PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO PUBLIC SECTOR CONTRACT MANAGEMENT PRACTICES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 14 AUGUST 2019

Members

Dr A.D. Buti (Chair)
Mr D.C. Nalder (Deputy Chair)
Mr V.A. Catania
Mr S.A. Millman
Mrs L.M. O'Malley

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Hearing commenced at 10.29 am

Dr DAVID RUSSELL-WEISZ
Director General, Department of Health, examined:

Mr MARK THOMPSON
Chief Procurement Officer, Health Support Services, Department of Health, examined:

Mrs AMANDA JEAN JALLEH
Executive Director, Resourcing and Purchasing, Department of Health, examined;

Mr JEFFREY MOFFET
Chief Executive, WA Country Health Service, examined:

Mr PAUL FORDEN
Chief Executive, South Metropolitan Health Service, examined:

The CHAIRMAN: Thank you for appearing today to provide evidence relating to the committee's inquiry into public sector contract management practices. My name is Tony Buti and I am the committee Chair and member for Armadale. With me today are, to my right, Mrs Lisa O'Malley, member for Bicton; and to my left, Mr Simon Millman, member for Mount Lawley; Mr Dean Nalder, the committee's Deputy Chair and member for Bateman; and Mr Vince Catania, member for North West Central. Thank you for your submission to the inquiry. It is a great help. We are likely to publish it after today's hearing, but I wanted to check with you to see whether you have any concerns that you would like us to take into account before we do so.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Although your evidence is protected by parliamentary privilege, this privilege does not apply to anything you might say outside of today's proceedings. Do you have any questions about your attendance here today?

Dr RUSSELL-WEISZ: No.

The CHAIRMAN: We have a series of questions, but do you have an opening statement that you would like to make?

Dr RUSSELL-WEISZ: I do have one, Chair, if you are happy for me to make that, just to put it into context. Thank you for the opportunity to address the committee today. You have met the team. My colleagues here have considerable expertise in contract management and will be able to assist with the specific questions today. We have two of our chief executives—one from country and one from metropolitan—our chief procurement officer and the executive director, Amanda Jalleh, in charge of the contract management in the department.

I would like to spend a couple of minutes to set the scene on how procurement and contract management works within a very large and complex agency such as Health. We have approximately 8 500 active suppliers who need to work as a complete supply chain to deliver excellent health care. These suppliers provide a range of goods and services, including information and communications technology, works, facilities, maintenance and community services. The Western Australian health system has over 2 200 active contracts, with an aggregated contract value over the term of $24 billion. These contracts are managed by more than 500 staff across the health system. Every

week we spend over $78 million with our suppliers through 5 500 transactions. Following the enactment of the Health Services Act 2016, the WA health system moved to a devolved governance, enabling decision-making closer to patient care. Health service providers, which are called HSPs, were established as separate statutory authorities governed by a board or a chief executive. This meant that all authority and accountability no longer rested with the director general and Department of Health. With an annual budget of just under $9 billion, approximately 44 000 staff and more than 90 hospitals, the WA health system is too large and too complex to be operated under centralised governance. Health service providers operate within a public sector accountability framework and have obligations under legislation, including the State Supply Commission Act 1991, the Financial Management Act 2006 and the Public Sector Management Act 1994.

The health service providers and the department have a partial exemption under the State Supply Commission Act that allows them to undertake their own procurement of goods and services and holds them accountable for managing their contracts. But for the most part, procurement expenditure and contract performance is managed as close to the customer as possible by health service providers, noting that under the State Supply Commission Act they are supported by the Department of Finance through procurement facilitation, oversight and education services. That said, some of the WA health system's procurement and contract management activity is centralised in order to leverage economies of scale. For example, the Department of Health manages a limited number of core services contracts that are utilised right across the health system, including service agreements for road-based transport, for example the St John Ambulance contract; respiratory; rural and remote health; palliative care; continence management; some home hospital services, for example, Silver Chain; and services for younger people with complex care needs, for example, the Brightwater contract. Since 2014, when a strategic procurement reform project was developed and implemented across the WA health system, WA Health has made significant improvements in the areas of contract management and procurement. The reform implemented 23 recommendations that involve developing a program of works to embed procurement policies and controls; promote training, education and capability development; and undertake procurement audits and review. Two subsequent programs followed in 2015 and 2016.

Over the past 12 months, through health support services we have further strengthened our policies and procedures around procurement. For example, we have implemented new purchase order terms and conditions that will improve clarity for suppliers and protection for the WA health system for all goods and services under $20 000. We have released the WA health supplier code of conduct to over 8 500 active suppliers to communicate expectations for both parties. We have established dashboards to provide a range of contract-related insights to improve performance, and delivered procurement and contract management-related training to an additional 1 245 WA Health staff, including executive teams.

I know that Mark Thompson, as the chief procurement officer, has some infographics that he could share with you that show how we go literally from the patient right the way through to procurement. The entire health system remains committed to continuing to improve our purchasing system controls for procurement and contract management. We are, as health leaders, taking the required action to achieve. We have a procurement and contract management system that reflects best practice.

The CHAIRMAN: Thank you. We all have some questions, but I will start. Mark, we will get on to that information shortly. Page 11 of your submission states that the overall approach and standard of contract management across the WA health system has scope for improvement, as noted by a range of previous reviews and reports. In what specific areas, or area, is this scope for improvement still most evident?

Mr THOMPSON: I will give you a list of the key things we are working on currently to improve that. We have come across quite a few areas in which we were buying off contract, so we are bringing those things on to contract. Recently, we brought an extra $13 million of spend into contract. That has done three things. First, it has taken about eight per cent out of the price. Second, it has improved our terms and conditions when we are buying things such as cochlear implants. Third, it has made us more compliant. That is one piece we have done just recently. We did that in a very fast turnaround.

I have been here about 14 months. When I came in, the terms and conditions on our purchase orders were not very explicit. They actually took you to a website and you were not quite sure what the contracted terms and conditions were. We have introduced three pages' worth of simple terms and conditions. They are quite contemporary and are communicated to the vendors. We implemented that in about a three-month period, which has given us a lot more protection around those smaller value purchases, because we still do a lot in that space. As a result of CCC findings, I released a supplier code of conduct that I communicated to the vendors. It refers to our expectations of them and their expectations of us. It also states that if they have any issues or concerns, they can contact us and flag them. We had a couple of parties come to us and talk about some things that were going on.

Probably one of the biggest things is that because we have such a big transaction volume and such a big spend, our analytics previously were not as good as they could be. We have much better visibility now into our buyer behaviour. We have 4 300 buyers in the system. There are 4 300 in Health who can go into our purchasing system and requisition things. We have a much better insight into what they are doing. Are they buying on contract? Are they buying off contract? We are starting to target those individuals to help them better use the contracts we have got. We have a much better visibility of our expiring contracts. We have 2 250 contracts, and most of those are expiring in the next four to six years, which creates a challenge of recontesting those. Currently, we are building a three to five-year contract pipeline, which will help us understand when we need to take things to market or go to Finance to see if they have the resources, because I think we are going to struggle with capacity in the system, and then we maybe need to come up with some alternative options.

