Submission No 8

INQUIRY INTO PROCUREMENT PRACTICES OF GOVERNMENT AGENCIES IN NEW SOUTH WALES AND ITS IMPACT ON THE SOCIAL DEVELOPMENT OF THE PEOPLE OF NEW SOUTH WALES

Organisation: NSW Nurses and Midwives' Association

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Submission to: Procurement practices of government agencies in New South Wales and its impact on the social development of the people of New South Wales

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NSW NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH
www.nswnma.asn.au
50 O'Dea Avenue
Waterloo NSW 2017
T 8595 1234 **(METRO)** • 1300 367 962 **(NON-METRO)**
F 9662 1414
E gensec@nswnma.asn.au

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes registered nurses, enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The NSWNMA has approximately 76,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

We welcome the opportunity to provide a submission to this Inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

CONTACT DETAILS

NSW Nurses and Midwives' Association
50 O'Dea Avenue
Waterloo, NSW 2017

(02) 8595 1234 (METRO)
1300 367 962 (RURAL)
gensec@nswnma.asn.au

The terms of reference for this Inquiry are broad and this submission will focus specifically on the impact procurement practices have on nurses and midwives working in healthcare settings across NSW, including where they deliver healthcare in aged care contexts and the broader healthcare system. The scenarios included in the submission reflect feedback from our members experience with procurement. Even if the systems they describe as 'absent' are in place, the fact that they are perceived as absent suggests they are ineffective, suggests a lack of governance, and the need for a widespread review of the entire NSW Health procurement system.

We support the recommendations of the Unions NSW submission to this Inquiry.

The position of the NSWNMA is that procurement must:

- Place no worker at risk because of supply chain issues or procurement failures.
- Ensure job stability and fair working conditions.
- Prioritise the public delivery of nursing and midwifery services over privatisation.
- Be ethical, ensuring industrial rights and conditions for workers as part of standard contractual obligations, including international contexts.
- Be transparent in awarding of contracts and maintain due diligence in regard to governance of public spending.
- Be accountable, ensuring enforceable compliance measures are embedded in contracts.
- Serve to build community capacity through local job creation, investment in housing and infrastructure in regions of industry decline.
- Be sustainable and seek to incorporate renewables and greener hospitals initiatives.

Recommendations

1. Procurement of workers must be aligned to a strategy of implementing nurse/midwife to patient ratios across all areas. This to enable better staffing forecasts, increase the availability of regular workers more generally, reduce agency worker costs and create overall cost-savings and enhanced patient outcomes.

2. Provision of competitive wages and affordable housing options as measures to procure a sustainable health workforce.

3. Union engagement in procurement processes must occur to ensure ethical procurement practices relative to labour hire and migration strategies to fill worker shortfalls in NSW. This would enable workers to seek appropriate protections, know their rights, and create ongoing cost savings for NSW Health. In addition, there must be similar strategies implemented to ensure the physical and psychological safety of employees from Aboriginal and Torres Strait Island, and culturally and linguistically diverse (CALD) backgrounds.

4. An extensive and comprehensive review of all procurement processes within Local Health Districts (LHD), and more generally across the breadth of NSW Health, should occur to identify cost-savings, ensure streamlining of procurement and remove preventable delays in acquiring life-saving equipment focusing on areas highlighted through this submission.

5. Specific policy which prioritises procurement of PPE for those employed in essential industries such as healthcare must occur.

6. NSW Health should develop state-wide healthcare procurement policies and practices to ensure the supply-chain (e.g., medical equipment, pharmaceuticals, and protective equipment) is transitioning to environmentally sustainable practice and net-zero emissions as a matter of priority.

7. Needless privatisation of public health services in NSW should be halted. Wherever possible, the principle that if a service could be delivered by NSW Health, it should be delivered by NSW Health should underpin procurement of services.

8. Use of public money must prioritise domestic supply chains and local job creation, particularly in those areas where there is declining local manufacturing, or potential to grow community capacity. Ensuring wherever possible, creation of jobs for Aboriginal Corporations or business registered with Supply Nation or similar.

9. An explicit 'Local, Secure and Fair Jobs' code that outlines industrial rights and conditions for contracts and requires suppliers to submit to WHS and Industrial audits, put together compliance plans and model industrial clauses in major contracts.

10. A range of compliance measures focused on giving unions representation in the NSW Jobs First Commission, standing to bring forward evidence of industrial non-compliance by successful suppliers and State Government publishing information about what successful suppliers have said they will do.

Procurement of workers

There are significant staff shortages across NSW Health including temporary vacancies e.g., sick leave, holidays, and long service leave backfill. Although the system allows vacancies to be filled and most hospitals operate a casual pool to reduce use of more expensive agency nurses and midwives, this isn't effective since workers generally enter into the casual pool to seek ad hoc work rather than short term full, or part time contracts e.g., long service leave cover. This increases burnout for regular members of staff who are often called upon to fill gaps in rosters, compounding workforce shortages.

Procurement of agency nurses to fill gaps in rosters is increasing. Whilst agency nursing can be a preferable career pathway for nurses, offering greater wages and flexibility than casual pools[1], its use to procure a sustainable workforce has negative consequences for patient outcomes and funding.

