And also the level of efficiency that will be associated with also freeing up staff. So ensuring that staff are able to focus on patients rather than having to focus on placing orders.

Q. Can I ask you to jump back to paragraph 87, which is on the previous page, page 30.
A. Yes.

Q. In relation to that one, can I just ask you to read that to yourself --
A sure.

Q. -- so you familiarise yourself with what we are talking about?
A. Yes. Yes.

Q. Where you refer to "volume discounts: That's fairly understandable. Talking about "equitable procurement across geographic areas", can I just ask you what you have in mind when you refer to that?
A. Given the scale of the system that we have in NSW Health, we're obviously spread across the entire state, and it is fair to say that it can be challenging logistically for those districts that are in rural and regional settings, what we're trying to ensure is for those districts to not be disadvantaged and have equity across that item portfolio. In other words, whatever a district in metro is able to order and procure, whether it be, you know, a particular good or a knee or a hip, or whatever it may be, that a district in rural and regional is also able to procure that and not be disadvantaged simply because they are, you know, 400 kilometres away from the city.

Q. When you say equally "able to procure", do you mean at the same price?
A. At the same price but also at the same availability.

In other words, you're not going to have to wait, you know, two weeks for a product that is readily available in metro. They're some of the things we're wanting to make sure, that every setting is the same.

Q. So dealing with consumables, medical consumables first, there's the Onelink warehouse we've heard about?
A. Yes.

Q. Items get delivered to the Onelink warehouse?
A. Yes.

Q. And are then distributed to LHDs?
A. Yes.

Q. Are we right in our understanding that there is a transport cost associated with delivery from the Onelink warehouse to LHDs? LHDs that are more remote from the warehouse pay more for the transportation?
A. There is a - my understanding is there is an add-on charge, simply because of the logistics costs with having to go out to that area. However, the base price of that product is the same.

Q. That's because the base price of the product is product as delivered to the Onelink warehouse?
A. So the product that comes out. So if we take a product that is costing $5, so a metro LHD would pay $5 for that product because there's no delivery charge, it's obviously built into that model. A district in rural and regional may pay $5.30, for example, because there is an added-on cost to be able to get there. However, the $5 price that's charged is the same across; it's just that additional cost for the recovery of that logistics.

Q. But in terms of the costs associated with getting that item to the more remote LHD, that's not a cost that's being absorbed system-wide?
A. No.

Q. It's being borne solely by the more remote LHD?
A. Correct.

Q. So the concept of equitable procurement, at least in that respect, is not working, at least in a perfect way?
A. No, but then you would have the issue of one subsidising the other. But the volume, I guess, if we - if

you look at it from a different perspective, the volume associated with some of the rural and regional settings is far less. So that additional supply chain cost may be - you know, when you actually compare it to the cost of the item itself, can be very, very small.

Q. So that's in terms of the transportation costs?
A. Yes.

Q. We have heard some evidence given by procurement people within the LHDs about this concept that metro LHDs might be able to acquire an item for a lower price than that which is on the statewide contract.
A. (Witness nods).

Q. And it's been, I think, suggested that the reason that that is not allowed to happen is because the single price means LHDs, whether they be remote or metro, should be able to procure the product for the same price, and that's the way in which equity, in the way I think it's described in paragraph 87, is delivered?
A. Can I clarify with your question, do you mean an item - you did say that it's not on the statewide contract, but is it an item that is actually even used in NSW Health at all?

Q. So, for example, this is a piece of imaging equipment, I think is the example that's been given.
A. Right. Okay. Probably imaging is not - I wouldn't say - I wouldn't use that example only because imaging is very transparent, so if you are transporting a piece of equipment, both metro and regional will have a delivery charge. If we take another consumable that's not through the ward, so it's an item that the suppliers deliver directly to the facility, those items are actually at the same cost. So suppliers don't actually charge an extra delivery charge, so there's equity when you compare those directly delivered items.