In concert with that, we have started measuring the DIFOT performance of our vendors; that is, delivery in full on time. We did not have that visible. For our goods, we did not know whether our vendors were delivering late or early, so we have now started some performance conversations with our vendors for the goods that come into our system. We have over 80 000 items that people can buy through our catalogue systems, so it is obviously very important to keep those deliveries in full and on time. We have been working with the Department of Finance over the past four months to reduce our cycle times for procurements. Unfortunately, some of our procurements can take up to two and a half years, which will not allow us to get through the expiring contract pipeline. We are currently working in collaboration with the Department of Finance to identify where the bottlenecks are and what we can do to reduce some of that cycle time.

Each HSP now gets a monthly or quarterly report, which allows them to see any non-compliance, any exemptions, because they all need to come through me, and any contract variations in an expiring pipeline. We are lifting the visibility of what is actually happening in that space.

The other piece that we are implementing, we are starting in HSS, is a thing called category management. Rather than just contract management, category management is a bit more holistic, when you take into account sourcing opportunities and also understanding of the market. Our traditional approach to contract management feels like it has been more process based, whereas I

want to move it to more commercial-outcomes based. The reason we do contract management is to try to get the performance out of new vendors. It is the reason we do the investment.

[10.40 am]

Then probably the last thing I will mention that we are doing currently, with 4 300 buyers, we have to find a way to give them information when they need it. Rather than make them just come to training, we have built little You Tube–like videos so that when they are stuck on how to use the purchasing system, they can go on to it—they can click a two-minute clip and they can kind of see what they need to do in the system to best use the purchasing catalogues that we have set up.

The CHAIRMAN: Thank you. What I noticed by reading the submission and also from the introductory comments is that there seems to be a strong thread that there has been a delegation of greater accountability to the HSPs. I can understand the rationale for that, at the coalface et cetera, but you also mentioned the CCC report. It concerns me a little from reading your submission that the department is trying to devolve or delegate more and more responsibility to the HSP, which is fine, but unless you have very stringent oversight and accountability of that delegation, I think the problem represented before the CCC may be repeated. I do not think you can delegate your ultimate responsibility; you can delegate the operations, but you, as the health department, ultimately have responsibility. I am wondering how you are addressing those concerns so that we do not have a repeat of that corruption that we all have to pay for as taxpayers.

Dr RUSSELL-WEISZ: I think that is probably an answer that I can give and then I may ask my chief executive, Mark, to give. Why we got into the devolvement of governance was that the health department, with 44 000 staff, when you are dealing with clinical services from Kununurra to Esperance to Fiona Stanley Hospital, you cannot have a department that is across every single item of clinical, financial, safety/quality or contract management. We have seen failures. The Department of Health is a relatively small agency of 800-odd staff, in comparison with the other 43 000 staff in the health service providers. We wanted to establish devolved governance where there was accountability. I have worked in both systems. In the past, there was a greyness between the health services and the department. There was basically, at times, a "delegate up" culture. If things got too hard—I am not just talking about contract management—the department was the default; the previous director generals were the default. The devolved governance clearly made accountability at the local level, but established in the act—this, Chair, goes to your point—the department as the system manager. Whenever I look at our role, besides the leadership, stewardship and oversight role the department has, we have three roles. We regulate, so we are hard regulators—we actually regulate certain facilities; there are certain things that we do. That is what you would say is a very hard-nosed approach. We assure, so we give assurance that contract management, for example, is as robust as possible. And we facilitate, so we support the health service providers.

What we have learnt through that CCC report, and in the work we have done since then, is we want to make sure we have the best prevention, the best education and the best detection for any—I hope there is never any—further fraud. Every agency head would say, "We hope we never have a repeat of that", or whatever has affected any other agencies.

But we also believe accountability at the local level, accountability through a board structure, will actually improve the prevention, education and detection rather than it all being invested in the Department of Health. That does not take away the role of the department as the overall system manager, as the overall assurer to government, that we are running an efficient, safe and honest system.

The CHAIRMAN: I understand that you need to devolve because it is so big. How are you therefore ensuring that you are very, very stringent regulators of that devolution of accountability?

Dr RUSSELL-WEISZ: You go first, Mark, and then I might ask Jeff to talk from a health services perspective.

Mr THOMPSON: To set the context, the Department of Health owns all procurement and contract management policies. The job of my team working with systems is to help assure and inform those and operationalise those. In terms of how we do assurance, we have a system. It is mandatory to use. All the workflows for any procurement and contracts need to go to the system. You cannot actually get anything unless you use that, so it provides full visibility. Anything over $250 000, we go to the Department of Finance, so they keep us honest in terms of the process steps. When I think about all the contracts, only two per cent of our contracts do not go through the Department of Finance, so the bulk—98 per cent of them—go through that procurement process in terms of its contract value. I personally have to approve every contract variation over $20 000, so they all come to me and I have to run my eyes over them, and I make those visible to the system as well and they go through a particular type of process.

Mr V.A. CATANIA: Since when has that occurred?

Mr THOMPSON: It has been in operation definitely in the last 14 months since I got there, but it might have been 2016. I can get you that data. I have a purchasing team that process all the purchase orders for the metro system, and any time they spot a noncompliance, they do not make payment. The team has to come to me and explain to me what has happened and then I have to note that in terms of what we are going to do going forward. Any noncompliance gets reported up to the relevant financial stakeholder and then a corrective action is put in place as well.

In terms of any exemptions from the State Supply Commission, I have to approve all of them. If we want to go direct to a vendor, if we want to have a term longer than five years, over 600 things come to me each year for me to approve in terms of providing that central oversight. It can often be a challenging position but that is kind of the role I play.

In addition, we have the audit that we do. We have the State Supply Commission audits that used to be done centrally but they now all run by the internal audit teams of the HSPs. There is quite a good bit of governance across the system at the moment. Coming in new from outside, I think there is quite good governance. It will not always pick up everything, but it picks up the bulk of things.

Mrs L.M. O'MALLEY: Going on looking at devolved systems, in putting a devolved system in place, did you look to other jurisdictions and are you continuing to look to other jurisdictions as to how those devolved systems work, where the benefits are, where the risks are, and what have you learnt so far?

Dr RUSSELL-WEISZ: Member, yes, we did. When this started in 2015—because we did not devolve until early 2016—there was a whole capability assessment of the health service providers. There was a huge suite of work looking at New South Wales, Queensland and Victoria, which all have devolved governance systems, all very different. Victoria has 88 boards. We did not go to that because we have seen some of the failures where you devolve to a lesser extent. It has gone down; 88 boards is far too many in my view. Queensland and New South Wales are very much established as we are established, so we went to those jurisdictions. I think Jeff was part of that at that time. We understood some of the potential failures that they had. We understood not just, in the devolved governance, establishing the health service providers was important, it was also changing the Department of Health to be a very good system manager. There was as much work on the department as there was on the health service providers. We could furnish you that work that we did pre-2016 that showed that we actually looked at the jurisdictions. We then decided to have seven—there are actually eight health service providers with the Quadriplegic Centre, but seven large ones. Initially, it started with six, but over the last year we have devolved PathWest into its

own health service provider. So there was an economy of scale. If you look at south metro, north metro and WA country, they are all around about the same amount of scale when it comes to budget and accountability.