It has been reported that Northern NSW Local Health District (LHD) agency workforce costs for the financial year 2022/23 totalled $148 million for locum doctors and nurses, including $16 million for agency nurse travel and accommodation. Murrumbidgee LHD similarly reported it had spent about $50 million on its locum and agency workforce in the past financial year[2,3]. Western Sydney LHD reported its spending on agency nurses has increased by 238 per cent in fewer than three years[4].

Data: Western NSW Local Health District/Graphic: ABC News

Aside from the increased cost of agency staff procurement, which could be redirected to more cost-effective nurse/midwife to patient ratios, health outcomes are also negatively impacted where agency or temporary staff are utilised. A study of missed care in UK hospitals found rates increased with higher use

1 ABC News Report (2023) *Nurses and midwives switching from permanent roles to agency workforce better pay, flexibility*. Available online at: https://www.abc.net.au/news/2023-12-21/nurses-switching-to-agency-work-in-australias-hospitals/103230020 Posted 21 December 2023

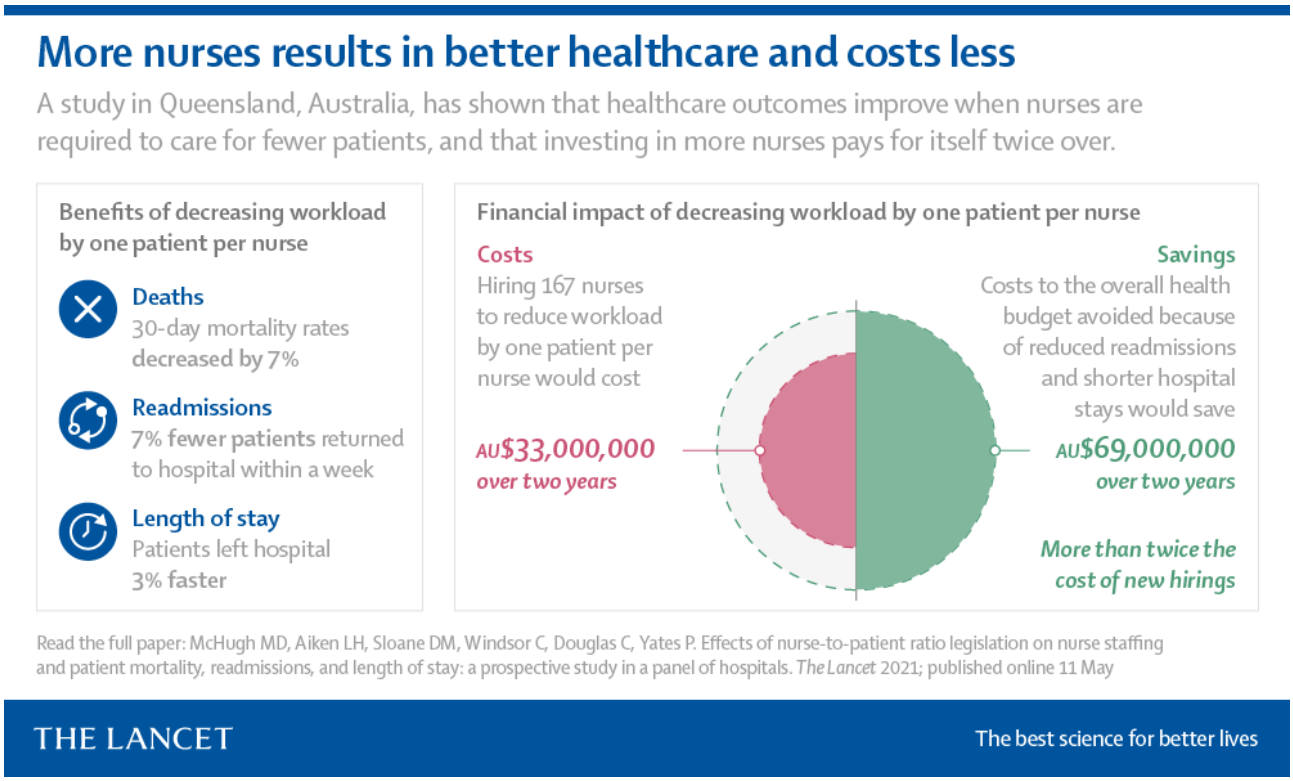
2 https://www.abc.net.au/news/2023-12-19/locum-agency-nurses-high-costs-health-staff-shortage-nsw/103195190

3 Auditor General NSW (2023) *Independent Auditors Report: Murrumbidgee Local Health District*. Available at: https://www.nsw.gov.au/sites/default/files/noindex/public%3A/2023-11/MLHD%20-%20Audited%20Financial%20Statements%20%28AFS%29%202022-2023.pdfMLHD%20-%20Audited%20Financial%20Statements%20%28AFS%29%202022-2023.pdf

4 ABC News report (2023) '*Hundreds of millions spent on agency nurses as NSW local health districts struggle to keep staff*'. Available online at: https://www.abc.net.au/news/2023-12-19/locum-agency-nurses-high-costs-health-staff-shortage-nsw/103195190?utm_campaign=abc_news_web&utm_content=mail&utm_medium=content_shared&utm_source=abc_news_web Posted 19 December 2023

of temporary staff. An increase in the proportion of temporary staff from 0 to 10% increased the odds of missed care by 6%[5]. A further study showed that increased staff ratios were only effective in reducing patient mortality if the nurse was a regular staff member, rather than an agency nurse or assistant in nursing, highlighting that agency, or lower skilled staff are not effective substitutes for registered nurses who regularly work in that area[6].

