Western Australian
Auditor General's Report

Health Department's Procurement and Management of its Centralised Computing Services Contract

Report 1: February 2016

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WESTERN AUSTRALIAN AUDITOR GENERAL'S REPORT

Health Department's Procurement and Management of its Centralised Computing Services Contract

Report 1
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THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

HEALTH DEPARTMENT'S PROCUREMENT AND MANAGEMENT OF ITS CENTRALISED COMPUTING SERVICES CONTRACT

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 200*6.

Performance audits are an integral part of the overall audit program. They seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

This audit assessed how effectively Health had managed its Centralised Computing Services contract.

My report identifies that governance and leadership of the contract was poor, resulting in the procurement of additional and unnecessary IT services worth millions of dollars.

It identifies the need for Health to better understand contract management and oversight of contracts, and to take action to address the inefficiencies.

I wish to acknowledge the staff at the Department of Health for their cooperation with this audit.

COLIN MURPHY

AUDITOR GENERAL

17 February 2016

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Auditor General's Overview

This audit arose from concerns raised with me by the previous Acting Director General of the Department of Health. I need to acknowledge this referral by the Acting Director General. He was acutely aware of the prospect of very public exposure of shortcomings within the department, but nevertheless chose this course in the interest of ensuring a rigorous, external and independent review of this significant issue.

Health established its Centralised Computing Services contract to provide high quality primary and secondary data centre facilities, to eliminate the need to build and manage it's own data centre facilities and to free up much needed cash for the health system. The contract established an important role for the private sector in the provision of public health services.

Large contracts between government and the private sector need to work well. Governments will never have all of the skills and capabilities required to deliver all of the services. Industry is ready and willing to provide services to government. Most importantly, government contracts need to deliver value for money.

The potential benefits of these arrangements are indisputable. But the risks are equally evident and if not managed well, prospective benefits can be lost.

This report demonstrates the importance of understanding and managing contract risks, particularly when they are of the complexity, the value and the length of Health's Centralised Computing Services contract.

Signed in 2010 with a value of $44.9 million, the contract has grown through 79 variations to a potential $175 million with components of the contract running until 2020.

The audit identified numerous and fundamental weaknesses in Health's management of the contract, ranging from a lack of identified need for the multi million dollar variations, to a failure in delegation and authorisation procedures, and from an absence of performance monitoring to inadequate checking of the accuracy of invoices.

Health, to its credit, has been implementing changes to address the issues identified in this report and has committed to further change. Thereafter, maintaining commitment to good practice is essential.

Unfortunately, too often we identify instances of agencies failing to follow their own approved practices or widely accepted good practice. The public is entitled to feel frustrated by these reoccurring events and justified in demanding improvements.

Executive Summary

Introduction

In late 2014, the Acting Director General, Department of Health (Health) wrote to the Auditor General advising of his concerns regarding the structure and performance of Health's Central Computing Services contract.

Following discussions with Health and a preliminary review of available information, we decided to audit the procurement and management of the contract as well as the financial and asset control arrangements for goods and services purchased under the contract.

Overview

In November 2010, Health entered into a $44.9 million contract with a large international company (the Contractor) to provide centralised computing services. This entailed the provision of high quality primary and secondary data centre facilities. A data centre is a facility used to house computer systems and associated components, such as telecommunications and storage systems. The secondary centre acts as a backup facility.

The contract also includes management and support of the computer and network infrastructure in the data centres and support to the data rooms at teaching, regional and other metro hospitals.

The contracted service was structured to ensure IT systems and applications had a high degree of availability. This would also guarantee critical information was recoverable and the systems flexible enough to handle the peaks and troughs of demand experienced by Health.

One of the key objectives of the contract was for the relocation of equipment from Health's existing data centres into better facilities within specified timeframes and with minimal disruption to Health's business operations.

The initial contract was for 4 years, with 2 x 2 year extension options valued at another $48.9 million. Health has exercised the first of these options and the contract will now run to at least November 2016.

Health's IT branch, the Health Information Network (HIN) managed the contract. During 2014, Health initiated a procurement review which led it to identify and start addressing many of the issues raised in this report. Health is implementing fundamental reforms to ensure greater oversight over its contracts.

Appendix 1 shows a timeline of key events during the course of this contract.

Audit conclusion

The Department of Health has not managed its Centralised Computing Services contract effectively. Governance and leadership over the contract was poor resulting in the procurement of additional and unnecessary IT services worth millions of dollars. In addition, Health had not properly planned and implemented critical data centre facilities costing millions of dollars that ultimately failed to meet service expectations.

Since coming into operation, 79 contract variations have added at least $81.4 million to the contract of which approximately $44 million of the variations were not authorised and should have been procured through an open tender process as they were arguably inconsistent with the scope of the initial contract. Health could therefore not demonstrate that it had received value for money for these services. It also had not assessed the business need for at least $41.5 million of contract variations, which it now recognises as exceeding requirements.

Analysis of the initial contract procurement process indicates that Health followed the required procedures and processes. Progress reports indicate that work undertaken under the initial contract is currently on track and close to budget.

However, Health did not follow good process for identifying and mitigating risks associated with work done under the contract variations. A mid-term review Health conducted in 2013 as part of its standard contract process identified several similar issues to those in this report, but Health did not address these, instead opting for another review.

Financial management was ineffective. Health did not increase the contract value in its financial system to account for the variations, was not coding invoices to the contract and failed to check the accuracy of the Contractor's invoices, consequently missing numerous discrepancies. It therefore could not meaningfully monitor and compare the contract expenditure against budget. It also did not seek Treasury authorisation to borrow in excess of $27 million for assets leased from the Contractor.

Key findings

Contract variations

Seventy-nine variations to the contract almost tripled its value in the first 4 years:

- The contract was initially valued at $44.9 million but due to 79 contract variations worth $81.4 million, the value, including the option to extend the contract, will now potentially exceed $175 million. The number and value of the variations suggests Health did not properly plan the initial contract.
- Two variations to the contract totalling $41.5 million were arguably inconsistent with the purpose and terms of the initial contract and given their size should have been procured under a competitive public tender process to obtain assurance that value for money was obtained. The 2 variations increased Health's data centre capacity and provided a non-production environment.
- Evidence indicates that the Contractor undertook the majority of the scoping work for the data centre expansion and that Health accepted the Contractor's proposal without its own independent validation. Health now finds itself with significant excess capacity and ongoing unwarranted expenditure:
    - Health is using only 65 of the 167 racks, or frames for mounting computer and related components, in 1 of its data centres. The value of the unused racks is $2,040,000 ($20,000 each). As well, Health is obligated to making ongoing payments to the Contractor for the space taken up by these unused racks. We estimate the cost of this unnecessary expenditure at around $90,000 per month.
    - Health is not using 5 network switches purchased in 2013, to connect devices together on the computer network, at a cost of $1.25 million ($250,000 each). These switches have guarantee periods that may expire before Health actually uses them.
- The second of the major contract variations, which runs until March 2019 was established to provide Health with access to a non-production environment (NPE). Health initially intended to utilise the capacity of this system to test applications before implementation and for training purposes. However, Health found that the capacity it acquired far exceeded NPE requirements and therefore now also uses this cloud environment for email and archiving software. The contract variation requires Health to pay the Contractor a baseline fee of around $265,000 per month, if the NPE is used or not, with additional fees to be negotiated as and when extra capacity is required. We were unable to assess

how Health had determined the initial capacity requirement for the NPE or the required duration for the contract.

- The Health officer who authorised the above 2 contract variations massively exceeded his $100,000 expenditure authorisation limit. The 2 variations were arguably also outside the original contract scope and should have been treated as new purchases. New purchases exceeding $150,000 must involve the Department of Finance to ensure transparency and value for money in the procurement processes. Approving what should have been new purchases as a contract variation resulted in Health breaching its partial exemption from State Supply Commission requirements.
- The original contract will run to 2018 if Health exercises the second of the 2-year extension options. However, the major variations referred to above have terms that expire in either 2019 or 2020. How Health resolves these timing differences is unclear though it may require for instance the payment of 'early termination' charges for these variations.
- To help ensure staff act within their delegated authority, Health has updated its delegations to be more specific regarding the circumstances in which contract variations are approved. It has also trained senior staff involved in authorising procurement.