To answer your question, absolutely we tried to learn from other jurisdictions and we set ourselves up with what we thought was best at the time.

Mrs L.M. O'MALLEY: What have you learnt so far, from your perspective?

[10.50 am]

Dr RUSSELL-WEISZ: From my perspective, I would never go back. I was very nervous coming into the role, probably four years ago, with having been used to a centralised system, probably being reliant that I could, in a sense, delegate up to the department if things got really tough, but what this has brought is significant accountability—accountability on safety and quality, on clinical performance and on budget performance, as well as contract management. We have much better line of sight. We have much better—I think the best—financial accountability, due to the two colleagues sitting to my right and left, and their boards and others. We had expenditure growing at an average of 10 per cent up to four years ago. We have now had expenditure growth of around two or two and a half per cent. We had to get the budget under control and we had to have accountability at the local level. What the department does—and this goes to the Chair's point about assurance—we have performance management meetings with the health service providers every month or every quarter, depending whether there are any issues. We do not just look at contract management. Number one, we look at safety and quality. What are the safety and quality KPIs? Do you have an issue? I did a review in 2017 of safety and quality. Because that is the most important thing health systems can do. Clinical performance—are we seeing our elective surgery patients on time, our emergency department patients on time? And there is our financial performance. Also, our culture—we have moved very much into culture. It is not just because of the CCC report, but because we want the boards to own their local culture at a local level. I would never go back. I do not think the Department of Health and the complex system we have today could be across everything the boards are.

Mr D.C. NALDER: By way of background, I spent 18 years inside an institution that had over 50 000 employees over dozens of countries with an excess of 12 million clients and customers that interacted millions of times a day with the institution. I actually was invited and spent time as part of the central organisation discussing and looking at and investigating devolvement and centralised control. I spent time process mapping—a business process for engineering—group procurement, group security, HR and other functions within the institution. One of the things that was found was that when it comes to the client—the devolvement—you put the authority as close to the customer as you can. I accept that. But it was also found, from a governance perspective—governance, compliance and economies of scale—that administrative platforms are often better to be centralised to give greater visibility and consistency of visibility, because one of the issues they have is that if you end up on different operating platforms and different reporting systems, it is hard to get that consistency. With that in mind, I want to get your perspectives—there are certain things that will be consistent across that are actually directed from the centre—that is, financial reporting, so that if you get a one page P and L you get the same looking P and L from each department. Those sorts of things, I would think, are critical. I just want to get some sort of reassurance that those sorts of things have been considered.

Dr RUSSELL-WEISZ: Member, I absolutely agree with you. In our submission, if you look at page 1, there is a very small diagram there. We will send you a bigger one because it actually goes into a bit more detail. There are a number of things that I mandate as the system manager, which are policy

frameworks. We have mandatory policy frameworks that the health service providers have to follow. We have a service agreement each year with the boards that I sign off and the board chair signs off in relation to what the health service provider will provide from clinical and financial procurement—any other services it may do. For example, ICT platforms—we have one patient administration system. Three years ago we had three. We have actually gone to one. We have consistency of financial reporting. The report I get every month is completely consistent between WA country and south, so I can measure whether WA country is doing more activity or has a safety and quality issue as opposed to south metro. We are completely consistent. I might ask Amanda if she wants to make any comment about any other systems that are consistent.

Mrs JALLEH: We have the health HSPR, which is basically where we report all our indicators for all the health service providers. That is one of the indicators that we have. For some of the big community service contracts, the department actually works with all the health service providers, for example St John and Silver Chain. That is because there are economies of scale, obviously. But there are aspects where the department has to manage. There is also—I am probably cutting into Mark's area—we do have delegation and authorisation schedules where, when we were creating the Health Services Act, that was something the department was quite keen to ensure that there were certain levels of authority that everyone would abide by. Those are some of the key measures, and also, Mark, if I am not touching on your area, through the contracts process in particular, we also have a sales supply council where a lot of the contracts, when they are going through the procurement planning phase and are coming through. A group of representatives from the HSPs as well as the department sits around and actually challenges procurement plans and asks questions about contract management. Those are some of the key things that we have put in over the period of time to really improve and focus on this area.

Mr D.C. NALDER: Just following up—you touched on ICT and that was one area I wanted to go into, given some past experiences as former finance minister. I am pleased to hear that you have moved from three client admin systems to one. What about other administrative systems? Have they been dealt with? Do you still have legacy systems that you are dealing with that you are trying to work out how they interact with each other? Pretty much every institution does. I am just trying to get a sense of where you are at because ICT spend across the state is a real concern and we do not have enough visibility on it as a state. I would be interested to see where you are at.

Dr RUSSELL-WEISZ: We do. There are always challenges in ICT. We did a lot of work to get certain systems stable. One, as I said, was our patient administration systems. We got rid of three systems and we went to WebPAS, which is a reasonably new system. We are now in the middle of implementing a new laboratory information system and we are also going through procurement for a new imaging system. It is a very large imaging system that is replacing our slightly older legacy system. We are also part of GovNext—we called it HealthNext—which is moving to the cloud, because we obviously have to go to a consumption-based ICT system rather than the old non–consumption based approach. When we get these major systems stable, we will then move to a platform which has an electronic health record in the future. That is clearly where we want to get to. That will be, we believe, consistent around the state. We do not mind health service providers in their areas doing small systems that do not affect any other area, but their ICT platforms, imaging, laboratory, general platform, HR systems—we have two, Alesco and Lattice. Some use Alesco and some use Lattice, but nobody else can go off and use something else. We have an Oracle system that everybody uses. The other thing I have the ability to do, and we have not had to do this, is that if one HSP board is going off-piste and wanting to do its own thing, I can issue directions. I have significant powers under the act to issue a direction that says, "No, you can't do that." We, hopefully,

act as a team and that has not happened. I think I have done one or two directions in three years, and not on these issues.

Mr D.C. NALDER: Last one—just on ICT contract management. How does the health department pursue that? Do you have a centralised ICT direct report—part of the organisation that is focused on ICT across the whole institution that covers off client interaction versus staff interaction versus financial interactions and so forth?

Dr RUSSELL-WEISZ: That is a great question. We have tried to get the balance right. We have tried to be consistent with devolved governance. One of our health service providers that is not board governed is health support services, of which Mark is the chief procurement officer. We have chief executives, like my two colleagues to my right and left, who are responsible for health support services, which is for the majority of ICT and support services. I have also established over the last two to three years an ICT executive board that has every chief executive and every assistant director general sitting on the board. That considers the key ICT major platforms. Nothing can go through without coming to the ICT executive board. We deal with some of the difficult issues. I am not saying we have got this completely sorted, because ICT is always a headache when it comes to very large agencies. But we have tried to get the devolved governance and the responsibility. For example, the imaging platform that we are going through procurement at the moment for—the responsible and accountable person is the chief executive of health support services. There is one accountable person and that person reports to a steering committee which I chair, which then reports to the ICT executive board. The large platforms, we bring around a table like this, and everybody has visibility on them. The smaller ones, the chief executive —

[11.00 am]

Mr D.C. NALDER: Can you just share how much the health department spends on ICT in a year, given that it is so important? It would be interesting to know.

