Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 20 February 2024 at 10.00am

(Day 006)

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

Also present:

Mr Lachlan Gyles SC with Ms Joanna Davidson for NSW Health
Mr Neale Dawson with Ms Laura Toose for NSW Nurses and Midwives' Association

<NICHOLAS MORRIS HOWSON, on former affirmation: [10am]

THE COMMISSIONER: You are on your oath from yesterday, Mr Howson.

Yes, Mr Fuller.

MR FULLER: Thank you, Commissioner.

<EXAMINATION BY MR FULLER CONTINUING:

MR FULLER: Q. Mr Howson, we finished up yesterday looking at paragraph 16 of your statement, where you were referring to an email from Ms Wright. Can you just explain how it came about that you received that email?
A. Yes. So in my role as the president of the New South Wales nurses and midwives' branch there, I get a lot of input from members and other people across the district, simply because of the role that I'm in, and I am aware of the policies and procedures surrounding these things.

And we knew those duress alarms that were installed at the then Bungarribee House unit, which would then later become the B22 unit at Blacktown Hospital, would be the same alarms that we would be having at Cumberland Hospital, so just out of courtesy and comradeship, they let us know that these new alarms that were installed, they were having issues with them at the time and to let us get ahead and perhaps see if we could address these issues in the rollout that would happen at Cumberland in the near future.

Q. When did you find out about this issue, do you recall?
A. At the time it happened, which is dated in that email, in the March 2021, from Eliza, we were pretty much kept up to date as it was happening, including the then SafeWork investigation into those alarms.

Q. You personally were kept up to date about it; is that right?
A. Yeah, by the members out at Blacktown, yes.

Q. Can I ask that you have a look at annexure E, please, which is a copy of the email. I will just ask for that to be shown on the screen as well.
A. Yes, I have it here.

Q. I take it you don't have any personal experience of

the things raised in this email, but they were communicated to you at the time; is that right?
A. No, at Bungarribee House, I do not - not personally, no.

Q. Just having a look at the individuals who received this email, do you recognise any of those names?
A. Yes, I recognise pretty much all those names still, apart from Al Owaimrin.

Q. Can you just identify the positions of the individuals who received these.
A. Sure. So the Arti Kumar, was a registered nurse and an HSR at Bungarribee House. Julia Norcott was the nurse unit manager at the time. Sukhpreet Singh was one of the other nurse managers there, one of the clinical nurse managers. Shivani Singh was another HSR and Crispen Mupedzi was another HSR at the time in Bungarribee House.

Q. Was there anyone on this email at the district level or was it just individuals at Bungarribee House level?
A. I believe this was an internal discussion with the unit manager at Bungarribee House, who would have then escalated it outside for hopeful resolution.

Q. The email, just in the last sentence, refers to a PIN notice given by SafeWork. Do you know what a PIN notice is?
A. It should actually read "improvement notice" because it was issued by SafeWork not by an HSR, in that regard, but there yes, was an improvement notice issued by Inspector Megan May regarding the duress alarms at Bungarribee House.

Q. A PIN notice is a provisional improvement notice?
A. Yes, a provisional improvement notice, yeah.

Q. That and would normally be issued by a HSR --
A. Correct.

Q. -- a health and safety representative -- -
A. Correct, yeah.

Q. -- rather than by --
A. Yes, they're generally reviewed by an inspector and either dismissed or made into an improvement notice, yeah.

Q. In this case, you're aware that an improvement notice was --
A. Correct.

Q. -- in fact, issued?
A. -- issued directly by a SafeWork Inspector.

Q. Have you seen a copy of that improvement notice?
A. At the time, yes, I was unable to find one in the short time frame for providing evidence for this Inquiry.

Q. I see. Do you know whether the issues raised in this email were escalated up to LHD management?
A. I'm unaware at the time if it made it all the way to LHD management but as the alarms were an LHD decision, I would have assumed that they made it up to there at some point.

Q. Do you know whether the improvement notice from SafeWork made its way to LHD management?
A. Yes. All improvement notices are sort of managed at a district level.

Q. How do you know that?
A. Experience with other improvement notices in the service issued directly to me as well as other senior executive members.

Q. So based on your knowledge of the usual practice --
A. Yes.

Q. -- with improvement notices, you would assume this improvement notice made its way to LHD management, although you don't know that for sure?
A. Yeah. So improvement notices are generally issued to the person conducting the business, and a representative, a worker, an HSR or someone in the workplace where it occurred, and it's generally some sort of higher level executive like director of people and culture or the CE themselves who gets a copy issued to them.

Q. Are you aware of any specific response to this improvement notice?
A. No, I am not. That would be sitting with SafeWork.

Q. I think the next event chronologically in your statement is at paragraph 20. If I can just ask that to be

shown on the screen, please.
A. Mmm-hmm.