Some of those examples that are being raised are probably relating to items whereby some suppliers, who have missed out on actually picking up a part of a contract, are then saying, "Well, I've missed out on the process. Let me try and go into the district through another avenue." So there's probably a level of undermining the actual procurement process itself by simply saying, "Let me try and go down that path", or, in some instances whereby we

have volume based - market share pricing, and that market share pricing relies on a certain volume or pooling of volume to a particular supplier, another supplier who may only have a certain market share would want to say, "Hey, I want to increase my market share. How about if I just simply, you know, give you a better deal", which again would then try to undermine - well, you've got another supplier who does all the right things, and who is offering a great price. Why is someone else trying to undermine it? My question to that would be if they can offer that, why didn't they offer it as part of the tender submission?

Q. Can I ask this about the process.
A. Sure.

Q. Is it the case that items sometimes could be acquired more cost effectively in the metro areas than in the rural and regional areas - not under the state contract. Were the metro and LHD to go it alone, they might be able to secure a better price for an item than, say, a smaller rural or regional LHD?
A. I don't believe rural or regional would hinder the ability of the metro LHDs in totality to be able to get a good price.

Q. So when you say that, are you saying that the price that is achieved for the metro LHDs --
A. Yes.

Q. -- is the best price available; it is not a compromise in any way to reflect the fact that that price needs to be delivered not only to the metros but also to the rural and regional LHDs?
A. I think we would have to look at the particular scenario and example. I don't think there is a one size fits all or a template solution to enable me - I can't answer that question fully without actually knowing a particular live example that would occur and the circumstances.

If I can add on that note, we have - again, you know, we do hear these things as well, and to address that, again, we're very open and transparent, and it's very important for me, and I've made this very clear to all the directors of finance across all the districts, no district should be worse off by being on a statewide contract. And what I mean by that is if there is evidence that you can

show me that by you coming on a statewide contract you've actually gotten to a worse position, both I and the CFO, the chief financial officer, will look at that and analyse the situation, this particular situation, and say, "Right, well, if, hypothetically, there is a total system benefit of $1 million for this particular whole of health contract, and the district may be able to get an additional $50,000 in there, then we will look at how we can adjust that so that the district doesn't feel like, 'Well, I'm actually worse off now, I'm trying to do the right thing but I'm in a worse-off position'". But as a system, holistically, we are in a better position by having a whole of health contract.

Q. In relation to that, can I just explore with you the sophistication of the modelling that goes into working out whether, at the time of entering into the whole of health contract, it does actually reflect the best value for the system?
A. Sure.

Q. So let's say a piece of capital equipment, bedside point of care machine, maybe?
A. Yes.

Q. To what extent, in working out whether or not a particular contractual arrangement is a good one, is an assessment made of the statewide fleet of point of care machines, the location and the - say the - which of them are toward end of life and where they might be?
A. Sure. So in this particular example, the first thing is obviously the - whether that machine is fit for purpose. So does it - the first criteria, and generally the first criteria for us is the non-price weighting of the assessment, and this would be fully reviewed by the tender evaluation committee.

So their focus is to say, "Right what we're procuring, is it fit for purpose? Is it innovative, in other words, does it actually offer the best in class, best in market? Is it going to really cover all our requirements from clinical service delivery?"

Q. So step one, you look at whether the piece of equipment you're buying is the most desirable piece of equipment in terms of its attributes?
A. Yes. Forget price for now.

Q. Step two is price?
A. Correct. So the second step is, "Right, here are all the items", so after they've actually put a weighting based on their evaluation and expertise on those - on the evaluation criteria. And, by the way, the evaluation criteria is set before we even go to market, so it's part of the procurement plan. When you are going to market, you have to set up a weighting and evaluation criteria that's preset, so there's no - from a probity perspective.

And price is not looked at when you're doing that first section. The price generally in some cases is only 30 per cent because it's very important, again, relating it back to patient outcomes, it's not about price, it's actually about getting the right outcome and the right outcome would be through procuring fit for purpose equipment.

The price is then looked at, so the commercial offering by that vendor or provider is looked at, and it may not be that one supplier covers everything. Generally, it's never one supplier covering an entire system, because in most cases, it's a risk as well, you are putting all your eggs in one basket. But also, there is a level of clinical choice, so we're not restricting and saying, "You must only have one supplier, and this is the only thing you must procure." There is a level of clinical choice out there, and because --

Q. Just asking you to pause there, in relation to that clinical choice, is consideration given at your level to the benefits of standardisation across the system?
A. Yes.