Contract management

Health's contract management and governance were insufficient, largely ineffective and meant that emerging issues went unaddressed:

- Despite the importance and value of the contract, Health did not adequately assess the performance of the contract or Contractor until November 2014. Health had not, as we expected:
    - assessed whether the Contractor was meeting the terms and conditions of the contract
    - assessed the accuracy and content of monthly performance reports from the Contractor. These included details of any incidents that were identified and resolved, disaster recovery testing completed and the operational performance against targets.
    - addressed areas of concern identified in the monthly reports.
- Health did not act to address serious concerns about the contract raised by a consultant conducting a mid-term review in 2013 and from 2 general IT procurement reviews in 2013. The concerns included procuring services outside the scope of the contract and the lack of a business case for significant variations to the contract. Poor documentation meant that we could not determine the extent that the issues were escalated to the various executive levels in Health.
- The Acting Director General improved the governance arrangements around ICT procurement and projects shortly after becoming aware of these significant issues. He also requested a comprehensive internal review of contracts and procurement, concerns from which led to this audit.
- Health did not monitor key contract deliverables to ensure its expectations on services were met. One of the key deliverables of the contract was for the primary data centre to be available for 99.98% of the time (out of action for 1.6 hours per year or less). One of the reviews in 2012 identified that Health was not testing this part of the contract. The effect became evident when the primary data centre had two outages causing the computer systems and the IT network to crash for a period of 14 hours in February 2015.

This meant Health could not use clinical and non-clinical computer applications and the IT network.

- Health did not have a contract management plan for this complex and high value contract. A plan would identify the risks to contract delivery and set out how to mitigate these. It would also identify the resources required to manage the contract effectively and define roles and responsibilities. The *State Supply Commission Act 1991* requires a contract management plan for contracts greater than $5 million.

- Despite the value and importance of the contract, Health did not appoint a dedicated contract manager until midway through the fourth year of the contract. Instead, a senior Health officer partially took on this role in addition to other roles as a member of the IT executive and the contract sponsor. It was evident that these other roles meant that he lacked sufficient time to properly monitor and assess the deliverables of the contract.

- Health's recordkeeping in relation to the contract is poor and as such, it has failed to comply with the *State Records Act 2000*. Health was unable to provide us with key documents including the business case and procurement evaluation reports or documents setting out the reasons for the millions of dollars of contract variations. The Act aims to provide security and retention of records for purpose of transparency and accountability and includes a penalty for non-compliance.

- An IT equipment and component check conducted by Health in mid-2015 showed that essential equipment purchased in late 2013 was not tagged (recorded) to enable sub-optimal performance of the equipment to be speedily identified and resolved. Tagging also enables Health to confirm that equipment purchased under the contract was installed and used. Both the Contractor and Health had some responsibility for tagging the equipment.

Financial management

Financial management was ineffective, contributing to regulatory non-compliance, large unbudgeted expenditure commitments, probable overpayments and a general lack of transparency:

- Health could not meaningfully monitor and compare expenditure against the contract budget as it was not increasing the contract value for variations or coding all relevant invoices to the contract. It also did not adequately consider the terms of multi-million dollar finance leases or check the accuracy of invoices, leading to unbudgeted expenditure commitments and overpayments. Examples of these are:

    - Health paid the Contractor 'mark-up' fees valued at $104,000 on 8 invoices it submitted to Health on behalf of a third party contractor despite mark-up fees being excluded from the contract. Health could not explain why it made the payments. The mark-up was the Contractor's fee for passing on to Health the invoices of a subcontractor. The Contractor advised us that Health requested it engage the third party as a subcontractor as the third party was not at the time registered with the Department of Finance as an approved provider under the relevant Common Use Agreement. For this reason, Health could not themselves directly engage the third party. The mark-ups represented 10% of the third party's fee.

    - We tested the accuracy of the invoiced services against the contract schedule of rates and noted numerous discrepancies that Health could not explain. Most of the discrepancies were over payments. We sampled 30 of the 642 invoices to 17 March 2015. The overpayments totalled $41,000 from 26 invoices, representing 8.8% of the value of the invoices. Of the other invoices in our sample, we agreed 1 to the schedule of rates and could not find 3 invoices. Health has done its own review of the

rates and also identified discrepancies. The contractor advised us that 'Health may have misinterpreted how the rate card applies to project service invoices' and that it is having meetings with Health to discuss the issue.

- Health entered into 8 leases through the Contractor for software and to move or supply and install racks, cabling and hardware for the data centres. The value of the leases was $27 million. However, essential governance steps were not taken with Health entering into the leases without a good understanding of the arrangements and without the necessary authority.
- Health did not properly assess whether the leases should be classified and treated as 'operating' or 'finance' leases. Operating leases are paid from operating funds while finance leases are paid from capital funds. Agencies can self-approve operating leases but a finance lease requires the Treasurer's approval[1]. This aims to prevent agencies committing the State to unbudgeted expenditure without the Treasurer's knowledge and approval:
  - Health classified 4 leases as operating leases but all 4 had financial lease components and should therefore have received Treasurer's approval.
  - Health did not seek the Treasurer's authorisation to enter into the other 4 finance leases.
- The schedule of operating lease payments and financial lease repayments agreed by Health for 5 of the leases were unusual in that they involved significant up-front payments. The combined value of these leases, the last of which expires in January 2020, was $16 million, of which $10.8 million or 68% was paid up-front, in June 2013. Health could not explain the rationale for this unusual payment arrangement, but it appeared to be linked to a desire to use the operating budget for that financial year. By making large up-front payments on an operating lease, Health runs the risk that the usage value from the asset will be less than the payment.
- When Health entered into the finance lease agreements, it assumed that it became the owner of the assets at the end of the lease. However, the Contractor disputes this and advised us that the terms of the agreement are clear. Health will need to resolve this issue.

[1] Treasurers Instruction (TI) 822 Borrowings

Recommendations

1. Health should immediately ensure compliance with the Treasurer's Instruction 822 Borrowings for all future lease financing activity.
2. As soon as possible to minimise unnecessary expenditure, Health should negotiate with the Contractor and the Government Chief Information Officer for other government agencies to use the non-production environment and the unutilised data centre space.
3. By March 2016, Health should:
    a. develop and implement a contract management plan for contract DoH 27210 as required by the State Supply Commission
    b. conduct a comprehensive risk assessment of the contract
    c. determine the level of contract management, including the need for a dedicated contract manager required for contract DoH 27210 and other contracts
    d. ensure that appropriate records for this contract are collated and maintained as required by the *State Records Act 2000*
    e. ensure that expenditure authorisation limits, including for contract variations, are suitable, defined and adequately understood
    f. clarify with the Contractor the ownership of the leased assets.
4. By June 2016, Health should:
    a. clearly separate the roles and responsibilities for contract management with that of contract management oversight
    b. define the policies and procedures it requires to achieve good practice in contract administration
    c. review all invoices for this contract to determine the accuracy of rates used in the calculations.
5. By December 2016, Health should ensure that there is adequate assessment and review of this contract's performance in accordance with the contract terms and conditions.
6. By June 2017, Health should:
    a. assess its required or predicted capacity requirements to ensure that appropriate data centre space, IT hardware and software are available as part of this contract
    b. ensure that appropriate records management policies are revised, communicated to staff and enforced by all Health entities as per the *State Records Act 2000*.

Response from Department of Health

As a result of internal concerns regarding the performance of contract DOH 27210, in late November 2014, the A/Director General of WA Health, Professor Bryant Stokes, requested that the Auditor General conduct an independent review of the performance of the contract and the proposed mitigation strategies for this centralised computing services contract.

Following the completion of the review, WA Health accepts all of the recommendations and notes that it has undertaken a considerable amount of work that has led to the completion of two recommendations and significant progress towards the implementation of the others. The anticipated WA Health timelines for completion of the outstanding four (4) recommendations is considerably shorter than the timelines outlined in the Summary of Findings.

We also note that whilst the procurement and contracting landscape in WA Health has greatly improved in the last two years, the work is ongoing to deliver further reforms and improvement in the planning, coordination and control of procurement and contract management for ICT and Goods and Services.

	Summary of Recommendation	OAG Timeline	WA Health Timeline
1	Compliance with TI822	Immediate	Jan 2016
2	Minimise unnecessary expenditure	ASAP	Mar 2016
3a	Develop CMP	Mar 2016	Feb 2016
3b	Conduct Risk Assessment	Mar 2016	Feb 2016
3c	Level of Contract Management	Mar 2016	Feb 2016
3d	Records Management for DoH 27210	Mar 2016	Mar 2016
3e	Manage Expenditure Limits	Mar 2016	Mar 2016
4a	Separate Roles and Responsibilities	June 2016	Completed and ongoing
4b	Policies and Procedures	June 2016	Completed and ongoing
4c	Reconcile Invoices	June 2016	Feb 2016
5	Review Contract Performance	Dec 2016	Mar 2016
6a	Access IT Capacity	June 2017	Jun 2016
6b	Revise Records Keeping Policy	June 2017	Jun 2016

Audit focus and scope

This was a Narrow Scope Performance Audit, conducted under section 18 of the *Auditor General Act 2006* and in accordance with Australian Auditing and Assurance Standards. Narrow Scope Performance Audits have a tight focus and generally target agency compliance with legislation, public sector policies and accepted good practice. The cost of the audit was around $320,000.