Mr THOMPSON: I would hate to guess. It is very, very large.

Mr D.C. NALDER: We will take that on notice. It is a deliberate question, because I am amazed, whenever I ask this question in government, that no-one knows. I do not think it is in any financial report. That is not a reflection on you; I am just saying that we do not actually report it, for some reason, yet it is so important. Everyone acknowledges how important it is.

Mr THOMPSON: Just to help you understand, we would have those numbers; they are in our dashboard. I just do not have them with me here at the moment. Just to give you some context, of our top 17 contracts, which represent about 72 per cent of our total $24 billion contract value, only four of them are ICT. So while ICT is a big spend in comparison with a lot of the clinical services–type spend, it is not as big. I just want to give you one extra point to help you understand where we decide to put contracts. Our objective is: if it is something that is not really health-specific, we try to use the CUAs as much as we can—the common-use agreements—for power, stationery, temporary labour hire. For anything that is non-health specific and is general consumption, we will revert to a CUA. For anything that has commonality across the HSPs, HSS, the business I work for, will put in a contract for that, like gloves, prostheses—the same sort of thing—and ICT platforms, but for anything that is very specific to, say, Fiona Stanley or the Kimberley region, the individual HSPs will contract that. That is mainly services-based, because they are quite different and unique, depending on how they are set up. But we do have a certain amount of centralisation, from CUAs, to whole-of-health panel contracts, to specific ones at the HSP level.

Dr RUSSELL-WEISZ: For example, Jeff is the contract manager responsible for the Royal Flying Doctor Service contract. I am not responsible for that contract, because obviously the majority of that

happens in the WA Country Health Service. He would be responsible for that. So there are still some large contracts and we are trying to devolve more of them. I do not know if you have got a comment on that.

Mr MOFFET: Perhaps just a broader comment on that balance between centralisation and decentralisation, because my observation over a long period of time is that centralisation itself lends itself to risk as well. There has to be balance. For highly centralised systems that are not in contact with suppliers and have a service partnership to work in, a lot of integrated services in Health will all purchase one piece—for example, diagnostic imaging or pathology—that needs to work with the rest of our services to be effective. Centralisation also has risks around both derivation of value, but particularly around control. I appreciate the member's point: it is an important balance to get right. I would also say that WA Health's history, as Russ described it, is really significant. We have come from a history of behaving as a single health system for a very long period of time, so we do have Health Support Services that actually supplies a whole range of services that are very consistent in their governance, oversight, reporting and regulation, including in ICT and supply.

We are very different, for example, to some of the health systems we looked at when we went and looked at how we were going to structure our legislation and arrangements back in 2014 or 2015. Victoria is very devolved, so you will find lots of different ICT systems that have different data-definition standards that cannot talk to each other and that lend themselves to all the issues you are referring to around inconsistency of comparison and all the risks around governance and performance. Even in places like New South Wales, for example, they have a level of independence that is higher than the HSPs in our system, which has also led to the implementation of, for example, electronic medical records systems—hundreds of millions of dollars' worth of systems—that do not easily talk to each other. In this state I think we have a very strong advantage. For example, we are the only state with a single medical record for every patient in the state. No-one else enjoys that advantage like we do. That goes to a culture of collaboration and I think a level of central systems and control that is very effective. In fact, sometimes it probably frustrates the HSPs a little bit that a little bit more discretion is not allowed, but to be frank, I actually support, for example, in the future a single medical records system, a single finance system, a single payroll system. That is the whole digital strategy for WA Health.

It is a very strong control environment, so as chief executive I report to a board. I report to the DG. The system manager has monthly meetings with me. HSS has an oversight function. There is a significant amount of regulation and oversight in terms of what I do. I would say that procurement, in particular, has an enormous framework, from the Department of Finance down. Compliance-wise, I report to my board on a monthly basis. There is a subcommittee of the board that meets monthly around finance, procurement and capital. They get standing reports. Our executive gets standing reports. So there is a significant amount of analysis. It has heightened a lot over the last five years, both from internal mechanisms—drivers for business improvement internally—but particularly as a result of devolution of controls and putting in place 10-member boards who equally want to be assured about the risks in the business.

We are a $2 billion business in spend each year between capital and operating. We are a very large business right across the state. Ninety-eight per cent of our spend would occur in regional WA. We do not have a very big Perth presence at all. It is really important that we have controls right through our business. There is always room for improvement. I think it was good Mark going through those improvements that have occurred. There will continue to be a strong push as digital technology allows us to measure, monitor and manage things much more effectively. We focus a lot on regional spend. With the common-use agreements, we do not use anywhere near as much. We will purchase stationery, supplies and anything appropriate locally, with local businesses. That is a very big

commitment of ours. In general, we get better value than using a CUA and paying separate transport functions. We have a very strong focus on complying with the rules, but, importantly, making sure that we support regional investment, regional spend and local regional businesses for our stationery, consumables—all sorts of things—food; we a big consumer of a lot of those sorts of things.

In terms of value, just going back to the example of the RFDS, RFDS came to us as a contract from the department probably over a decade ago now. It is a good example where there is a relationship between procurement, contract management and then the partnership. You have to bring the best information and knowledge in those three areas to be able to get good value out of a contract and also to manage a contract well, because it is a very high-risk service in terms of the transport of critically unwell patients. It is also a service that has to work very effectively with ambulance, with our hospitals—both the dispatching and receiving hospitals. Since we have received that service, we have worked very hard with RFDS to have much more information about clinical metrics, clinical performance, management of risk at the interface and relationships between us and RFDS and St John on the ground. So we have a very robust framework now with them—a really deep contract that is quite different to when it was handed to us.

The centralisation of contracts does not lend itself well to good knowledge of the service impact and the service performance. We focus very heavily on making sure our users of the service—so our doctors and nurses in this sense, for example—have strong input into the performance and the quality of that service. That is not just in procurement cycles; that is in contract management throughout. We have the same arrangements with St John of God Health Care. We have large contracts with the community controlled sector. KAMS does a large renal contract for us in the Kimberley. All the same things apply—strong metrics around clinical performance informed by users on the ground, but obviously procurement happening right up through to the Department of Finance on making sure that the procurement processes are appropriate.

There is a real balance in all of that. As a large organisation, I think we have largely got it right. We have our own chief procurement officer and a procurement contract division. We have our own forward procurement plan, so there is a great depth. And our chief procurement officer is well connected with Mark and the team. You run a network. I actually think there is a level of assurance in having HSS providing support and oversight for us as an agency as well. I get feedback regularly from Mark, but importantly, with Rob Toms as well, around the performance of our organisation as well as his, whether that is payroll, accounts, finance or supply, for example, or ICT services.

Mr V.A. CATANIA: You mentioned RFDS and the contract you have negotiated. Do you have the same sort of negotiation with, say, St John Ambulance in providing a service not only to metropolitan areas but to regional areas as well?