Having mandated ratios of nurses and midwives would enable better staffing forecasts and increase the availability of regular workers more generally. A minimum nurse/midwife-to-patient ratio not only creates better patient outcomes[7], but also significant cost savings[8].



There is a recognised worldwide demand for nurses across all sectors and current consultation on a National Nursing Workforce Strategy[9] which will no doubt conclude the urgent need for enhanced measures to both grow and retain the workforce. Factors such as pay and conditions have a direct impact on procurement and retention of nurses and midwives required to achieve good nurse/midwife to patient ratios, retain skills and prevent turnover.

[5] Senek, M., et al (2020) *The association between care left undone and temporary Nursing staff ratios in acute settings: a cross- sectional survey of registered nurses*. BMC Health Serv Res **20**, 637. Available online at: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05493-y#citeas
[6] Zaranko, B. at al (2022) Nurse staffing and inpatient mortality in the English national Health Service: a retrospective longitudinal study. BMJ Quality Safety online. Available at: https://qualitysafety.bmj.com/content/qhc/early/2022/09/27/bmjqs-2022-015291.full.pdf
[7] Dall'Ora, C. et al (2022) *Nurse staffing levels and patient outcomes: A systematic review of longitudinal studies*, International Journal of Nursing Studies, Vol.134. Available online at: https://www.sciencedirect.com/science/article/pii/S0020748922001407?via%3Dihub
[8] McHugh, M. et al (2021) *Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals*, The Lancet online. Available at: https://www.thelancet.com/infographics-do/nurse-ratios.
[9] https://www.health.gov.au/our-work/national-nursing-workforce-strategy

NSW is falling behind its neighbouring states in terms of both nurse-to-patient ratios and pay[10]. This, despite the cost of housing far exceeding other states and territories particularly across the Sydney metropolitan region, but also regional areas. Proportion of income required to service a new mortgage is close to record highs at 46.2%[11]. This inquiry must consider the benefit of creating competitive wages and affordable housing options to procure a sustainable health workforce, provide competitive conditions of employment to attract and retain workers and ensure the best health outcomes for the people of NSW.

Index results as at 30 November, 2023	Change in dwelling values				
	Month	Quarter	Annual	Total return	Median value
Sydney	0.3%	1.8%	10.2%	13.4%	$1,125,533
Melbourne	-0.1%	0.6%	3.0%	6.4%	$779,914
Brisbane	1.3%	3.9%	10.7%	15.4%	$779,270
Adelaide	1.2%	3.9%	7.6%	11.9%	$704,267
Perth	1.9%	5.4%	13.5%	18.9%	$646,520
Hobart	-0.1%	0.1%	-3.0%	1.2%	$656,568
Darwin	-0.3%	-0.7%	-1.5%	4.7%	$496,792
Canberra	0.5%	1.1%	-0.3%	3.7%	$842,677
Combined capitals	**0.6%**	**2.2%**	**8.2%**	**12.0%**	**$827,659**
Combined regional	**0.6%**	**1.8%**	**3.4%**	**7.9%**	**$602,645**
National	**0.6%**	**2.1%**	**7.0%**	**11.0%**	**$753,654**

Media enquiries: media@corelogic.com.au

CoreLogic Home Value Index
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Increasingly international migration will be utilised to bolster workforce. However, due diligence relative to the psychosocial and physical safety of internationally qualified, Aboriginal and Torres Strait Island and culturally and linguistically diverse (CALD) onshore nurses and midwives procured to work in healthcare must occur. It is not uncommon for incidences of direct, indirect, and systemic racism to occur in the workplace[12]. To date, there has been no effective engagement of these workers to develop strategies that will benefit them.

A 2011 study calculated the costs to the Australian economy arising from racial discrimination was 235,452 in disability adjusted life years lost. This is equivalent to $37.9 billion per annum, roughly 3.02% of annual gross domestic product (GDP) over the period 2001–11, indicating a sizeable loss for the economy[13]. The negative impact of racism on victims, perpetrators and bystanders is far reaching and is known to cause physical and mental ill health and, in some cases, death[14]. Workers from CALD backgrounds have higher rates of work-related compensation claims across all industries and occupational status[15].