The focus of this audit was contract DoH 27210 Centralised Computing Services initiated by the Department of Health (Health) and managed by its Health Information Network (HIN).

We met with the Acting Director General and Acting Chief Information Officer to get more information on the matters raised as areas of concern, and an understanding of the steps Health was taking to address these concerns.

We reviewed the procurement activity during the contract as well as the contract management and administration, which occurred during the initial 4-year term of the contract. We assessed whether Health followed the Department of Finance's Procurement Practice Guide when it undertook the initial contract procurement, though we did not assess how comprehensively Health met these requirements.

We focused on 3 lines of inquiry:

1. Were the processes for the purchase and approval of goods and services suitable and followed?
2. Was there suitable contract management and oversight of the IT Contractor?
3. Was there suitable financial and asset control arrangements in place for all goods and services purchased under contract DoH 27210?

In conducting this audit:

- we reviewed prior reports and investigations at Health by the Corruption and Crime Commission
- we reviewed Health documents and data
- we spoke to Health staff, analysed the information they provided, reviewed contract variations and tested a sample of invoices and leases. We also attended asset counts, viewed the data centre at Malaga and used advanced tools to analyse email traffic and content
- we provided the Contractor with a redacted version of this report and met with them to discuss references to them in the report.

Background

Organisational structure

When the contract commenced in 2010 and until the reorganisation in 2014, the basic organisational structure of Health was as represented below. The State Health Executive Forum (SHEF) was responsible for setting strategic direction. The SHEF ICT Committee was a subcommittee of the SHEF, and was mainly responsible for ensuring ICT projects were aligned with ICT strategy.

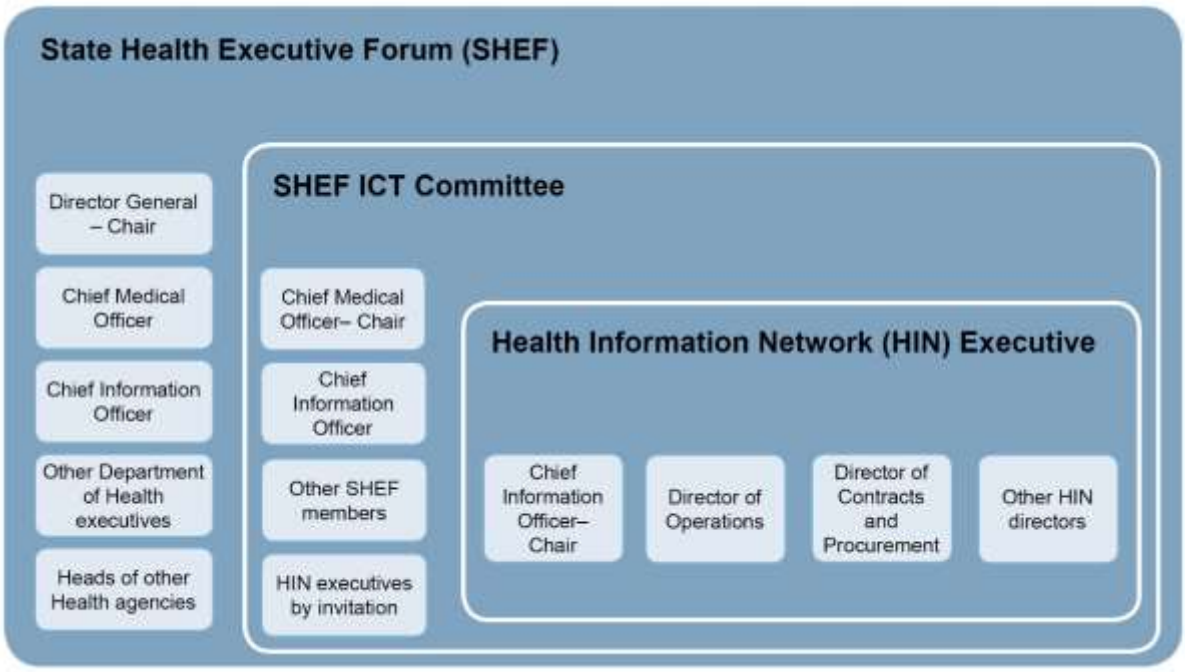


Figure 1: Health's organisation structure during much of the contract period

The above structure changed in April 2014 as part of a major reform project.

Health established an ICT Executive Board and gave it oversight and endorsement where appropriate of ICT investment decisions and projects. The ICT Executive Board is also responsible for approving annual implementation plans and monitoring the success of the ICT strategy. The Director General chairs the ICT Executive Board with support of an ICT Program Committee that oversees delivery of the ICT strategy and ensures ICT projects and programs are delivered on time, on budget and according to agreed scope.

In September 2015, Health also reorganised its support services, which includes HIN, to strengthen further the overall governance and management of ICT across Health.

Description of contract

Health entered into a contract with the Contractor for the provision of:

- infrastructure (2 x data centres) to be available almost continuously or for 99.98% of the time. This would also include reliable and active support to ensure consistency of services

- recovery of systems to be consistent with the need for applications, this would include disaster recovery services which meet Health's business requirements
- flexibility to handle peaks and growth in demand, through suitable data centre facilities and capacity planning aligned to business drivers
- secure data centre occupancy to ensure further relocations were not required
- the relocation of computing equipment located in the existing primary and secondary data centres to the replacement primary and secondary data centres within timeframes specified by Health and with minimal disruption to business operations.

The contract was awarded on 30 November 2010 with a transition period of April 2011 to move equipment from existing data centres to the new data centre at Malaga. The initial contract period was for 4 years with 2 contract extension options of 2 years each, giving a total potential contract period of 8 years. Prior to the end of year 4, Health exercised the first of its options and extended the contract to November 2016.

The contract requires the main data centre to be Tier 3 aligned. A Tier 3 data centre does not shut down for equipment replacement and maintenance. It also must have a secondary delivery path for power and cooling to ensure systems are available and operating so that each and every component needed to support the IT processing environment can be shut down and maintained without impact on the services provided.

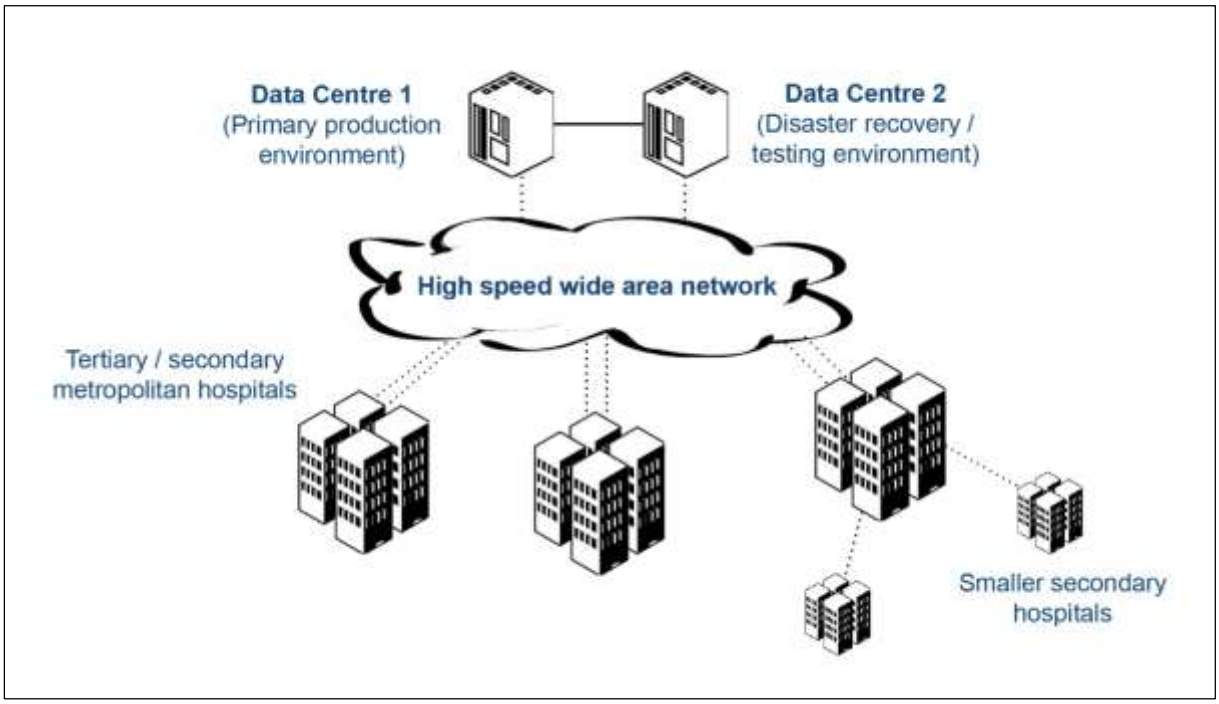


Figure 2: A schematic description of Health's data centre arrangement

Contract variations

There were 79 variations to the contract in its first 4 years. These consisted of a variety of items, as can be seen below. Although most did not significantly increase the contract value, 10 variations cost between $1 million and $6 million and the 3 highest value variations were for $8.2 million, $20.4 million and $21 million.