Q. In paragraph 20, you talk about testing your alarm at the start of a shift on 25 February 2022. Based on your answers yesterday, I take it that was shortly after you personally first started using the duress alarm?
A. Correct.

Q. But that's the AiRISTA duress alarm; is that right?
A. (Witness nods).

Q. You say that the self-test function didn't work. Can you just explain what you mean by that?
A. So as I mentioned yesterday when we had the picture up of the alarms, pressing the blue button on that style of alarm initiates what the manufacturer calls a "self-test". You end up getting a message on the alarm that just says, "Self-test succeeded."

It doesn't really give you any feedback on what it's testing, whether it is testing connectivity, functionality of the three alarm modes, being man down, pull cord or button press. It doesn't really give you much feedback at all other than, yes, you've pressed a button; yes, you've got battery.

Q. And so in this case, you did the self-test but it didn't say that it was successful?
A. Nothing happened, and then when - I guess, as the paragraph says, the pull cord didn't function, the man down didn't work and the button trigger didn't alert either after that self-test failed.

Q. I'll just go through each of those if I can. So the pull tag function didn't work? Can you just explain, firstly, what you --
A. That's the pull tag function where it's attached to your clothing. I know the image isn't up at the moment, but there is a tag on the top, and as soon as you pull it a little clip pulls down and the alarm goes off. It's one of the more surreptitious methods of triggering your alarm so people don't notice. It doesn't give any feedback to you other than a slight click, and it certainly doesn't give any feedback to anybody else around, so it's a nice little way to call for help. It's just a quick (indicating) and you're done.

The other one on there is the man down alarm which is, as it says, when there's no movement or the alarm is not in a vertical position, it will sound a brief warning and then if the alarm doesn't get cancelled within five - I think it's about five seconds, it will trigger. And then the button alarm is the button alarm. You press the button, it goes off.

Q. What did you do to test the pull tag?
A. I just pulled it. I pulled the tag and the alarm separately, so physically in front of me.

Q. And nothing happened; is that right?
A. No. I observed the click that indicated it had been pulled and there was no response.

Q. So you heard the click but no response?
A. No. No other alarms nearby that anybody else was wearing went off, my alarm didn't give any feedback, and there was nothing.

Q. So both the case that, to your knowledge, the alarm didn't notify anyone else and obviously there was no response; is that right?
A. Yeah, that's right. No response.

Q. The man down alarm, how did you test that?
A. I held it flat in my hand, indicating that it was horizontal rather than vertical, and I also put it on the desk.

Q. And to your knowledge, that didn't notify anyone else; is that right?
A. No, it did not.

Q. What would normally happen if the man down alarm is working? Would you be able to see on the device that something has happened?
A. Yeah, as it commonly does accidentally go off if you're sitting down or if it's in a wrong spot or if you're leaning back in your chair a bit far or whatever you're doing, it gives you a brief warning. It says, "Are you okay", and you have to dismiss the "Are you okay" by pressing one of the buttons - I can't remember off the top of my head, it is a bit of muscle memory at this point - and then it dismisses that warning.

Q. And the button alarm, I take it, you attempted to press it for five seconds?
A. Yes.

Q. And nothing happened; is that right?
A. And no response, no.

Q. You say that you report those issues to the nurse manager; is that right?
A. Yes.

Q. You submitted an ims+ report. What is an ims+ report?
A. It is the incident management system that NSW Health uses across the state to record any and all incidents from clinical incidents to work health safety incidents to corporate incidents. Anything that isn't clinical is pretty much recorded in the ims+ system.

Q. Why did you submit an ims+ report on this occasion?
A. It is the standard procedure for any sort of incident to be recorded as part of our incident reporting policy.

Q. Can I ask you to have a look at annexure F, please, and for that to be put on the screen?
A. Sure. What is F? They are not titled "Annexure" in here.

Q. Do you have numbers in your folder rather than --
A. No.

Q. I will just try to find the number to assist. Do you have a number 45 - tab number 45?
A. Yes, thank you.

Q. Thank you. You recognise that as an ims+ report; is that right?
A. That is an ims+ report. So that's the version that you can get after you submit an ims+ and you can print a copy for your own records.

Q. So the ims+ system is a sort of electronic form; is that right?
A. It is.

Q. And this is the print-out of that form?
A. Yeah.

Q. There's no name on this version of the form. Are you confident that you submitted this ims+ report?
A. Yeah. You, at the time, can only see incident reports that you submit, unless you're a manager of an area, so any ims+ that you have access to as a user is one you submitted.

Q. So you wouldn't have been able to print out this ims+ report if it wasn't one that you submitted?
A. No, so this is - and I can also say this would be mine because it is in the unit that I worked in at the time, which is notified on the second page, the Hainsworth unit at the top.

Q. If we just have a look at the second page, about halfway down, there's a heading that says. "What happened?" And then "Details"?
A. Mmm-hmm.