The Australian Human Rights Commission's Concept Paper: a national anti-racism framework[16] released in March 2021, flagged a need for greater community understanding of the different dimensions of racism and racial inequality in Australia acknowledging racism is a significant economic, social, and

[10] ANMF (2023) *Nurse & Midwives' PAYCHECK August 2023 – January 2024*. Vol. 22 (2) pp.33-36. Available at: https://www.anmf.org.au/resources/nurses-and-midwives-paycheck
[11] CoreLogic (2023) *Hedonic Home Value Index 1 December 2023*. Available at: https://www.corelogic.com.au/__data/assets/pdf_file/0029/19955/CoreLogic-HVI-Dec-2023-UPDATED.pdf
[12] NSWNMA (2019) *The Cultural Safety Gap*. Available at: https://thelamp.com.au/wp-content/uploads/2019/09/CaLD-Report-FINAL-lr.pdf
[13] Elias, A., and Paradis, Y. (2016) Estimating the mental health costs of racial discrimination. BMC Public Health, 16, 1205.
[14] Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019) *Racism and Health: Evidence and Needed Research*. Annual review of public health, 40. pp105–125.
[15] Smith CK., Wuellner S., & Marcum, J. (2023) *Racial and ethnic disparities in workers' compensation claims rates*. PLoS ONE 18(1): e0280307. https://doi.org/10.1371/journal.pone.0280307.
[16] Australian Human Rights Commission (2021) *Concept Paper: a national anti-racism framework*. Available at: https://humanrights.gov.au/sites/default/files/document/publication/ahrc_cp_national_anti-racism_framework_2021_.pdf

national security threat. Racism also creates poor work conditions. Discrimination, and hostility in the workplace impact job satisfaction, well-being, and job security[17].

The Diversity Council of Australia recently found employees who feel excluded at work are five times less likely to be satisfied with their jobs, three times more likely to feel work negatively impacts their mental health and three and a half times more likely to leave their employer[18]. The psychosocial impact of discrimination in the workplace and the financial implications to NSW Health, although not reported on, are likely to be significant as nurses and midwives exit the sector and seek compensatory pathways.

There is a role for union engagement in procurement processes to ensure ethical procurement practices relative to labour hire and migration strategies to fill worker shortfalls in NSW. This would enable workers to seek appropriate protections, know their rights, and create ongoing cost savings for NSW Health. In addition, there must be similar strategies implemented to ensure the physical and psychological safety of employees from Aboriginal and Torres Strait Island, and CALD backgrounds.

"I received comments from relatives regarding Islanders mostly working as security guards and in the labour industry and how I get to work in the hospital. Also, some colleagues identify Islanders in general as obese and not very intelligent". #755 (NSWNMA Cultural Safety Gap Report)

"Several staff were subjected to bullying, intimidation and harassment in this workplace, which had a significant impact on their mental health". #523 (NSWNMA Cultural Safety Gap Report)

"Bullying, harassment and discrimination are actually very common in the nursing profession and there is a lot of cover up by management and some are involved in it. It is something that really needs to be addressed in the profession". #471 (NSWNMA Cultural Safety Gap Report)

"Generally, I don't report. I speak up at the time, say my bit and move on. Sometimes I move workplaces. It isn't worth the emotional trauma. It is all well and good to say to me. 'If you don't report nothing changes', but it takes a lot out of you emotionally and professionally". #80 (NSWNMA Cultural Safety Gap Report)

"I have been treated really badly in comparison to other new-grad nurses who are not from a different cultural background. I have been questioned about my work and have been made to feel worthless by one of the staff. They were also in my face and so rude to me while communicating. All this made me so intimidated to work with her and I was upset the whole shift. I could not do my best in front of her because she made me feel everything I did was not good. I could not stop crying during break". #1167 (NSWNMA Cultural Safety Gap Report)

[17] Bargallie, D. (2020) *Unmasking the Racial Contract: Indigenous voices on racism in the Australian Public Service*. Canberra, ACT: Aboriginal Studies Press.
[18] Diversity Council Australia (2021*) Inclusion@Work Index 2021-2022: Mapping the state of inclusion in the Australian workforce (Synopsis Report, 2021)* 14 <https://www.dca.org.au/sites/default/files/synopsis_2021-22_inclusionwork.pdf

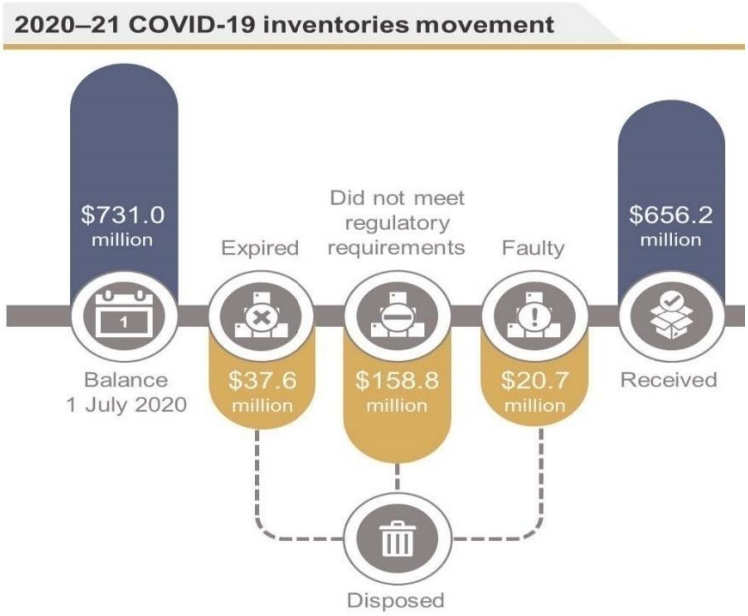
Procurement of equipment

COVID-19

The COVID-19 pandemic was pivotal in exposing the impact of unprepared procurement on the general population of NSW, and nurses and midwives across healthcare settings. During the initial phases of the pandemic Australia experienced supply demand deficiencies of personal protective equipment (PPE), leading to nurses and midwives reporting having to make face shields, re-using PPE, and in some instances, employers hoarding PPE rather than allowing its use.