There were 2 main periods of activity. One was from 25 October 2011 to 8 October 2012 where the value of variations totalled $55.9 million. These included the Data Centre

Implementation, Network Management Services Extension, Data Centre Expansion Project, Non-Production Virtual Environment and the Network Expansion Phase 2.

The second period was from the 4 June 2013 to 21 June 2013 where a total of $13.2 million of variations were processed.

Health reviews of the contract

Health undertook several reviews in the first 4 years of the contract. A number of issues raised in these reviews are referred to throughout this report. The last 2 reviews shown in the table below were undertaken at the direction of the Acting Director General due to concerns about ICT procurement and contract management.

The Contractor advised us that only the findings of the mid-term review were provided to it for comment and that it disagrees with some of the main findings of the other reviews.

Name of review and who conducted	Report dated	Purpose	Main findings
Internal Analysis, HIN Procurement and Contracts Group	June 2012	Analyse the contract spend to date to establish how the contract was performing against budget.	• projected $25 million overspend at current rate of expenditure • 3 different contract numbers were being used
HIN Operations and Delivery Review by an expert consultant	August 2012	A qualitative review of HINs operations and delivery of services from the perspective of Health employees	• unclear roles and responsibilities • poor internal communication • poor organisational structure • planning for recruitment and retention of suitable staff was lacking • no structured approach to vendor engagement or management • inconsistent approach to planning with very little third party input • culture of avoidance of issues, lack of accountability and complacency.
Internal Analysis, HIN Procurement and Contracts Group	October 2012	Analyse how the contract was performing against key measures.	• solution description was outdated • Murray Street facility unable to function as primary data centre (i.e. does not have the same or similar capacity and capabilities of its primary counterpart to enable it to handle all critical traffic) • testing of full data centre disaster recoverability not being done or planned • procedures manual not being updated and training in procedures not taking place • equipment inventory not accurate or being adequately updated

Name of review and who conducted	Report dated	Purpose	Main findings
Contract monitoring by an interim contract manager	January 2013	Analysing invoices to assess if the expenditure was in line with the terms of the contract	• mark-ups paid on some pass through invoices.
Mid-Term Review of the contract Experts contracted for this purpose	November 2013	Assess expenditure, delivery and quality of service, barriers to service improvement and the identification of areas where performance could be improved.	• poor understanding of the contract • $26.7m overspend of the contract, against base contract value • paid for data centre (DC) expansion without a budget • cloud services procured in conflict with current strategy • an estimated 65% more DC capacity than required • no overall ownership for contract in Health.
Review of ICT Procurement at the request of the DG Experts contracted by Internal Audit	June 2013	Effectiveness of ICT procurement in Health, as part of the 2012-2013 Internal Audit Plan	• business cases were not recommended • a lack of evidence of good contract management • no contract management plans • no contract management system • poor records management.
Procurement Review Health's Chief Procurement Officer	August 2014 (draft report)	Part of the strategic procurement reform program for Health. This review looked at DoH 27210 as part of a larger group of procurement activity.	• contracts not actively managed by a dedicated contract manager responsible for performance or financial monitoring • inadequate risk monitoring and management • deficient checks of contract compliance against obligations • ineffective recordkeeping

Table 1: Reviews that had findings relevant to the contract

The contract value increased by $81 million in the first 4 years, largely without authorisation

Variations to the contract have seen the locked in contract value increase from $44.9 million in November 2010 to at least $125 million in November 2014 and potentially $175 million by November 2018. The variations have not only significantly expanded the contract scope, they have also locked Health into expenditure to 2020, which is beyond the initial 4-year term of the contract and the 2 x 2 year optional extensions.

Several of the variations were made early in the life of the contract, and did not have a significant impact on the overall cost. This is not of particular concern, because large new contracts will often require minor modifications as they 'bed down'. However, a few of the later variations significantly increased the overall cost (Figure 3).

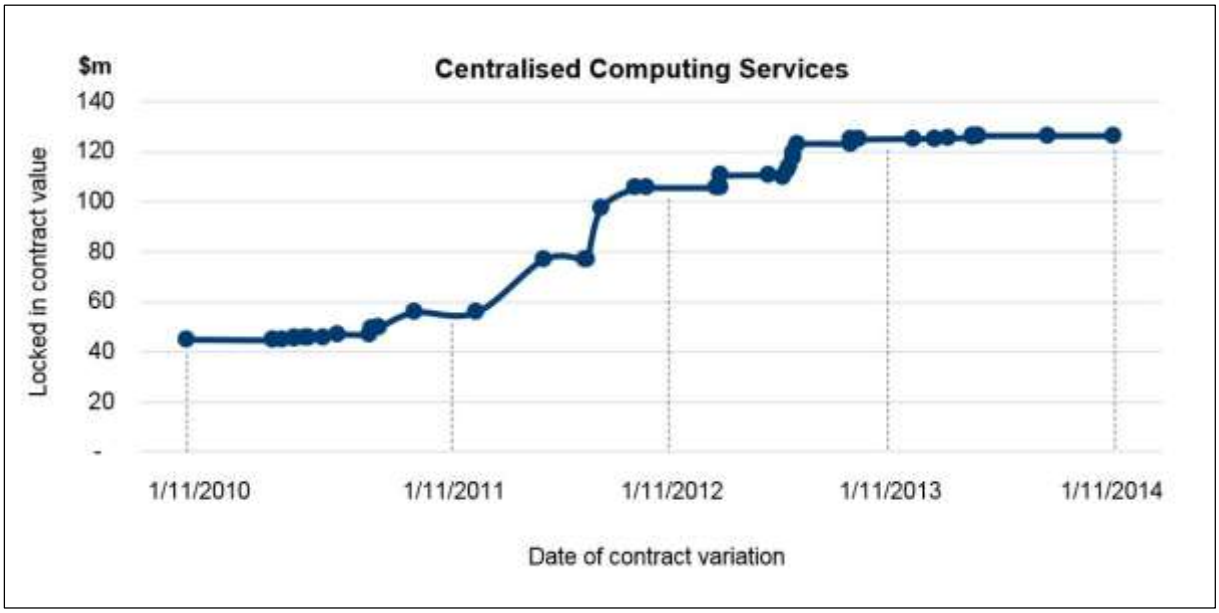


Figure 3: Growth in the value of the contract

Evidence suggests that Health followed the processes and procedures required by the Department of Finance (Finance) to procure the initial contract. These included evaluation reports of the various tenderers, which showed the scoring of the tenders combined with a final recommendation for selection of a preferred respondent.

The contract's initial term ended in November 2014. However, Health required a contract extension to complete the ongoing review of all services.

In the 4 years after signing the initial contract, Health agreed to 79 contract variations worth $81.4 million. In some cases, the variations were arguably inconsistent with the scope of the original contract and under government procurement policies, should have led to a new procurement process rather than sole negotiation with the Contractor. Figure 4 shows examples of these variations.

Health is required to comply with WA Government procurement policies issued by Finance, which regulate the way agencies purchase from private sector suppliers.

To facilitate efficient procurement, Finance has exempted larger agencies including Health from some procurement requirements. At the time of the variations, Health was exempted from some requirements up to a value of $150,000, though this has since increased to

$250,000. These rules aim to ensure an open and competitive process that provides value for money for government.