Mr MOFFET: Not at the moment, no. The board recently commissioned a country ambulance review, and one of the recommendations was that we would contract-manage country ambulance services. We have been in discussion with the department. In fact, we had a meeting on Monday about this issue. We feel that, again, having users much closer to the service would provide better value over time and, more importantly, a much better sense of the clinical performance and the direction and development of the service as well, in the same way that RFDS has been on a journey over the last decade.

[11.10 am]

Mr V.A. CATANIA: Because you would appreciate that St John Ambulance is used to transfer patients hundreds and hundreds of kilometres away from their town—Meekatharra, Mount Magnet and Cue. They often get transferred to Geraldton and that obviously can be a seven or eight-hour

round trip or a full day. Noting the pressures that St John Ambulance have been put under, say, in Toodyay and Northam, and having to go down to Midland or other hospitals in Perth, how you take that ambulance service out of rotation and obviously the cost and what have you involved, are you saying there is no contractual obligation that either parties have in providing that service at the moment? The pressure on the volunteers seems to be having a major impact on the end result, not only for the patient having to wait in hospital ramping, coming from a regional area, but also in taking volunteers away from that town, which often leaves it without having any ambulance or any volunteers to cater for emergencies.

Mr MOFFET: The department has the contract. There is a contract between parties—between the department and St John Ambulance. WA country health is not a party. The issues you described came up in extensive consultation, independent consultation around country ambulance. There were many issues raised including those you have raised around inter-hospital transfers taking crews away for long periods of time. Where we landed importantly was that there was strong policy about what was to be provided in country WA, that the contract would come to us to manage directly, and we would put in place a series of metrics around performance. Currently there is not much visibility about the issues you described. We would like to have much more knowledge of those as we do, for example, with the RFDS, in order for us to plan properly and invest and develop properly over time.

Mr V.A. CATANIA: With your country hospitals, because it is a major issue, is there an agreement or policy in place to, at a particular level, move patients safely by RFDS? It is commonly talked about as a taxi service for the WA health system to move patients with minor and major health issues to a major hospital. Is there a directive? Is there a policy that says that once you get to a certain level, off you go into an RFDS plane or in an ambulance from, say, Meekatharra to Geraldton or Meekatharra to Perth? Is there a push to move patients to major centres? Is that part of the contract agreement that you have with RFDS?

Mr MOFFET: No. That is not the case from a policy perspective and we do not have a contract with St John, but it does not feature as part of St John's or RFDS's contract. In fact, it is to the contrary. Care close to home, keeping people in the right setting as local as possible, including in their home, is the strategy here in WA, but it is an emerging strategy nationally and internationally. In country health we spend a lot of time investing in technology and what we are now calling our command centre. We have a command centre in Perth that directly supports our clinicians to provide care in a local setting that otherwise would require transfer to a larger district or regional site. That is a 24/7 service with GPs, mental health professionals, emergency medicine staff and nurses. It is a very popular service that is producing amazing outcomes. It has been fully evaluated. We are also driving into getting more chemotherapy happening as close to home as possible and making sure that geriatric services are getting close to home. There is a very big push with digital capability and with the workforce to be trained remotely and supported using remote technology to give care close to home. We want to avoid every transfer that we possibly can.

Mr V.A. CATANIA: So with patient-assisted travel, has there been a reduction in the patient-assisted travel in terms of funds and people being able to access that?

Mr MOFFET: No. Last year's budget saw an uplift in funds. The volumes have settled a little bit as a result of a lot of investment in services being pushed out. I think we have seen some growth in 2018–19. I do not have the data with me. It is not finalised yet. We have not had a lot of growth for a period of time. It has stabilised over the last three or four years in terms of patient volumes. But costs have naturally risen as CPI goes up and airfares go up and as policy changes occur. PATS continues to be a large budgetary area of around $40 million, similar to the RFDS contract. Again,

we try to manage that very judiciously. Particularly for outpatients, we try to avoid people extensively travelling to Perth for a 15 or 20-minute appointment. We are actually providing an enormous number of appointments now. Around seven years ago we probably had less than 10 000 occasions of service through telehealth—emergency and elective. We are well over 45 000 now and on the rise. The sustainable health review, which Russ participated in, was released recently and really mandates a target to achieve more outpatient care by telehealth keeping people home.

Mr S.A. MILLMAN: Is that telehealth located in the command centre that you mentioned earlier?

Mr MOFFET: It is a combination. Telehealth is all around the system. Paul has telehealth capability. Every health service has that capability. Our command centre currently sits on the sixth floor of Royal Perth Hospital in one of the wings. We have a large ETS—emergency telehealth team—inpatient team and mental health team. Patient transport is a developing feature that will coordinate transport better.

Mr S.A. MILLMAN: Is access to that real estate by arrangement between you guys and East Metropolitan Health Service?

Mr MOFFET: Yes.

Mr V.A. CATANIA: Just on PATS, the cost of flights really does affect the amount you can give out to people for PATS. Given that the cost of flights is very expensive and has an impact, do you negotiate or try and apply pressure to the airline companies to say that it affects the bottom line of patient-assisted travel? What I find as a local member is that sometimes—it is one of the biggest issues that we face as a member of Parliament in the regions. People really have to fight hard to sometimes get PATS because of the costs associated with flying down, whether it is from Carnarvon, Broome or Kununurra. It does have an impact. Directly it has an impact sometimes on people receiving PATS. Do you ever, as part of your contracts, speak to the airline companies and say, "We spend X millions of dollars a year on flying patients down to Perth and back."? Do you ever use that as a bargaining chip to try to reduce the cost of fares?

Mr MOFFET: That is a common-use agreement. Mark might like to talk to that one. We actually do use the whole-of-health purchasing arrangements. It is premised on the best fare of the day. There is an assessment of value the whole time in terms of what gets procured. Obviously, airlines bid competitively through a procurement process for that work. It is very high-volume work. I think the general assessment is that the government gets fairly good value for money, but Mark is probably better placed to comment on that one.

Mr THOMPSON: That is a good example of the health system could try to do its own thing with X amount of spend, but it is actually stepping back and would rather leverage off government spend. The government spend is a much bigger pie and therefore the rate is more attractive. I would not imagine us as a health system would actually get a better deal than the CUA.

The CHAIRMAN: We are running out of time. Simon has a couple of questions. Are you able to go through the flow from the patient through?

Mr THOMPSON: Yes, I will give you that.

Mr S.A. MILLMAN: My first bunch of questions is for you, Mr Thompson, if I may. You have been the chief procurement officer for 14 months. Was there someone in the position before you started?

Mr THOMPSON: A gentleman called Will Monaghan was in the position.

Mr S.A. MILLMAN: How long had the position existed for? Maybe Russ is the person to answer that question.

Dr RUSSELL-WEISZ: The position actually was there before I started. The CPO was brought on after the first strategic procurement review was put in. I have to get the exact date but I think it was late 2014 or early 2015.

Mr S.A. MILLMAN: There are 4 300 buyers. Lisa O'Malley asked you questions about a comparison with other jurisdictions. That seems like a high number. How does that number of buyers compare with other jurisdictions?

Mr THOMPSON: When I say buyers, I mean requisitions, so people who go into our system and say, "I want some bandages" or —

Mr S.A. MILLMAN: People who are authorised to spend the money?