Australia was ill prepared and suffered because of our place within the global supply chain. Available stock was either retained within manufacturing countries, or flowed to demand from more lucrative markets, namely the US and Europe. Under such pressure, the then government entered contracts that failed to provide safe PPE with a flow-on effect on NSW.

For example, 2021 saw $775.9 million of COVID-19 inventory impairments and write offs. While there were improvements in 2021-22, there was still $451.6 million in COVID-19 inventory impairments and write offs[19]. The figures do not include rapid antigen tests (RAT), which are expected to account for a further $186.7 million in impairments. In addition to the impairments and write-offs of COVID-19 inventory and RATs, another $29.4 million has been allocated for disposal of impaired COVID-19 inventories.



Audit Office of New South Wales Heath 2022 Report, p13

The report also identified flaws in the forecasting of consumption highlighting a system reliant on retrospective data lacking in the flexibility to quickly pivot to account for unprecedented events such as the COVID-19 pandemic.

[19] Audit Office of NSW (2021). *Health 2021*. Available at: https://www.audit.nsw.gov.au/sites/default/files/documents/Health%202021.pdf

Australia, and more specifically, the NSW Government need to be able to circumvent barriers within free trade agreements as they pertain to local procurement. Indeed, there must be capability and capacity to always ensure sovereign manufacturing capacity for healthcare equipment. The potential for profit to over-ride the healthcare needs of our citizens and compromise the safety of health and aged care workers who look after them must be negated through procurement practices. In addition, specific policy which prioritises PPE availability for those employed in essential industries such as healthcare must be considered.

General goods

HealthShare NSW is NSW Health's central point for goods and services tendering and contracting[20]. However, whilst they maintain a degree of governance around more frequently used items, through coding and contracts guaranteeing reliable supply and consistency of pricing, specialised orders can be managed differently.

In one LHD it is reported there is significant wastage owing to lack of control over who is responsible for purchasing decisions, particularly in relation to specialised and bespoke equipment procurement. Individuals targeted by sales representatives from private companies to purchase their equipment led to the recent purchase of equipment totalling $10,000 which when supplied, was unfit for purpose.

Decisions about what COVID-19 money was used for was down to two specialists within the same LHD. This led to the purchase of 30 machines to deliver high flow humidified air, purchased with a COVID-19 cost code. Of the 30, only one was used and it is now costing money to maintain the remaining in store. In addition, around $100,000 of foldable isolation booths were purchased, but found ineffective by the Infection Prevention and Control Nurse.

The NSWNMA is aware that in a second LHD it is common for non-clinical staff to procure everyday items leading to improper supplies. In addition, lack of engagement with nurses and midwives around purchases leads to wastage. For example, ordering of dressing packs containing several items, only one of which needing to be used. It is reported there are no systems to evaluate what equipment is being used, and to adjust procurement accordingly.

Procuring regularly used items through HealthShare NSW also leads to waste, since many items need to be procured through a bulk order. For example, one rural hospital required only one specialist paediatric ventilation tube but had to procure a whole box as that was the only code available. Inevitably the remainder go out of date before they are required again.

There is lack of uniformity in the overall supply chain, meaning LHDs have capacity to order the same type of equipment, but manufactured by different suppliers. This has led to mismatch of equipment when patients are transferred between LHDs and even healthcare settings within LHDs and wastage. An example of this is intravenous tubing which if not standardised may mismatch connectors or cannulas, causing supplies to be wasted.

[20] https://www.healthshare.nsw.gov.au/services/procurement.

Specific examples of waste, or inappropriate procurement include:

- Scissors being taken out of a pack that contain forceps, tweezers, and scissors. The forceps and tweezers being wasted as surplus to requirement.

- Morphine being wasted from a syringe-driver where tubing was incompatible with the syringe due to differences in equipment used across LHDs as patients are transferred between hospitals for care.

- The purchase of sodium bicarbonate impregnated mouth swabs being refused, as they are only allocated to Intensive Care Units (ICU) and High Dependency Units. The alternative being for nurses to create a sodium bicarbonate solution using powder and a small bottle of sterile water and mouth swabs that are not fit for purpose. The time and equipment for nurses to make the mouth wash far outweighs the cost of the requested original mouth swabs.

- The change of practice to use cheaper gowns when using cytotoxic medications, the previous gowns had elasticated cuffs and were made of thicker material. The policies for the handling of cytotoxic medications requires elastic cuffs. The procurement change left nurses less protected when handling the medications. Similarly, restrictions were placed on the thicker purple gowns which were only available in cancer services and ICU.