Q. How does that factor in to the evaluation of a tender?
A. So you have to strike the right balance, and when I say by describing the right balance, is if, at the moment, we're moving from 10 vendors of one item, which essentially is there because we've allowed, you know, everybody to really choose whatever they want, versus a tender evaluation committee that is made up of clinicians and experts and subject matter experts saying, "Actually, we can really go from 10 down to 4", as an example.

Q. For example.
A. Yes, as an example. Then clinically, if there is no

need to - and, you know, deemed by the SMEs, the subject matter experts - if there is no need to go beyond the four and, you know, we can actually achieve the same clinical outcome and then have greater level of value by pooling and more greater level of volume through the system, then why do we need to do that?

So in my consideration of contract award I do look at the evaluation report and the recommended evaluation report, particularly for whole of health contracts, where I can sort of see the variability in some of the pricing, the variability of the evaluation committee - and also the evaluation committee also has to sign off on that to say "Yes, we agree with the recommendation".

Q. So the evaluation report sets out the way in which the particular item has been assessed relative to a number of criteria?
A. Yes.

Q. Including patient outcomes?
A. Yes.

Q. And perhaps performance of the contractor?
A. Correct. There are a number of, I guess, "must haves" within the contract. So the supplier has to conform to some minimum requirements, like any other engagement, because we do have, you know, liability insurance, et cetera, et cetera, et cetera, so there are a number of "must haves" that they have to conform to, and if they do want to deviate from that, then obviously we won't completely rule them out but we have to obviously have that conversation. Then the assessment of the clinical aspects of that product is then conducted by the tender evaluation committee.

MR MUSTON: I note the time, Commissioner. I've probably only got about 10 minutes to go, if you are continue to sit on.

THE COMMISSIONER: I'm content for you to continue.

MR MUSTON: Q. I think you told us a moment ago that price is only around 30 per cent and so 70 per cent is made up of this other array of considerations --
A. Yes.

Q. -- as to what's perceived to be the value of the particular product?
A. Yes. Approximately - it can be 30, 35, depending on the item.

Q. Could I ask this: do you know the extent to which that sort of 65 to 70 per cent worth of the considerations are monitored, as to whether or not they are achieved, after the contract has been entered into? Perhaps if I put it a different way: if patient outcomes is a 20 per cent or a 40 per cent consideration --
A. Yes.

Q. -- do you know whether there is any ongoing monitoring or assessment of whether the patient outcomes which have been hoped for in choosing to get that product have actually been achieved?
A. There is certainly feedback of data through our colleagues in ACI and also the system reform branch and essentially the value based health care team and commissioning for better value team, they would monitor some of those patient outcomes flowing through.

Q. To what extent is that a formalised process, in the sense that if a particular wound care item is chosen because the clinical evaluation or tender evaluation committee come to the view that, "Well, that one, we think, is going to produce better outcomes", to what extent, in relation to a run-of-the-mill item like that, would you expect to see any monitoring or reporting back of whether or not these outcomes have been achieved?
A. I think probably that question is more - would be better directed to ACI around how that monitoring works, because I certainly don't have that level of interaction.

Q. In terms of other considerations like general performance under the contract, to what extent, if at all, are you aware of any monitoring of contractual performance, in terms of things like, say, delivery standards and the like?
A. Yes. So what I'm advised of and aware of is that for whole of health contracts, HealthShare, being the category managers per se, they have a responsibility to monitor the performance of those suppliers and have regular supply meetings to go through some of those metrics that the supplier said, "I'm going to comply with this" - have they actually complied with those metrics or not? Then also it

is an opportunity to provide feedback that would have filtered up or made its way up from the districts. So districts have a channel whereby they can contact the HealthShare respective category manager and provide that feedback to them.

Q. Without going through it in detail, the sense we've got from some of the evidence given is that noncompliance with - let me take it back a step, that failures in terms of delivery and the like make their way up to HealthShare in a reasonably ad hoc way, and only when it becomes a serious problem.
A. Yes.

Q. In those circumstances, would it be right that, at least insofar as you are aware, there is no overall system-wide monitoring in a forensic way --
A. Yes.

Q. -- of the extent to which those sort of KPIs are being complied with by --
A. Not at present, no.

Q. And you would agree, wouldn't you, that noncompliance with delivery requirements and the like produces knock-on costs in LHDs in terms of time spent dealing with suppliers to remedy the problem?
A. Possibly.