Mr THOMPSON: They are authorised to request but then it will go up to someone who has the financial delegation to actually approve it, of whom there are less, which aligns with our authorisation schedules.

Mr S.A. MILLMAN: Perfect.

Mr THOMPSON: It is about right for the size of the system. If you think about it, if a person on a ward needs to know what they need for their ward, they have a requisition almost per ward, and we have over 1 000 of what are called imprest rooms. You know when you go into a hospital and they disappear into a little room and get the things, we have 1 000 stocking points just in the metropolitan area alone. So 4 300 does not seem too many for me. The big thing we are doing with that cohort of people is trying to educate them on how better to use the catalogues that we have got and make them easier to search.

[11.20 am]

Mr S.A. MILLMAN: How do you measure their access of those resources that you have available? You mentioned the YouTube channel before. I mean, at 4 300, there would be a standard distribution of people who are keen to improve the work that they are doing, so they will access the resources. But usually you will find it is not the people who are accessing the resources who cause the problem; it is the people who are not accessing the resources.

Mr THOMPSON: Through our analytics we have much better visibility into the buying behaviour of all 4 300 people. So, who is using the catalogues, who is using what is called free text. We have those analytics. We have been sharing them across the HSPs with their procurement leaders, and we are now starting to work with those individuals or groups to try to improve and help them better understand how to use the system.

Mr S.A. MILLMAN: Who has responsibility for putting extra items in the catalogue in addition to the 80 000 items that are already in the catalogue?

Mr THOMPSON: So, HSS will have a range of contracts. Where there are contracts, let us say, for gloves or prostheses, there is a client reference group, which is made up of members from all of the HSPs. They will get together and they will say, "Look, we want to discontinue this product. We want to bring these new products in. We need to trial it. We need to negotiate price." The vendor is novated from one to the other, so it is actually a controlled group and it is within our procurement arrangements—describes the mechanisms.

Mr S.A. MILLMAN: Perfect. Thank you for raising the HSPs. In terms of the audit of the HSPs, you said that audits were either monthly or quarterly. Is there a risk matrix to determine whether a particular HSP will get a monthly audit or a quarterly audit? Does that change over time? Is that dynamic or is that static?

Mr THOMPSON: Sorry, if I have misled you. Audits are annual—State Supply Commission. But what I provide to the HSP senior leaders is—because I am getting 600 things that I need to either approve or note per year, noncompliances, contract variations, they are made visible to HSP leadership either on a quarterly or monthly basis, depending on their board reporting cycle. Additionally to that, what I also instigated is every time I get a request for an approval, it is copied in to someone of seniority in the HSP so they know it is going on. They are not part of the approval process, but at least they have visibility of the work that is going through.

Mr S.A. MILLMAN: Do you check whether or not they pay attention to that? I mean, receiving an email in your inbox saying "This has been approved" and paying attention to it are two different things. Is there a way of measuring whether or not they are paying attention to it?

Mr THOMPSON: Yes. Within our system PDMS—I will get you the abbreviation—the workflow cannot continue until I have pressed my button. So, there is actually a workflow piece that does not allow a contract to be entered into or varied until I have done that. In the instances when that happens outside the system, we capture that as a noncompliance and then there is a learning piece that goes on from that.

Mr S.A. MILLMAN: Thank you very much. I have two questions for you, director general. What are the consequences if people do not follow the mandatory procurement framework?

Dr RUSSELL-WEISZ: Any policy framework, if it is not followed, we would obviously investigate why it has not been followed. We are still going through it at the moment. As we have gone through devolved governance, we had a—I will get you the right number—1 500, what used to be called an operational directive, and some of them went back to 1982. We sort of tried to get rid of a lot of the non-contemporary ones and turn and get them down to a level of numbers where there are mandatory policy frameworks, but not getting into the micromanagement. If we find that somebody, let us say on procurement, has gone completely outside it, there are levels of intervention the system manager can take. If Mark alerts me that one of the health services has gone completely off piste, immediately I would go and see the chief executive to please explain. That would be the first thing I would do, because he or she may need to look at it and there may be very good reason for it.

Like with anything else, if we get from an assurance perspective concerns, there are five levels of intervention that are actually specified that we can go up to. For example, with the North Metropolitan Health Service, with the issues that were going on—not related to the CCC issues, but with the issues that we had with the performance of the North Metropolitan Health Service last year—we did go up to an intervention level 3 because we were concerned. Since then, the new board and the new chief executive have done an extraordinary job in bringing that health service back. There are levels of intervention we would enact. It depends on the sort of breach.

Mr S.A. MILLMAN: Is it the same process for people in breach of your directions, so as you issue a direction if there are people in breach of your direction, there is the same tiered hierarchy of responses?

Dr RUSSELL-WEISZ: Yes, I would have to check that, but the directions are under the same legislation so the intervention policy would apply.

Mr S.A. MILLMAN: The final part is: what is your audit process for identifying when something has gone wrong that is a breach of the mandatory procurement framework or one of your directions? How do you spot it?

Dr RUSSELL-WEISZ: Firstly, Mark would, through the health support service in the chief procurement office, they would say, "Look, this is—if it is a procurement system and it is very overt to the system,

health support services would alert me, alert the chief executive first, to a buying pattern that was really off —

Mr S.A. MILLMAN: Sorry to interrupt. This is an anomaly in the analytics. Is that what you are talking about?

Mr THOMPSON: There are two things we do. We do analytics at a procurement level, but we just actually implemented a tool that will look at all the purchasing transactions and go looking for things. It returns lots of false positives but then you try and whittle it down through your internal audit team and say, "Which ones am I going to go and investigate?"

Dr RUSSELL-WEISZ: I think Paul can talk about what South Metropolitan Health Service does because it is responsible—this guy is responsible to the board for making sure that his services procurement practices are robust.

Mr FORDEN: I think there is a danger that we assume that all the controls can be held at HSS level. I get a signed budget every year from the director general. I actually then delegate that down where people sign for their budgets, which goes along activity, quality and finance. That is delegated down again. Variation of $1.8 billion at a high level can be quite large. By delegating it down and getting it to a level of detail—for example, we just picked up a potential fraud where somebody has diverted a piece of kit worth $250 into their own domestic arrangements. That would never been picked up at the very highest level, but that system of delegation down and that system of culture and check by being pushed down into the system allows us to pick up levels at that point of $250. At an HSP level, that would never be seen. It is really important to understand it is a triangulated approach. Also, we talked about audit. At an HSP level, we also have an internal audit and we use that to direct it towards our own service where we think there is risk, and we have a risk register against all those areas.

Dr RUSSELL-WEISZ: In our integrity function now, which we have beefed up significantly, if I have a, let us say—I will take someone from Paul's area. Paul would have to let me know if he has stood anyone down, anything that is reportable—it is called section 146 under the act—on an individual of a certain level will come to me. It comes through my integrity directorate. I will then make a call. I will read each one diligently and I will either let the other HSPs know—the majority are not related to procurement or fraud; what I worry about the most is safety and quality. Have I got somebody who is out of scope on their clinical practice who might go and work off somewhere else? Also, if somebody has been charged for fraud outside their work or medications have gone missing and the health service is undertaking a misconduct investigation, I have a very low threshold for taking other health service providers. We also have a matrix on our system that if someone is applying for a job, there is a flag against those people if they have been either caught for misconduct or a determination has been made. We are trying to get that detection as tight as possible.