Examples of 3 significant variations that were outside the original contract scope:

- CR022 was to increase the data centre space beyond that provided in the initial contract. To do this, Health paid for the construction and fitout of additional data centre space at the Contractor's Murray Street facility, which it then leased at market rates from the Contractor.
- CR024 was for the creation of a Non-Production Virtual Environment, which is a cloud/hosting environment for testing software applications prior to rolling them out across Health.
- CR030 was for the upgrading of Microsoft Exchange 2003, which is an email application supporting 38,000 email accounts to a newer version of Exchange 2010.

Variation	Description	Value	Contract period
CR022	Data Centre Expansion	$21,090,119	May 2012 to January 2020
CR024	Non-Production Environment	$20,445,055	November 2012 to March 2019
CR030	'Exchange 2010'	$2,454,616	June 2013 to May 2014
Total		**$43,989,790**	

Figure 4: Examples of significant variations made to the contract

As seen above, 2 of the variations committed Health to expenditure past the initial 4-year term, and beyond the full contract term that ends in November 2018, making it difficult and potentially more expensive for Health not to extend the contract.

Health varied the contract without sufficient planning

Health did not adequately assess its data capacity and component requirements before signing up to major contract variations with the Contractor. As a result, it now has significant and expensive over capacity.

In May 2012, Health signed a contract variation worth $21 million to increase significantly the potential capacity of the data centre. Also in 2012, Health signed a $20.4 million variation for the Contractor to provide a virtual non-production environment, or cloud service for testing new applications prior to implementation. Figures 5 and 6 illustrate the outcome of these variations.

$21 million variation to expand data centre capacity

The $21 million contract variation saw Health increase its data centre capacity. Health now leases 4 data rooms from the Contractor comprising its original data room at Murray Street, a second purpose built room in Murray Street and 2 rooms in Malaga.

Documentary evidence at Health indicates that the Contractor undertook the majority of the scoping of work for the data centre expansion and that Health accepted the Contractors proposal without its own independent validation.

Health now recognises that the capacity it has acquired far exceeds requirements:

- only 65 of 167 racks at 1 of its data rooms in Malaga are used. Of the racks that are used, 10 had less than 50% utilisation while another 9 racks had a utilisation rate of

between 50% and 80%. Overall, only a third of the available rack space is used. The value of the unused racks is $2,040,000 ($20,000 each)

- the second data room at Malaga is using 61 of its 65 racks with an overall utilisation rate of approximately 80%
- 5 network switches Health purchased in 2013 to connect devices together on the computer network at a cost of $1.25 million ($250,000 each) are not used. These switches have guarantee periods that may expire before Health actually uses them.

Health has not assessed its utilisation of the 2 data rooms in Murray Street, each of which is equivalent in size to the second data room at Malaga.

Figure 5: $21 million variation to expand data centre capacity

$20.4 million variation to provide a non-production environment

Health varied the contract to include the provision of a non-production environment. This environment was to be used to test applications before implementation. As data space is essential at the time of testing, but not afterward, Health decided to implement a cloud-based service for the non-production environment to provide flexibility and scalability. However, Health was unable to provide us with a business case or any other analysis to justify this project.

The contract variation requires Health to pay the Contractor a baseline fee of around $265,000 per month and additional fees to be negotiated if it exceeds the baseline service.

The initial purpose was to provide an on demand service that Health could use to test environments such as those required for new hospitals. However, because capacity exceeds requirements, Health now also uses this service for emails and storage. In our discussions with Health management, we received conflicting views on the extent of actual and planned future use.

This variation runs until March 2019 – 4 months after the full contract term ends in November 2018.

Figure 6: $20.4 million variation to provide a non-production environment

Variations were approved without proper authority

Three Health officers authorised 19 of the 79 contract variations worth $77 million despite the value of the variations far exceeding their delegated authority. In 2 cases, the variations exceeded $10 million and therefore required the approval of the Director General of Health. The result was that substantial commitments were made without authorisation and budget support.

Table 2 shows the extent to which staff exceeded their delegated authority when approving variations.

Title	Employee	Delegation Limit	No. Exceeded Limit	Range of approvals	Range Exceeded %	Dollar Value
Executive Director		$10,000,000	0		0%	$
Chief Information Officer		$5,000,000	0		0%	$
Director of Infrastructure	Employee A	$100,000	4	$171,902 – $1,328,988	72% – 1,229%	$2,296,225
Director of Applications	Employee A	$100,000	1	$20,445,055	20,345%	$20,445,055
Director of Applications	Employee B	$100,000	1	$200,640	101%	$200,640
Director of Operations	Employee A	$100,000	12	$216,510 – $21,090,120	117% – 20,990%	$53,176,967
Manager Central Platform Services		$100,000	0			$
Project Manager	Employee C	$100,000	1	$3,365,215	3,265%	$3,365,215
Total			**19**			**$79,484,102**

Table 2: Instances where staff exceeded their delegated procurement limits. Employee A occupied various positions at different times

Guidance was unclear and fragmented

Health did not have clear policies and procedures, on what constitutes a contract variation or when a separate procurement process is required.

Agency obligations relating to procurement and payment are derived from a range of sources. These include the Department of Finance and State Supply Commission guidelines and requirements, Treasurer's Instructions and Health's internal procurement processes. These multiple sources made it more difficult for Health employees to understand their obligations. A single point of reference better enables employees to comply with requirements and to meet their obligations.

In line with its partial exemption under the *State Supply Commission Act 1991*, Health issued a Procurement Delegations Schedule in July 2014 that clearly defines who has the authority to vary a contract depending on its nature and value. Health also established an intranet link for staff to access procurement and contract management information to support improvements in procurement outcomes.

Governance and accountability for the contract was poor

Fundamental contract management arrangements were not established

Our expectation for a contract of the value and complexity of Health's centralised computing and services contract was that it would be supported by comprehensive governance arrangements to ensure that the desired objectives were achieved. In particular, we expected to see a dedicated contract manager, a contract management plan, and contract management guidance to assist the contract manager to perform their role. However, this was not the case.

Contract manager

Health did not appoint a dedicated contract manager to oversee the contract until June 2014, 3 and a half years after the contract commenced. Instead, a senior Health officer partially took on this role in addition to his other roles as a member of the executive of the Health Information Network (HIN) and the contract sponsor. It was evident that these other roles meant that he lacked sufficient time and arguably the independence to manage the contract effectively.

For instance, a contract manager with sufficient time to monitor contract performance may have recognised that the way the data centres were set up meant that both could not support Health's critical applications in case of an outage. The capacity for either centre to operate as the sole data centre was a contract requirement and essential for ensuring that disaster recovery services met Health's business requirements. Health felt the impact of this lack of essential capacity in February 2015 – see later in this report.

The contract manager's role is critical as the list of responsibilities below show:

- ensuring that performance measures are met, outcomes achieved and reporting results to senior management
- managing and addressing contract risks
- identifying and addressing opportunities to improve the contract
- communicating and maintaining good working relationships with the Contractor
- scheduling regular contract management meetings
- addressing problems and conflicts that may arise
- assessing and (where required) seeking approval for any variations to the contract.

If Health applied a risk-based approach to monitoring this contract, it may have recognised early on that more dedicated management was required. However, the use of specialist contract managers was not the HIN's practice when the contract commenced in 2010.

HIN's practice for contracts it considered sizeable or complex was to identify a relatively senior staff member who could provide some oversight of the contract. These staff were supported by 3 staff in the HIN's Procurement and Contracts Group who administered more than 300 Health Information Network contracts. Contract administration functions alone meant that these 3 staff were unable to take on any contract management role.

Health appointed a contract manager for this contract in June 2014, though other persons have variously taken on this role since then.

Contract management plan

Since 28 December 2007, State Supply Commission polices have required agencies to implement a contract management plan for contracts greater than $5 million. The purpose of the plan is to identify and document the key activities and tasks required to ensure achievement of the contract objectives. Health did not implement a contract management plan for this contract.

The importance of the plan and the amount of detail it contains will vary according to the risk and complexity of the contract. We consider Health's Centralised Computing Services contract to be complex and high risk. Some of the key components of a contract management plan are listed below:

- a description of the contract, its purpose and the term and extension options
- the roles, responsibilities and contact details of the contract manager and the Contractor's liaison
- payment conditions, incentives and penalties or disincentives
- invoicing requirements
- performance measures and a description of the performance monitoring and data analysis that should take place and its frequency
- the contractors obligations under the contract
- reporting requirements
- schedule of Contractor meetings
- risk assessment and management strategies.

A key to an effective contract management plan is an assessment of the potential risks and planned mitigation actions to limit their effect. Without this, obvious and perceived risks may eventuate and prevent contracts achieving their intended benefits.