- The use of cheaper patient pads in the ward areas, and the more higher quality pads restricted to ICU.

All the above could be resolved through diligent governance and consultation with nurses and midwives in stock ordering and supply.

The following matters add complexity to the procurement system and do little to support cost efficiency measures. The cumbersome system for procurement can lead to ordering of the wrong supplies. Where supplies arrive and are deemed unsuitable, unfit for purpose or the incorrect item has been ordered, it is not common practice to return items leading to unwanted items being kept in storage until they naturally expire. Even if there was intention to return items, the window of opportunity to do so can be as little as one to two weeks even if the shelf life of the product is far greater. Given work demands of staff, this timeframe is unrealistic and provides little opportunity to make returns in the given timeframe.

Duress Alarms

A further example where a lack of due diligence in governance impacts worker safety is in the procurement of duress alarms. A variety of suppliers currently provide duress alarm systems to NSW Health. The tender process is flawed since duress alarm capabilities vary between suppliers. This includes variations in the technical specifications of devices, contracts for system maintenance and response requirements. Procurement decisions appear to be at the discretion of LHDs/facilities, and this is problematic for worker safety. The tender system should ensure all suppliers meet minimum requirements, including person (man) down functions that cannot be disabled and digital display of location of alarm activation.

Requirements for procurement must include testing across all new facilities and where a new system is introduced in a redevelopment, that system should be rolled out across campus to eliminate duplication

of systems in place. NSW Health has clear policy around personal duress alarms set out within *Protecting People and Property*. This policy outlines who needs to wear personal duress alarms (workers in Emergency Departments (ED), and then more broadly based on risk assessment), as well as the features personal duress alarms must have.

The NSWNMA has identified more than ten different types of duress alarms currently being used across NSW Health facilities (there are likely many more). Of these alarms, none were fully compliant with the requirements as set out in *Protecting People and Property*, (although some were significantly better than others) with issues including alarms not working in all areas e.g., toilets, staffrooms; location info is not specific, it just identifies the ward; device does not notify of faults, and workers not alerted that a duress has been activated.

Not only are different devices being used in different LHDs, the NSWNMA has also identified two LHDs using at least four distinct types of alarms and have identified situations where different alarms are used in various parts of the same facility. Further, the NSWNMA has identified sites where the device will work in some areas of the facility but not others, even when staff are required to work between both areas (e.g. different devices in mental health and the ED, with devices only working in their programmed area, even though mental health nurses may work in the ward and the ED, or may be required to transport patients between the two).

In addition to decisions about which model of alarm to purchase, LHDs are also making decisions about what types of service agreements to enter. These service agreements may influence the features of the device that are accessible, as well as maintenance arrangements and response times when problems with the operations of the system are identified. Further details of concerns are outlined in our recent submission to the Special Commission of Inquiry into Healthcare Funding[21].

There should be consistency relative to procurement of potentially life-saving equipment. Procurement through HealthShare NSW must guarantee a minimum standard of equipment that is not only universally available across all LHDs but meets safety standards and the needs of the service, identified through worker consultation.

Any procurement through HealthShare NSW must guarantee best quality, adhere to safety standards and be cost-effective. The policy and practice across all LHDs and within HealthShare NSW must be that items deemed unsuitable can be returned and refunded.

It is essential there are systems to ensure supply of all equipment, including specialised and bespoke items, is subject to a 'litmus test' of suitability prior to purchase orders being approved regardless of who is requesting the item.

Consultation with workers using equipment, including nurses and midwives, should form part of local governance of procurement. In addition, where equipment is not fit for purpose, or does not meet safety standards there must be avenues for complaint with enforceable consequences where this causes risk to workers and people receiving care.

[21] https://www.nswnma.asn.au/wp-content/uploads/2023/11/NSWNMA-Submission-to-the-Special-Commission-of-Inquiry-into-Healthcare-Funding-Appendix-included.pdf, pp72 -74

Sustainability considerations in procurement decisions

NSWNMA members repeatedly identify procurement processes as a barrier to implementing sustainability initiatives in their services, and a barrier to getting projects 'off the ground'. They report identifying an issue or a change to practice that could result in either environmental protection (waste reduction) or cost savings; often suggested measures will result in both. However, lack of flexibility in procurement practices creates a barrier. Often, members will have an approved business case (sometimes sourced from another facility, or LHD), with associated cost savings, but are told that is not possible due to contract/procurement issues.

These barriers also function in the opposite direction. For example, Baxter Healthcare provides intravenous (IV) fluid bags. Baxter can accommodate 'polyvinyl chloride (PVC) recycling' in a program they claim is diverting more than 200 tonnes of PVC waste from landfill. Launched in 2009, this sustainability program collects and recycle Baxter intravenous (IV) fluids bags, as well as PVC oxygen masks and oxygen tubing.

A Sydney hospital, with an established PVC recycling program, changed from Baxter IV products to another company called Fresenius. When this change happened, the PVC recycling program ceased, as Fresenius don't offer a recycling program.