Mr S.A. MILLMAN: Because that job application would not be to you. It would be to Jeff or Paul, presumably.

Mr MOFFET: And even three or four layers below us.

The CHAIRMAN: Lisa has a question and then I have one. Do you mind staying for another five minutes?

Dr RUSSELL-WEISZ: Not at all. We were told it was to 12.

The CHAIRMAN: Were you? Okay. We will sit for a little longer.

Mrs L.M. O'MALLEY: How does the department and the HSPs ensure that individuals assigned to manage major contracts or contracts with high risk have the appropriate level of skill and capability?

Dr RUSSELL-WEISZ: I am going to go exactly to what the HSPs do, and then maybe Mark wants to talk as well. Who wants to take that?

[11.30 am]

Mr MOFFET: We actually identify contracts that we think are complex or high risk. Our procurement area has a series of criteria. Those have, I guess, particular attention from the director of our contract management directorate. In terms of the monitoring of those, we have commenced a procurement contract management subcommittee of our executive to support the executive and the board dealing with risk issues around procurement and contract management. There is a lot of visibility; we have a standard dashboard and reporting. I report to both the full board but, importantly, the finance subcommittee, which gets a range of information and queries me and management staff about any sort of issues, anomalies, risks coming up. There is a lot of transparency of our higher risk contracts and a lot of declaration of that risk, and then naturally a lot of assurance and questioning around that and further production of documents and deep-dive audits. We have recently done a very deep audit in relation to some of our procurement activities around PATS, maintenance in particular, and some of our contracts with our visiting medical practitioners, our doctors. That was extensively done right through the business to the extent of really checking that things that were said to have been done were done—inside roofs and inside engineering plants and having independent inspections inform the independent auditors. So we do very deep dives on things from time to time as well. That audit came up with very low risk, which was good. We went to some very targeted sites like Carnarvon and Derby and Broome, in very remote parts of the state, where we wanted to be assured that our controls were actually working. So that was reassuring. That means we will have to do that on a fairly regular basis. I think that is really important. We have a strong education program through our supply offices. I have met personally with all of our supply and facilities and maintenance directors to make sure they understand the changing nature of accountability and expectations, and their role in all of that. They have an assurance role within their regions as a single senior officer to make sure things are as they should be and that they are surveilling and aware of things enough, and reporting conduct, escalating concerns very quickly to their regional directors.

Mrs L.M. O'MALLEY: I think that is the important point that you just picked up on. I guess that is where I was going with that. Where is the training, education and support for those contract managers?

Mr MOFFET: I think that has to be continuous. There is a really good level of training now available for procurement. Fundamentally, you want your staff to feel confident that if they have a concern, they can raise it, even if they cannot characterise the concern. If something does look right or smell right to them—we obviously have PID mechanisms, formal mechanisms—that they can raise it with their manager, or if it is in relation to their manager, that it is right and appropriate and responsible to escalate. We have promulgated that message a lot. One of the strengths of the health system is that professionals, by their nature, have strong ethical standards. It is a very strong culture in terms of nursing, doctors, allied health professionals. I think we are fortunate that we do have strong ethical behaviours—I am generalising here—that are not only organisational but also profession based around a national scheme with codes of conduct. My observation is when staff are given permission to raise issues, they do.

The CHAIRMAN: The ethical behaviour—obviously, doctors and health professionals are some of the most ethical people we know, but they are ethical in regard to medicine; they may not necessarily know what is ethical in regard to other issues that are not necessarily related to the

patient. Obviously, there have been problems so they cannot all be that ethical, because there have been problems in the health department.

Mr MOFFET: Sure, but my observation would be the cultural reaction to those issues was profound from our health professionals and from our administrative professionals. They were profoundly concerned at what a small number of people had done.

The CHAIRMAN: But the point is that people did it.

Mr MOFFET: I think you need to be realistic about human behaviour in systems of 50 000 people, as you are referring to, member. It is that bell curve concept that was being discussed. There will always be people in large populations who choose to do the wrong thing. You would hope that they are the minority, but the main issue is that they need to be detectives. Staff who work with them—nursing staff are a very good example—they understand what is going on in maintenance and what supply practices are recurring. They have very good radar for what should and should not happen in sites. Nursing is a massive safety net in terms of all sorts of standards in our facilities—use of facilities, use of information, procurement practices. I am not suggesting that we should ever be complacent because you have to be ever vigilant, but we are fortunate that we do have, as a large part of our professional body, people who come to work to do the right thing and have a strong ethical base. That was my broad point.

The CHAIRMAN: My wife was a nurse, so I agree there! The issue is the capability. It is not really just a health thing. Generally in the public service there is an issue about whether there are enough capable people when it comes to managing contracts and so forth.

Dr RUSSELL-WEISZ: I would make a comment on that. I just want to say something on your last statement. I have witnessed the distress of the people who were working very closely next to those three people, or broadly; actually witnessed people I knew who had nothing to do with it, but did not see it, and the sort of soul-searching they would have done saying, "What did I miss?", because these were three or four bad people, other contractors outside the system—as Jeff said, 50 000 people. We have really had this push now, a bit like safety and quality, if you see something, say something. It does not actually matter that it might come to nothing; there might be nothing in it. We would rather you told us. We have had a bit of that in the department, but the health service providers—Paul may want to comment on this—have had much more at a local level, because they have actually said, "Tell us. If you think something is odd, you can't put your finger on it, please just tell us." It is that culture of safety and quality. We want to hear about, in a sense, misadventure. We want to hear about when something has gone wrong with the patient so it does not go wrong again. We want that same sort of ethical behaviour and voluntary reporting in the procurement space and the anti-fraud space, and that is why we have had that focus on detection, education and prevention.

Mr D.C. NALDER: Can I take that a little bit further? I understand when you are talking about corruption and bad eggs within the system, but if I bring it back to Perth Children's Hospital: what we saw from the health department were massive changes of scope on the way through and we saw different things, and there was a lot of finger-pointing going on. This is not to lay blame on anywhere or anyone, but from a contract management perspective that one had lots of problems on the way through. It is about making sure that we have learnt some lessons from there and making sure there are processes in place such that if we build another major hospital somewhere, which will happen, or an expansion somewhere, we do not go down that same path, because there were obviously flaws within that process for that hospital.

Dr RUSSELL-WEISZ: Revisiting Perth Children's Hospital and having been involved in two different roles—one commissioning a large hospital, in Fiona Stanley, and then involved as the director

general in overseeing the health part of it—this is my own views—we did not have that much visibility of the contract in relation to the builder. That was managed by the Department of Finance through Strategic Projects at the time. We managed the health; the commissioning process. I think there have been lessons learnt from that; there is no doubt about that. That was a particularly challenging contract, as the Fiona Stanley Hospital was, but not on the building front. Actually, the infrastructure front went particularly smoothly. It was much more on the commissioning front. The hospital certainly learnt lessons from that. I think if there is anything to take from that, it is better integration. The one thing I would always take is: there are seven streams when you commission a hospital. Infrastructure is but one, and I hate to say it but it is the least important stream. It is actually what you do in that hospital. It is the clinical practice and the outcomes for patients that should determine the infrastructure, the facilities management, the workforce. It is the clinical commissioning that is key. That is my own learnings.