A detailed contract management plan would have identified the importance of contract management and monitoring of the contract. Insufficient management and monitoring contributed to:

- problems with the recording and tagging of purchased IT equipment
- non-compliance with State Supply Commission procurement requirements in regard to the contract variations
- insufficient assessment of the Contractor's invoices resulting in what may be overpayments.

Contract management guidance

Clear guidance on how to manage contracts is an important component of the governance framework for contract management, and especially so in the HIN which uses non-specialist staff in this function. However, as observed earlier, guidance was fragmented as well as incomplete.

The knowledge required by contract managers is varied which is why specialist managers are preferred for complex and sensitive contracts. For instance, contract managers are not only required to follow sound contract management practices, they must also comply with other policies such as a Code of Conduct, Misconduct and Discipline, Public Interest Disclosure, Acceptance of Gifts, Prizes or Inducements/Attendance at Functions, Conflict of Interest and Recordkeeping.

Health introduced a Contract Management Framework on 3 February 2012, which should have acted as a guide to ensure better practice. However, the new guidance requirements were not implemented for this contract. For instance, the framework required that all contracts greater than $5 million were to have in place a contract management plan. This contract valued at $44.9 million did not have a contract management plan in place from the inception of the contract or after November 2014 when the first 2-year extension was signed.

We have included further characteristics of effective contract management in a checklist in Appendix 2 to this report.

Health's analysis of the Contractor's performance reporting was inadequate

A fundamental component of any contract that involves ongoing service delivery is for periodic performance reporting by the supplier to enable the purchaser to assess whether they receive what they are paying for.

We found that the Contractor provided Health with monthly performance reports covering 32 different aspects of the contract. These included performance information such as:

- data centre availability
- incident management
- accurate and timely updating of the configuration management database
- billing accuracy.

The extent that Health's part-time contract manager or others assessed these reports and compared them to contractual requirements is unclear due to a lack of documentation. This suggests to us that analysis and comparisons were infrequent and management was minimal.

For instance, refurbishment of a data room in Murray Street was scheduled for completion in December 2012 but not completed until February 2015. Despite the significance of this project, we saw no evidence of how Health managed the impact of the delays.

We saw some evidence of regular meetings between the Contractor and the contract manager though records of these meetings were rarely evident. However, the Contractor advised us that it minuted the meetings and agreed them with Health.

Another expectation given the contract's significance to Health's operations was that the contract manager or others would periodically report to the HIN executive on the performance of the Contractor, such as on a 6 monthly basis.

We were told that the contract manager did regularly brief the HIN executive on issues associated with the contract but we found little documentary evidence to show what was discussed. We did find 1 written report covering the period May 2011 to June 2012. The report concluded that the service performance for the most part was sufficient however, it predicted a $25 million overspend for the total 8 years. There were also alleged contract non-

compliance issues, though the Contractor advised us that these were never brought to its attention.

The issues included:

- the contractor was not updating the solution description every 6 months
- knowledge management was not being dealt with in accordance with the contract terms and conditions
- asset tracking and management was not occurring as it should.

The report also identified issues with the current systems in place such as a lack of interchangeability between data centres. That is, the ability to switch between data centres and the inability to test aspects of the disaster recovery capability. The contract schedule requires that the secondary data centre should be capable of operating as a primary data centre.

Health engaged a Consultant to undertake a mid-term review of the contract in accordance with its standard practice. The Consultant advised that Health was not adequately assessing the quality of the Contractor's service (other issues raised are discussed later).

An example we identified was the reporting by the Contractor on their requirement to provide Health with a Tier 3 data centre – a key deliverable of the contract.

Data centres are typically rated between 1 to 4 with Tier 4 being the most reliable. A Tier 3 centre, among other requirements, should be available for 99.98% of the time (less than 1.6 hours of downtime in a year).

The contract did not require the Contractor to report to Health and Health were not tracking whether the data centre's disaster recovery procedures were fully tested. Ensuring the disaster recovery procedures were fully tested would have enabled Health to address any shortcomings in the procedures, before a disaster.

Appropriate analysis of the current service levels would have highlighted that disaster recovery for all systems did not meet expected standards, including appropriate recovery timeframes. The impact of this oversight was felt in 2015 and is illustrated in Figure 7 below.

Data centre outage

In February 2015, Health's clinical and non-clinical applications and network were unavailable for 14 hours following an incident at the Malaga data centre. The data centre lost power on 2 occasions, the first for 1 hour and 29 minutes and the second, a week later for 1 hour and 6 minutes. During the second outage systems were down for 14 hours in total. The time taken to reboot the applications made up the balance of the 14 hours.

Health found that contrary to its expectations, it was not possible for system operations to move from 1 data centre to another using its disaster recovery procedures.

The impact on Health was significant. This included a loss of clinical systems such as the patient administration and theatre management systems and a loss of access to computerised patient records.

Figure 7: Data centre outage

Action to address identified governance issues was belated

Serious governance issues identified on a number of occasions during the early years of the contract did not lead to corrective action. It wasn't until after Health undertook an internal procurement review between September and November 2014 that the seriousness of the issues were recognised and corrective action began.

Warnings about this contract sounded as early as 2012. The concerns were raised by different groups but were often the same:

- An email in 2012 from a person within the Procurement and Contracts Group to his line manager warned that the contract variations would see at least a $25 million overspend across the 8 years of the contract.
- An internal review of Health's Operations and Delivery and a consultant's review of Health's ICT Procurement identified similar issues with the contract. Both reviews were conducted in 2012. Their findings included a lack of accountability, absence of a proper contract management function, unclear roles and responsibilities, inconsistent monitoring of contract costs and poor recordkeeping.
- The previously mentioned mid-term review warned in November 2013 of:
    - significant overspend of the contract
    - cloud services procured as part of the contract were outside of the original scope
    - paying for significantly more data centre capacity than required
    - no overall Health ownership for the contract.

Following the mid-term review, Health's Director of Operations provided responses and additional information to various Health meetings, including to the HIN executive. The minutes show that the HIN executive asked for another consultant's review of the contract out of concern that the mid-term review may not have considered information that was commercial-in-confidence to the Contractor.

After ordering this further review, the HIN executive closed out this matter in January 2014. However, it appears that the review never proceeded. In any event, the reasons for undertaking another review appear questionable given the consistent concerns already expressed by credible experts.

Health has since undergone significant structural changes in that HIN no longer exists as a separate unit within Health. Health's Office of the Chief Procurement Officer now has responsibility for setting the policy framework for procurement and its compliance. This Officer has established a compliance audit team which reviews procurement and contract management activities across Health. Health advises this will assist in ensuring compliance with the State Supply Commission and Health's Policies and Procurement Delegations.

Poor recordkeeping further limited performance and management

Document management was poor and not in accordance with the State Records Act

Health was unable to demonstrate sound document management for both procurement and contract management documents.

Crucial procurement and contract management documents, such as the signed procurement plan, business case and evaluations reports could not be located during the audit. Health administrative staff who searched for the documents were sometimes unable to establish if the documents were misplaced or never existed.

Health has a dedicated document management system and is required to conform to the *State Records Act 2000* as well as its own internal policies on records management. The Act aims to provide security and retention of records for purpose of transparency and accountability and includes a penalty for non-compliance.

Not all contract equipment was receipted, tagged and recorded

Health's system of recording and tagging IT equipment purchased by the Contractor on its behalf is unreliable. As at November 2015, Health did not have a complete record of purchased equipment. If not recorded, then only the Contractor potentially knows what was purchased, where it is located and if it is used.

The contract requires the Contractor to tag and record IT equipment purchased on behalf of Health. However, because the equipment is recorded in Health's Configuration Management System (CMS), the adopted practice is for the Contractor to tag the purchased equipment and then advise Health who records the purchase and location in the CMS.

Tagging enables equipment operating at a sub-optimal level to be speedily identified so that performance issues can be resolved. It also enables Health to confirm its installation and use.

Health first became aware of problems with the non-recording of equipment in 2012 through an internal review. Health attributed blame for this to the Contractor.

The problem re-emerged in mid-2015 when Health started checking equipment located at the data centres and found equipment purchased in late 2013 was yet to be tagged or installed. Limited testing we did around the same time confirmed that not all equipment was tagged. Since then, Health has been working to identify all equipment and update its records.

The Contractor advised us in December 2015 that it has met its obligation of advising Health when it purchased equipment and that to the best of its knowledge, it has tagged all equipment for which it is responsible.