NSWNMA member suggestions include:

- Build sustainability practices into decision-making processes and streamline with dedicated roles (include in mandatory training).
- Amend contracts and procurement to include targets for sustainability (e.g., if one company will do recycling of IV bags, should be mandated that this is the company to use, and recycling of IV bags is compulsory).
- Tailoring equipment to workflow (e.g., what actually needs to be in equipment/dressing packs in operating theatres).

> *"Sustainability projects are run off the goodwill and energy of individuals – usually nurses or midwives; something needs to change, and it really needs to come from the top".*
>
> Registered Nurse (hospital sustainability committee member)

NSW Health should develop state-wide healthcare procurement policies and practices to ensure the supply-chain (e.g., medical equipment, pharmaceuticals, and protective equipment) is transitioning to environmentally sustainable practice and net zero emissions at a matter of priority.

Tender process and approval should include a sustainability outcome indicator/measure (such as ISO 24000 – sustainability procurement).

Earlier in this submission we noted the need for local procurement on connection with demand and supply chain incompatibility. Local procurement can also contribute to lower carbon footprints across the supply chain and therefore this should be factored into decision making, even where this creates added cost given the financial burden of climate crisis related healthcare impacts.

Systems and building procurement

Our members frequently report safety concerns regarding poor procurement decisions relating to health infrastructure, despite those awarded contracts for major building works being cited as experts in their field. A recently commissioned birthing suite failed to consider safe access in an out of birthing pools in its design, delaying the opening of the facility.

Separately, changes to a hospital rebuild did include consultation with nurses but was described as a 'tick box' exercise, resulting in areas of a department being commissioned then found unfit for purpose once open. A circumstance that led to a near fatal suicide attempt of a patient. A refurbishment in another hospital resulted in a much-needed clinical area being too small for practical use and is now being used as a storeroom.

Procurement of electronic patient records systems including medication records, have been cited as unfit for purpose, but their purchase and implementation was a significant expenditure for the government. Issues such as systems not being compatible with those in other states have led to serious patient safety issues in facilities which are situated near state borders. An example being substance-dependent patients from the ACT 'doctor-shopping' to gain medication in NSW where past medical history records cannot be sourced owing to incompatible healthcare record systems.

There must be accountability and due diligence, as well as involvement of unions and workers in any major capital investment in health infrastructure including new build and refurbishment. This must include penalties should opening of services be delayed or found unfit for commissioning owing to preventable errors in design. Similar governance measures should be applied, including worker engagement and penalties where electronic systems are unfit for purpose once operationalised.

Procurement of services

Western Sydney LHD entered into a contract with private provider Silverchain to deliver palliative care services within the district under a Social Impact Investment scheme[22]. The principles of the scheme require delivery on value for money and ongoing outcomes-based measurement to monitor progress, risk and returns on investment.

Our members reported there were teething problems associated with the transition from public to private hands.

Whilst privately contracted services should be subject to transparent evaluation and a clause to return services to public hands for contractual failures in service delivery, there appears to have been only one publicly facing report on Silverchains delivery of palliative care services[23], despite it being suggested two further reviews would occur in 2022 and 2025. Whilst the report was cited as being independent, it was

[22] https://treasury.gov.au/programs-initiatives-consumers-community/social-impact-investing/australian-government-principles-for-social-impact-investing.
[23] Paxton Group (2020) *Silverchain: Evaluation of the Silverchain Community Palliative Care Service Western Sydney – Social Impact Investment*. May 2020. Available at: https://golab.bsg.ox.ac.uk/knowledge-bank/resource-library/silver-chain-evaluation/

commissioned by Silverchain. It is questionable why a service commissioned using public funds should not be subject to independent and ongoing governance.

Due to the length of time Silverchain has been operating the service, they are now well embedded in the care delivery models in operation for palliative care services in Western Sydney. For this reason, their return to NSW Health is less likely leading to privatisation by stealth of public sector services.

Aged Care Assessment Services are currently out to tender by the federal government as part of the move towards creating a Single Assessment System[24]. There has been significant lobbying by the NSWNMA to maintain these services in public hands, and job uncertainty over multiple contract cycles for those employed. Whilst the tendering process is determined by the federal government, NSW Health has a duty of care to its employees to lobby for permanent delivery of these services by existing teams.

The NSWNMA is strongly opposed to the privatisation of public health services in NSW, and the negative impact it has on the delivery of healthcare and health outcomes to people in NSW. We refer to the NSWNMA submission to the Special Commission of Inquiry into Healthcare Funding[25] for further detail and recommendations.

Further governance measures

In one LHD in NSW there is an approval chain for purchases with a delegation manual stating who is allowed to approve money at various levels (one to six) depending on amount. Previously all direct purchases for lower amounts could be done locally by a Nurse Unit Manager (NUM). This enabled requests for everyday purchases such as single use items required to keep people alive to be approved by the NUM. As a result, there would be local level governance around suitability and quantity.

From 2023, without explanation to staff, the amount of money able to be signed-off by a NUM was reduced to $500. This means many of the everyday items require higher level approval. The procurement system automatically sends most purchase requests to the Director of Nursing, resulting in them receiving more than 300 requisition requests a day for everyday life saving supplies.