Mr THOMPSON: Can I just add a point about your discussion about capability. I will give you the sense of what I see, because I am new to government. I see a system which is very heavily process regulated. For me, coming from a more commercial background, contracts are more about the outcomes of the contracts—you use processes to try to get you the outcomes. When we typically measure process compliance, we often do not measure the contractual outcomes: are we getting the service; are we getting the price; are we getting the risk reduction? And it feels much, much safer for people just to follow the existing process, even sometimes when they go, "It doesn't suit the market that I am dealing with or the particular type of agreement." At the moment, I am a member on the State Tender Review Committee. When the panels come and present to me, I am talking about the commercial outcomes. Sometimes it is challenging, say, "We thought we were going to do this process, we got to the end of the tender, things have changed a little bit, and to improve commercial outcomes we may need to jeopardise slightly our process contract." I am kind of okay to make a risk-based call on that. That is very challenging for the system.

The CHAIRMAN: While you are at it, Mark, do you want to give us that thing that you want to talk about—the little chain?

[11.40 am]

Mr THOMPSON: Every time I come to one of these, it helps me sort of crystallise the little map I built myself to give a sense of some of the numbers of how this works. We have got a population of about three million people who rely on 44 000 staff to deliver health care, and then we have got other contractors. They have got over 80 000 individual items that they could pick to help them do that, whether it is the goods—4 300 buyers have to try to find ways to get those things and fulfil them. We have 500 named contract managers across our 2 000 agreements. Four hundred of those 500 only manage two or less agreements, so it is like a part of their job; it is not their full job. The full job might be marketing or something and they get given a bit of contract management on the side. If you look at our contracts—there is $24 billion across 2 500—only two per cent of that dollar spend is under the 250K, so you know in the Department of Finance, we go for facilitation. Health in its own right, when you play around with two per cent of that contract value, 98 per cent of it goes through the Department of Finance oversight processes, but it represents 43 per cent of all the contracts. You can imagine all the work gets tied up in a very small percentage of the spend, and typically that small percentage of spend is not the long-term contracts, so they are constantly refreshing. Part of the challenge, I think we have got, is that we get so consumed in the low-end work and the processes that sit behind the low-end work, and we have not shrunk the process for that, that sometimes we miss some of the bigger things. On the whole, we manage our really big contracts very well. We have got dedicated people, they are professional, they are organised. We have kind of got this middle range of contracts, and the volume is so huge. I think this year we have

got 400 or 500 expiring—two a day—and you have got to try to figure out how you use the processes with the resources to get through that.

The CHAIRMAN: HSPs—Paul, you might want to answer this question. I think that previously, in the last term or whatever, we talked about HSPs, and there is a healthy competition between the various HSPs, which is good, but what about the transfer of knowledge and capabilities between the HSPs? Is there enough of that, or are people too protective?

Mr FORDEN: The other point I make is on the member's question about qualifications et cetera. My senior contracts team are all qualified in procurement contracts. Some of them are lawyers, et cetera, so they are not nurses who have been moved into doing a new job. They are very professional individuals. Where a HSP might be undertaking a new contract, they need somebody with that experience. We traditionally loan them from our HSP, or we borrow them from other HSPs. Whilst we are all in healthy competition, I think that is a positive. It cannot be where it is to the detriment of anybody else. We are actually a WA health family here, which is a different feeling to other jurisdictions I have been in. It is actually quite a collaborative group, so there is definitely that. Even with the children's hospital, we actually loaned our senior executive director for procurement to the children's hospital to help them through the later stages.

The CHAIRMAN: You talk about lawyers, what are the criteria for—I know you second lawyers from the SSO—but what are the criteria for having to seek advice from the SSO?

Mr FORDEN: We have our own in-house lawyer in procurement specialism, which is not to do with the State Solicitor, and then we also have our own in-house State Solicitor's lawyer, and she acts as a funnel between any questions that we have, and the whole of SSO, so we have somebody on the site we can go to straight away, ask questions, and a number of those she can answer for us and give us guidance, and she takes part in the executive discussions, et cetera. Equally, if we have something that is more specific—it might be about employment law, or it might be about procurement law—she can actually go and use the whole gambit of the SSO.

The CHAIRMAN: So that lawyer—the one from SSO—is she seconded, I assume, for a period of time from the SSO?

Mr FORDEN: I pay SSO for her time, to be on my site.

The CHAIRMAN: So you are her client?

Mr FORDEN: We are her client, but actually she is part of the team as well.

The CHAIRMAN: It is a difficult issue, and I am sure it would be difficult for her. She is an SSO employee, and the SSO client is ultimately the state, but she is seconded to you—the HSP—so really there can be a conflict there.

Mr FORDEN: It actually works surprisingly well. We are aware of where the tensions might be, and I think it comes back to, again, getting the right people, and how we work together. That is the important bit I also wanted to say about contracts we have for services. For example, we have got a contract for running a whole hospital in Mandurah—Peel hospital. We could never deliver the services we deliver through that hospital if we just kept to a contract. It is actually how we work together, and having that common goal and that kind of common relationship. We only bring the contract out when there is a problem. Most of the time, the contract is never referred to. It is about delivering the services. I walk around that hospital and I know the staff in the same way as they know me. We can talk about how we change services and how we redirect things, and how we do things differently. I might ask them to take up some slack from Rockingham Hospital one day, because we might have a closure in the MRI or something. That is the relationship it is so important

to get on these, and it cannot just be through the contract on its own. It must be much more than that.

Dr RUSSELL-WEISZ: I think that shows, just to add a point there to Paul's, on the PPPs , the ones we have, say at Midland with St John of God Health Care, that is a contract managed by the east metro health service, because it is delivering a service to the east metro residents. Paul contract manages the Peel Health Campus contract and north metro manages the Joondalup health contract. When there is any major infrastructure expansion, or ICT expansion, then the department will do that in unison. I will just say, on your question about lawyers, we originally had a very large legal department in the Department of Health, so the HSPs would come in and talk to them and get advice, and we would go to SSO. Now it is much smaller. We still use the SSO, but the actual general counsels at the site means there is local presence.

The CHAIRMAN: In regards to that secondment, are you paying the lawyer's salary, or is the SSO paying it?

Mr FORDEN: SSO pays the salary, and we pay SSO, through an agreement.

The CHAIRMAN: Yes, through a fee structure.

I have a closing statement that I need to read. Thank you for your evidence before the committee. We will forward a copy of this hearing to you for the correction of transcription errors. Please make these corrections and return the transcript within 10 working days of receipt. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on any particular point, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence.

There are many questions that we did not get through, so we will send them to you in written form. Thank you very much; it was really interesting.

Hearing concluded at 11.47 am

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