Financial management was poor, contributing to overpayments

Health was not appropriately tracking contract costs

We expected Health to have sound financial controls over this high value contract to enable it to monitor contract expenditure and take timely corrective action. Examples of the controls we expected include:

- ensuring the contract budget was recorded accurately and in sufficient detail to enable monitoring of contract expenditure
- recording of expenditure in a manner that would ensure it could be readily identified as contract expenditure
- checking of invoice details to the contract terms and conditions to ensure justified expenditure.

Tracking costs against budget

Health does not appropriately track contract costs against the approved contract and its variations. Health was tracking the contract cost against the 8 year initial contract budget of $93.8 million instead of tracking it against each distinct component shown in Table 3. This gave Health a false perception of where the actual expenditure was tracking against budget and therefore it could not easily recognise the need for any remedial action to bring expenditure in line with the budget.

Contract component	What the budget includes	$ value (millions)
Initial contract	First 4 years of the initial contract	44.9
Initial contract extension options	2x2 year extensions	48.9
Sub-total	*First 4 plus both extensions = 8 years*	*93.8*
Contract variations	Various – depending on the variation	81.4
Total	**All contract components**	**175.2**

Table 3: Contract composition

When approving contract variations that had a cost impact, Health also did not update the budget against which it measured contract cost, or measure the variation component separately, making it difficult to monitor actual contract performance. This was because it did not have a standard process for recording contract variations on its contract management system or any other system to enable financial monitoring of the contract. Contract variations were recorded in a number of locations including:

- Health's contract management system, which was not set up to monitor financial performance of the contract, but rather was a repository for contract documents
- a spreadsheet maintained by the Procurement and Contracts Group (the Group)
- hardcopy files in Health's records management system
- hardcopy files kept by various project managers who had responsibility for specific contract variations.

Unreliable coding of invoices

Health has not consistently coded invoices to the contract number in the finance system and therefore it is difficult to determine actual contract expenditure.

The contract's expenses were allocated to a number of business units. The approval checks were inconsistent between business units as not all were checking that contract invoices were linked to the contract number in the finance system. It is therefore impractical to determine if there were contract invoices not coded to the contract and difficult for Health to know how much it spent on the different elements of the contract.

From around mid-2014, the Group tried to track expenditure by manually totalling the invoices they were aware of, to arrive at the expenditure to date. They would then write both the amount spent to-date and the current budgeted figure on invoices received to assist the incurring and certifying officers to fulfil their role of authorising payments.

Unfortunately, this manual work-around was not reliable because Health did not have a consistent route for circulating invoices to the Group prior to payment.

The absence of effective financial procedures is further evidence of how the lack of a dedicated contract manager affected Health. Given that a role of a contract manager is to monitor actual expenditure against budget, the inability to make this comparison should have seen these weaknesses identified early and addressed. Not addressing these weaknesses increased the risk of undetected contract overruns.

Health has advised that it procured and established a 'procurement development management system' that is being rolled out across the health system to address systemic weaknesses in procurement and contract management. Health has advised that this system will ensure compliant workflows and sound records keeping and users will be required to use the system once policy is issued in July 2016, following the delivery of a training program.

Health did not check Contractor invoices to contract rates

Up until mid-2014, Health did not check invoices to the agreed contract rates prior to payment and as a result, overpayments appear to have occurred.

Contract managers are required to ensure that expenditure is for valid contractual purposes and in line with the terms and conditions of the contract. We tested a sample of 30 invoices from the start of the contract in November 2010 to 27 March 2015. The sampling took into account all 642 known invoices for this contract, excluding payments made in 'terms of lease' agreements.

The unit rates in 26 of the sampled invoices deviated from the rates agreed in the contract. We found 23 invoices where the rates over-charged Health and 3 invoices where rates included an undercharge. Overall, the discrepancies suggest a net overcharge of around $41,000 or 8.8% of the invoice values. The rates charged in only 1 invoice agreed to the rate card in the contract while Health could not locate 3 invoices.

Health's own review of the rates also identified discrepancies. The Contractor advised us that Health may have misinterpreted the rates card and this could be a cause of most of the discrepancies.

Health's finance, operations and contracts branches all reviewed the invoices. However, none were matching the rates used in invoices to those agreed in the contract. Responsibility for this was not clear as all branches claimed that it was the responsibility of another person or branch. Clear responsibility for checking invoice details would help ensure that Health does not make incorrect payments.

From mid-2014, Health assigned responsibility for checking the rates to a contract administrator and then in November 2015, transferred responsibility to the new contract manager.

Given the high number of discrepancies we found, we have recommended to Health that it review the invoices paid from 2010 until mid-2014.

Health paid invoices outside the contract agreement

Health paid the Contractor 'mark-up' fees valued at $104,000 on 8 invoices from November 2012 to June 2013 that it submitted to Health on behalf of a third party contractor. The contract specifically excluded mark-up fees. Health could not explain why it made the payments.

The mark-up was the Contractor's fee for passing on to Health the invoices of a subcontractor. The Contractor advised us that Health requested it engage the third party as a subcontractor as the third party was not at the time, registered with the Department of Finance's as an approved provider under the relevant Common Use Agreement (CUA). For this reason, Health could not themselves directly engage the third party. The mark-ups represented 10% of the third party's fee.

A CUA is a whole of government standing offer awarded to pre-qualified suppliers to provide commonly used goods or services to agencies. CUA suppliers are assessed by the Department of Finance as meeting required price and quality standards that deliver value for money.

If an item is available on a CUA, an agency must buy it from 1 of the CUA suppliers, unless certain criteria are met to warrant an exemption. By using a party who was not on the CUA, Health breached procurement policies, and could not demonstrate value for money.

The third party also charged rates that were not in accordance with the contract. We calculated the cost of this work to be about $84,000 more than the cost at the agreed contract rates for similar work. The total additional cost to Health of this arrangement was arguably therefore $188,000.

Staff approving the invoices for payment did not query the mark-ups at the time. A staff member of the Procurement and Contracts Group identified the mark-ups on the November and December 2012 invoices. He raised concern about this with his line manager just days prior to payment of the January 2013 invoice though no subsequent action appears to have been taken. Without proper scrutiny of invoices, potential overcharging may lead to significant losses.

Health entered into 8 leases without understanding the arrangements and in some cases without authority

Health entered into 8 leases through the Contractor to the value of $27 million without a good understanding of the arrangements and in some cases, lacking the necessary authority.

Three of the leases were for moving or supplying and installing racks, cabling and hardware for the Murray Street data centre, while 3 were for software or software upgrades. The other 2 leases were for various equipment, services, and miscellaneous items. The last of the leases expire in January 2020.

Leases are agreements that allow the lessee to use specific assets for an agreed period of time in return for a payment or series of payments. A lease is classified at the draft agreement stage as either a 'finance' or an 'operating' lease. A finance lease allows the

lessee to use the asset as if it were its own, for a major part of the useful life of the asset. All other leases are operating leases.

Health did not properly assess the nature of these arrangements and as a result incorrectly classified 4 as an operating lease. The type of lease determines key requirements including approval and funding source as shown in Table 4 below.

Event	Operating lease	Finance lease
Approval	Health staff – according to delegation schedule	Treasurer – as part of the annual budget process
Funding	Operational	Capital
Accounting	Expensed as the asset is used	Asset is recognised Liability for the debt is recognised
Ownership	Assets are not owned by the lessee	Assets may become the property of the lessee, either at the end of the payment terms, or by paying a nominal amount.

Table 4: Impact of lease classification

As a consequence of not properly determining the lease type, Health breached Treasurer's Instruction 822 'Borrowings' that requires the Treasurer to approve finance lease borrowings. It had also incorrectly accounted for the leases in its financial statements and paid all the lease costs from operational funding.

In June 2015 Health sought expert accounting advice on the correct classification for each of these leases. The consultants advised that:

- the purchase of software was not a lease and the purchase price should be capitalised as an intangible asset (number 4 in Table 5)
- the costs of relocating assets is neither an operating lease or a finance lease and the costs should be expensed (number 3 in Table 5)
- the remaining leases are considered finance leases. However, around $3.9 million included in these leases (parts of numbers 1, 7 and 8 in Table 5) were not assets and should be expensed.

Payment and ownership of the assets

The combined value of 5 of these leases, was $16 million, of which $10.8 million or 68% was paid up-front, in June 2013. Health could not explain to us why it had agreed to pay these amounts at the start of the leases, 3 of which were initially classified as operating leases.