Q. And the potential need to reorder or rearrange operations within an LHD to deal with that noncompliance at a practical level?
A. Possibly. I guess it's important also, if I may add, supply chain is not a perfect science, in that in any supply chain setting there will always be situations where sometimes, you know, the delivery in full on time may not occur. But it is how you actually manage that. That's the key thing for me. I think by having an end-to-end ecosystem that we're looking to build by saying, right, well, from the time the stock arrives at the dock and it's been receipted to how it actually then goes into the stock room, and making sure that items are recorded within the system, would then enable us to have a bit more visibility and transparency so that we can have a greater level of data about performance.

Q. So you anticipate that the reforms, once they become

more mature, will enable a greater level of data gathering in terms of performance?
A. Yes.

Q. Is there any document that has been prepared which sets out in a detailed way the pathway and ultimate destination of these reforms?
A. So there are business cases, so SmartChain, if we take SmartChain, so SmartChain has a business case that sets out the current phases for the SmartChain initiative or the SmartChain project, I should say, and it obviously sets out the benefits associated with the solution and the different phases that are within SmartChain. So, you know, traceability being one of them, which you touched on previously as relating to h-trak. So there is that document that outlines what the solutions are. But it's also fair to say - and we've proven with this procurement reform - that once you establish a foundational enterprise platform and say, "You know what, we can actually tap into this platform further than what we've got and continue to evolve" - so with supply chain, it's always an evolution, so we can continue to evolve and add on other features where possible, but for us, we've prioritised these streams at present because we feel they are critical and important for us, but it's fair to say that it's an evolution, we will continue to evolve.

Q. In terms of the roles and responsibilities, who do you understand to be ultimately responsible for the contract management of the statewide and whole of health contracts? Is it HealthShare?
A. Yes.

Q. So to the extent that monitoring of performance metrics needs to be done, it's something which needs to be done or needs to be driven by HealthShare?
A. Yes.

Q. So even if the only way at the moment of doing that is by inviting procurement teams within the LHDs to gather the requisite information and pass it on, that's something which HealthShare should be doing?
A. Yes. So we have - I mean, to that point, we've recognised the importance of contract management, and certainly invested - and the ministry - the ministry has funded 76 FTEs, 43 across the districts, across the LHDs, as a one-off investment for two years, and then 33 across

HealthShare, eHealth and pathology, to really address that, to just ensure that there is that contract management investment within the system. It's a crucial part of the procurement lifecycle.

Q. In terms of other contracts, not the statewide and whole of health contracts but, say, the contracts in excess of $250,000 where the tendering is delivered by HealthShare, who do you see as being ultimately responsible for the contract management of those contracts?
A. If it is a local agreement, so if it is a local contract only for that district, it is the district that will be managing that contract.

Q. Could I ask you to go back to paragraph 48 --
A. Yes.

Q. -- on page 14 of your statement.
A. Yes.

Q. First, it is a long paragraph. Can I ask you to go over two pages to page 16. You see subparagraph h at the top there, where you identify some of the actions taken as including embedding value based health care into the system-wide procurement activity?
A. Yes.

Q. Again, you have told us a little bit about value based health care as you understand it, but do you want to add anything to what you have already told us about how you see value based health care as having been embedded into the system-wide procurement activities?
A. No, nothing further.

Q. Would it be right to say that the way in which value, as represented as a patient outcome, is assessed, is wholly through this tender evaluation committee process?
A. Yes.

Q. Can I ask you to turn back to page 15, where you refer in subparagraph f at the very bottom of that page to what you have perceived to be the benefits of or a benefit in implementing a NSW Health community of practice?
A. Yes.

Q. Who do you anticipate might be incorporated into that community?

A. So a perfect live example is the pharmaceutical procurement governance committee which I chair, and that is made up of all - or a number of directors of pharmacy across the system, and in this situation, what we're saying is, right, we're obviously discussing the formulary and how it's being implemented across the system, but at the same time, it's then focusing on phase 2, which is, right, how are we then maximising the benefit of that formulary through the procurement contracting piece, so implementation of a statewide contract for a certain tranche of pharmaceuticals, how are we tracking on that? So this is a community of practice where we've got directors of pharmacy from across the system who are actually providing that feedback to us around directly any challenges, how can we help them, what level of support they need from HealthShare, given HealthShare is really driving that contract management piece and have supported and provided a level - a good level of support into implementing those contracts.