This change in process has resulted in delays in equipment such as simple ventilatory units while their purchase is approved by three layers of management. It has created multiple incidents of emergency department, intensive care units and operating theatres running out of supplies resulting in constant escalations to management. To address this, it is reported the system has been circumvented so an administrator can override the log in system and sign off requests, resulting in no governance around quantity, quality and suitability of supplies being ordered.

There is a lack of a known overarching governance strategy for dispensing of medication by hospitals or services, where the medication could be more cheaply purchased in a local pharmacy. For example, it is reported in some areas people have accessed ED simply to obtain simple over-the-counter medicines e.g. paracetamol for a headache. Whilst staff have a duty of care to treat people, the cost of procuring simple medications such as paracetamol come at a much greater cost to NSW Health than would otherwise be the case if purchased by the individual in a supermarket or local pharmacy.

[24] https://www.health.gov.au/topics/aged-care/aged-care-reforms-and-reviews/single-assessment-system-for-aged-care
[25] https://www.nswnma.asn.au/wp-content/uploads/2023/11/NSWNMA-Submission-to-the-Special-Commission-of-Inquiry-into-Healthcare-Funding-Appendix-included.pdf. Pp 24-38.

A report from the UK identified in the year prior to June 2017, the NHS spent approximately £569 million on prescriptions for medicines, which could otherwise be purchased over the counter from a pharmacy and/or other outlets such as petrol stations or supermarkets[26]. There should be consideration of cost efficiencies in the purchase and supply of over-the-counter medicines.

A review of all procurement processes within LHDs and more generally across the breadth of NSW Health should occur to identify cost-savings, ensure streamlining of procurement and remove preventable delays in acquiring life-saving equipment. Where contracts and awarded, or supplies procured, wherever practicable these must be subject to early review as to suitability and have return clauses embedded. In addition, there should be systems for enforcement where suppliers fail to meet quality and safety standards or are found to have poor or unethical labour practices with mechanisms to enforce penalties for breaches.

Modern slavery is highlighted as a risk relative to procurement of goods in health services[27]. This was emphasised during COVID-19. The push for mass PPE created a marketplace where worker exploitation could thrive and usual due diligence in procurement governance sidelined, due to the pressing nature of the ensuing health crisis. This led to allegations of international forced labour in the supply of equipment such as single-use gloves[28, 29]. Specific provisions as listed in the referenced document (no.24) provide a useful template going forward which can be embedded in procurement contracts to ensure worker protections.

Repeat global pandemics are entirely predictable, procurement of onshore manufacturers would enable greater control over employment practices, bolster the local economy and ensure a timely supply chain of goods and equipment which meet Australian standards should a situation like this recur. The procurement of PPE such as single-use gloves is ongoing and predictable, there must be a plan to reduce the international procurement of continual and frequently used items for health services.

Public spending must be accountable with clear lines of governance. The principles which should underpin acquisition of PPE, must also apply across the breadth of procurement. Use of public money must prioritise domestic supply chains and local job creation, particularly in those areas where there is declining local manufacturing, or potential to grow community capacity. Ensuring wherever possible, creation of jobs for Aboriginal Corporations or business registered with Supply Nation[30] or similar. Indeed, it is often much more cost effective to source local supplies.

In addition to the above, the following governance measures are recommended.

Introduction of public good considerations to the awarding of contracts via additional weightings for suppliers who can demonstrate a range of factors such as local content, job creation, economic benefits, development of sovereign capacity and investment in regions of industry decline.

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[27] Australian Human Rights Commission and KPMG (2021) *Modern Slavery in the Health Services Sector: Practical responses for managing risk to people*. Available online at: https://humanrights.gov.au/sites/default/files/document/publication/ahrc_20211115_modern_slavery_-_health_services_v9_web.pdf

[28] Sydney Morning Herald online (2021) *'Gloves off: Ansell under fire over 'modern slavery' at Malaysian supplier*. Available online at: https://www.smh.com.au/world/asia/gloves-off-ansell-under-fire-over-modern-slavery-at-malaysian-supplier-20211221-p59j9q.html

[29] Bhutta, M. et al (2021) *Forced Labour in the Malaysian Medical Gloved Supply Chain before and during the COVID-19 Pandemic: Evidence, Scale and Solutions*. Available online at: https://www.bsms.ac.uk/_pdf/about/forced-labour-in-the-malaysian-medical-gloves-supply-chain-full-report-july-2nd-2.pdf

[30] https://supplynation.org.au/about-us/

An explicit ‘Local, Secure and Fair Jobs’ code that outlines industrial rights and conditions for contracts and requires suppliers to submit to WHS and Industrial audits, put together compliance plans and model industrial clauses in major contracts.

A range of compliance measures focused on giving unions representation in the NSW Jobs First Commission, standing to bring forward evidence of industrial non-compliance by successful suppliers and State Government publishing information about what successful suppliers have said they will do.

Submission to: Procurement practices of government agencies in New South Wales and its impact on the social development of the people of New South Wales

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NSW NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH
www.nswnma.asn.au
50 O'Dea Avenue
Waterloo NSW 2017
T 8595 1234 **(METRO)** • 1300 367 962 **(NON-METRO)**
F 9662 1414
E gensec@nswnma.asn.au