It appears to us that the payments made in June 2013, may have been an attempt to reduce operational payments in the following years. However, by paying for services or the use of assets up-front, Health runs the risk that its actual use of the asset or service will be less than the amount paid.

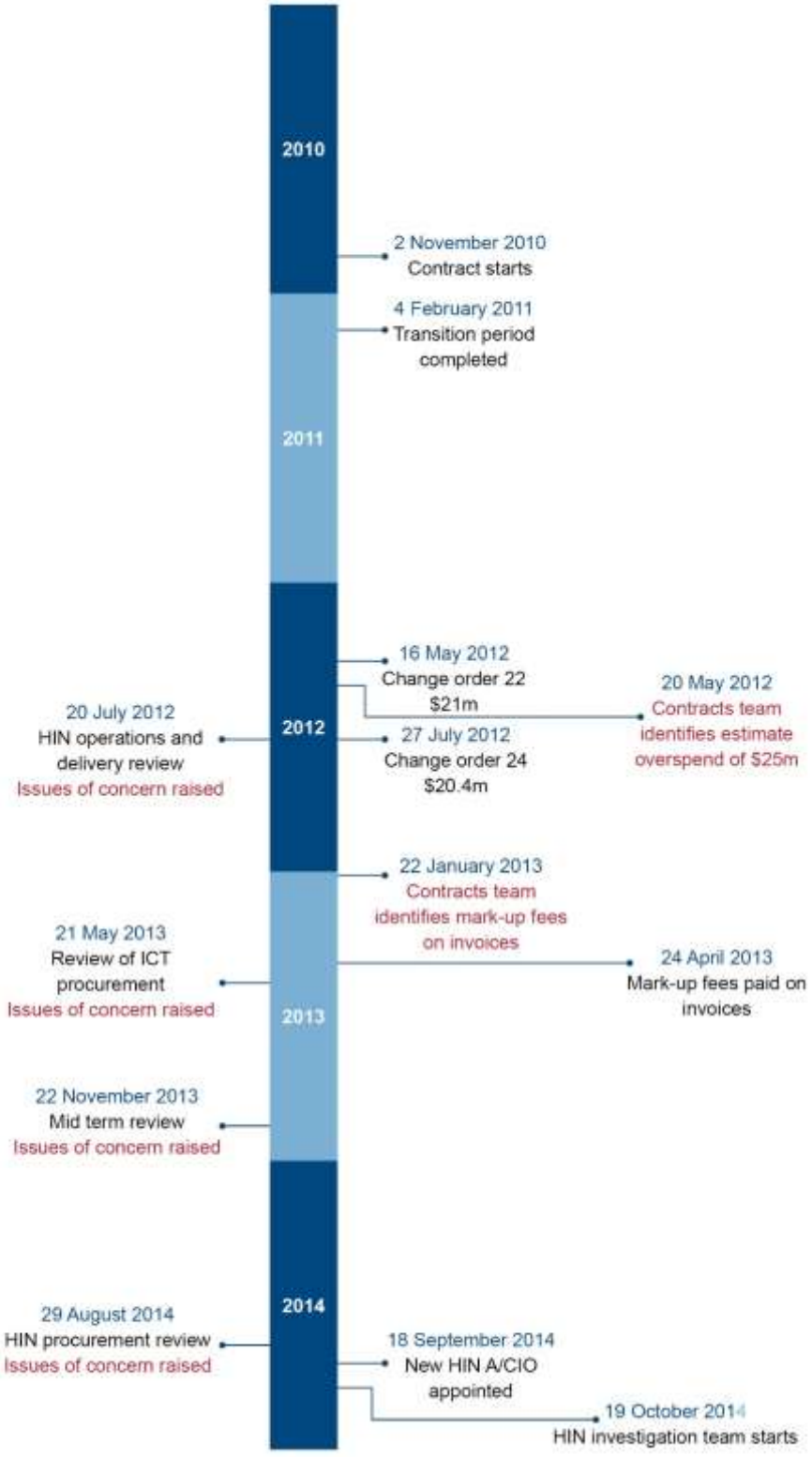
No.	Leased Items	Total value	Unusual payments	Monthly payments (No. of months)	Health's initial/current classification
1	Murray Street, Data Centre Provisioning Stage 1	$7,208,020		$85,810 (84)	Finance Lease Part finance lease and $96,990 expense
2	Murray Street, Data Centre Provisioning Stage 2	$1,849,893	$484,000	$17,290 (79)	Finance Lease Finance Lease
3	Murray Street, Data Centre Provisioning Stage 3	$610,498		$16,959 (36)	Finance Lease Expense
4	Purchase of email archiving software	$2,046,247	Paid out $1,847,153 $197,000 in interest paid	Terminated after 1 monthly payment	Finance Lease Expense
5	Purchase and install servers and storage devices. Email software upgrade Part A	$4,259,073	$3,172,630	$18,107 (60)	Operating Lease Finance lease
6	Email software upgrade Part B	$615,071	$458,178	$2,615 (60)	Operating Lease Finance lease
7	Storage devices, implementation services, miscellaneous items and prepaid training credits	$7,408,295	$4,900,000	$69,675 (36)	Operating Lease Part finance lease and part expense
8	Storage devices, implementation services, project services and hardware commissioning costs	$3,263,557		$90,380 (36). Five monthly payments totalling $452,000 were not reflected in the combined lease	Operating Lease Part finance lease and part expense
	Totals	**$27,260,654**	**$10,861,961**		

Table 5: Summary of leases

The ownership of the assets also influences the correct classification of the arrangements. Generally, if Health does not own the assets at the end of the lease period this would indicate an operating lease.

Some uncertainty currently exists in Health as to the ownership of the assets at the end of the lease period due to different interpretations of the various contractual components. However, the Contractor disputes this and advised us that the terms of the agreement are clear. Health will need to resolve this issue.

Appendix 1: Contract timeline – Key dates from the start of the contract until December 2014



Appendix 2: Characteristics of effective contract management

Characteristic	What it entails
Planning	• effective governance arrangements are planned • roles and responsibilities are clearly defined • the contract manager understands the contract terms and conditions • risks to the delivery and ongoing management of the contract are identified • development of a contract management plan • early engagement with stakeholders
Administration	• collation of key decisions and documents • monitoring timeliness and quality of deliverables • compiling activity or performance reports • assessment of invoices to contract terms and conditions
Assessment and Evaluation	• planning for and assessment of contractor performance • tracking of performance against budget • assessment of contractor self-reporting information • variations are assessed on how they contribute to the initial contract • assessment of benefits against the contract objectives
Reporting	• regular and consistent reporting to all stakeholders • timely identification and appropriate escalation of issues • ad hoc reporting to resolve identified issues • recommendations on suggested variations
Active Management	• active engagement and ongoing management of issues • management of contract disputes, variations, reviews for extensions • the transition in and out of the contract • manage and address underperformance

Auditor General's Reports

Report Number	Reports	Date Tabled
26	Verifying Employee Identity and Credentials	2 December 2015
25	Operating Theatre Efficiency	18 November 2015
24	Audit Results Report – Annual 2014-15 Financial Audits	11 November 2015
23	Information Systems Audit Report	5 November 2015
22	Safe and Viable Cycling in the Perth Metropolitan Area	14 October 2015
21	Opinions on Ministerial Notifications	8 October 2015
20	Agency Gift Registers	8 October 2015
19	Opinions on Ministerial Notifications	27 August 2015
18	Controls Over Employee Terminations	27 August 2015
17	Support and Preparedness of Fire and Emergency Services Volunteers	20 August 2015
16	Follow-On: Managing Student Attendance in Western Australian Public Schools	19 August 2015
15	Pilbara Underground Power Project	12 August 2015
14	Management of Pesticides in Western Australia	30 June 2015
13	Managing the Accuracy of Leave Records	30 June 2015
12	Opinions on Ministerial Notifications	25 June 2015
11	Regulation of Training Organisations	24 June 2015
10	Management of Adults on Bail	10 June 2015
9	Opinions on Ministerial Notifications	4 June 2015
8	Delivering Essential Services to Remote Aboriginal Communities	6 May 2015
7	Audit Results Report – Annual 2014 Financial Audits	6 May 2015
6	Managing and Monitoring Motor Vehicle Usage	29 April 2015
5	Official Public Sector Air Travel	29 April 2015
4	SIHI: District Medical Workforce Investment Program	23 April 2015
3	Asbestos Management in Public Sector Agencies	22 April 2015
2	Main Roads Projects to Address Traffic Congestion	25 March 2015
1	Regulation of Real Estate and Settlement Agents	18 February 2015

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