Q. Do you see a role for suppliers on that or within that community of practice? For example, the community of practice that you have just spoken of, do you see potentially a role for pharmaceutical manufacturers to come and be part of that community to say, "This is what you guys think is the way to go. We, with our various product offerings, think there is a different way, perhaps a better way, that you could go, which would produce better outcomes"?
A. Possibly. We are, on that note, actually embarking on having supplier forum days, and this is - you know, one of the supplier forum days which we have booked in the agenda at the moment is to actually bring in our top two suppliers to talk about a number of opportunities and the direction for health, so that it is important that we have a two-way relationship with our suppliers so that they also know where we are heading, the same way we know about them.

But, yes, it's possible to have a specific supplier forum that addresses this. We have to obviously be careful around confidentiality and how we - what issues are discussed as part of that forum.

Q. And the same presumably would apply to medical technology suppliers?
A. Yes, correct.

Q. Am I right in my understanding at the moment, to the extent that there might be some advance or development in medical technology which could be to the benefit of patients in New South Wales, the primary way that it enters the thinking is a representative of some company that manufactures this device or technology might seek to persuade a clinician somewhere within the system - or more than one clinician - that it is a great development and something that should be used?
A. That is one path that exists but the other path is also when a head agreement is set up, or a standing offer agreement is set up - and let's take the example, it is set up for five years - within that five-year period there are opportunities to refresh that panel and refresh the, in this case, medical piece of equipment, say if we take a CT scanner or an MRI machine. There is that opportunity through the refresh of that standing offer agreement to enable us to understand what has occurred over, say, the last two years, and enable additional technology to be added to the SOA through the supplier panel.

Q. But just in relation to that refresh process, how does the fresh water flow into the tank? Where does it come from, this new information about developments?
A. It comes from suppliers to HealthShare.

Q. So these are suppliers who are already on contract?
A. Or they may not be on contract and we add - we can add them to the contract by going out to market. So it's an open - we're not restricting it by any way and we're saying, right, there may be other pieces of technology out there that have been finalised and completed over the last 12 or 24 months - technology is evolving and it is important for us as a system to ensure that we can have that adaptability within our head agreements.

MR MUSTON: I have no further questions for this witness, Commissioner.

MR GYLES: I just have one question, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Mr Gendy, the statewide contracts are obviously an integral part of what you are trying to achieve, and that facilitates standardisation of products for the reasons you have already told us, that benefits can

be obtained from that?
A. Yes.

Q. So just again so we can understand, the statewide contracts in the formation stages, HealthShare has a role in that, but ACI and the clinicians - do they have a role in that process and, if so, how does that work? How does that come about?
A. In terms of the introduction of new pieces of technology or --

Q. Well, no, no, just in statewide contracts generally, the role of ACI and/or clinicians in those decision-making and the formation of those contracts?
A. They are directly involved in the assessment of the non-price criteria, which essentially assesses the fit for purpose, whether that product is going to be, I guess, meeting our requirements for safety and clinical service delivery as well.

Q. And that's, in effect, part of a value based as compared to --
A. Correct.

Q. Sorry, a value based method of procurement?
A. Correct. And it's important also that as part of that consideration from a commercial perspective, that the total cost of ownership is taken into account.

So there is no point in taking on a piece of equipment that has a very small up-front cost but does cost us quite a lot every year to maintain because of a certain level of consumables - again, I'm not the expert, but that could be a scenario. So it's important that we take that holistic approach when we are doing that evaluation.

MR GYLES: Thank you. Thank you, Commissioner.

MR MUSTON: Might the witness be excused?

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

THE WITNESS: Thank you, Commissioner.

THE COMMISSIONER: You are free to go.

<THE WITNESS WITHDREW

MR MUSTON: Thank you, and can we extend our gratitude to the court reporters who have sat 20 minutes longer than normal.

THE COMMISSIONER: Yes, thank you.

We will adjourn until 10 on Monday.

AT 4.25PM THE COMMISSION WAS ADJOURNED TO MONDAY, 26 FEBRUARY 2024 AT 10AM

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