Q. And do you see there the first four items of are the four things you have identified --
A. Yes.

Q. -- in the paragraph of your statement that we just looked at?
A. That's correct.

Q. You say "duress alarm system not functioning". Did you mean anything more by that?
A. Simply that mine didn't work and then after doing that report none of the others worked, which sort of led me to conclude that the system was not working at all. A few phone calls, I believe, were made to other units, "Hey, are your tags working?" And the answer was, "No, we self-tested and got nowhere", and then I thought, "All right, well, I'll do an incident report and flick it up the line."

Q. So did you test other tags?
A. No, I just rang. I rang. It's a standard procedure for everybody to be able to test those alarms and I would trust any response from my colleagues, if I asked, "Are your alarms testing or working", and if they said, "No", they would have gone through the same process that I did.

Q. Just so I understand, after you tested your alarm, you

asked other people whether --
A. Yes.

Q. -- theirs were working and they said they weren't?
A. So I would have - I immediately asked the people in my unit as well as checking some of the other units.

Q. If we have a look at the bottom of this page, there's a line that says "Initial harm score", and the number is 3. Can you just explain, is that on a scale?
A. Yeah, there's four harm scores now, 1 to 4, with 1 being the most serious and 4 being the least serious. It's calculated by the things that you choose. It's not a user input number.

Q. Do you know what inputs would have resulted in a harm score of 3?
A. So there's things directly above that, would have pretty - my understanding is the way the assessment options are selected is what the harm score comes out to. Three and 4s are generally managed at a unit level; 1s and 2s are managed at a hospital or district level.

For reference, a harm score 1 is something that leads to, you know, a serious adverse event like a death or permanent disablement, problems with surgery, et cetera, big clinical risks - things like that. 2s, serious injury with no, you know, long-term lasting damage, and 3s and 4s are missed medication, slips, trips and falls, people absconding, things like that.

Q. Would you agree with a harm score of 3 in relation to this incident?
A. Whilst it is more serious than a 3 would indicate, it's a report for that unit, because I was - you're unable to report at a higher level than to your direct manager when you do these incident reports. So when the system looks at it, when you're saying it needs a local management response only, that's because you're escalating to your manager and they're escalating up.

So I would have assumed that it should have at least been a 2, because it is not just a unit, it was a hospital, and at that point it did turn out to be a district-wide issue, so that would indicate a much higher harm score should have been assigned, but it is again a limitation of the system itself.

Q. Do you know who received this ims+ report?
A. So a copy is generally sent - an email notification gets sent to your immediate line manager and the clinical governance unit also has overview of all incident reports coming in for your sort of management structure that you are in. So that would be the Cumberland Hospital mental health service level.

Q. And your immediate manager would have been the nurse unit manager?
A. Yes.

Q. Did you receive any feedback in response to this report?
A. Yeah, a few phone calls saying, "You tested and they're not working?" I was like, "Yep", they're like, "All right, we'll look into it" because the nurse managers up the chain also receive copies of it and if they're in front of a computer, they'll get an email notification that an incident report was submitted.

Q. Who did you receive phone calls from?
A. I couldn't tell you the individual but I could tell you the role at the time. It would have been one of our either acute nurse manager or the recovery nurse manager, one of those people in those roles is sort of responsible for the day-to-day running of the clinical incidents for that shift that they're on. So they're sort of the point of escalation before it goes from the clinical setting to an executive setting like a deputy director or a director.

Q. Do you know whether this issue was escalated beyond those managers?
A. I do believe it went up to district because Digital Health Solutions got involved to let us know that, yes, there was an IT breakdown at that point, and I think that's in one of the emails further down.

Q. What was the outcome of Digital Health Solutions getting involved?
A. In this particular incident, I think it was down for about 24 hours before we got a notification that it was back up. Although I may be getting confused with the C4A/C4B issue further down the line, which we haven't got to the in timeline yet.

Q. But to the best of your memory it was about 24 hours that the system was down.
A. Yeah.

Q. Did you receive any feedback as to why the system --
A. No.

Q. -- had not --
A. I believe at the time there would have been a communication for telecommunications breakdown, the digital health service is generally pretty good at sending notifications out when certain things aren't functioning. We get, like, a broadcast across the district.

Q. Did you continue to experience issues with the duress alarm system at Cumberland Hospital after this incident?
A. Personally, no, because I ended up in higher-grade duties after that and I was only putting alarms on when I entered units as I wasn't walking directly on the floor. And then I also ended up on secondment outside of health for six months after that.

Q. Did you have other people reporting issues --
A. Yes.

Q. -- with duress alarms?
A. I did.

Q. At Cumberland Hospital during the period?
A. At Cumberland and within the emergency departments base at Westmead where we also have mental health staff based.

Q. I'll ask you about the Westmead emergency department.
A. Yes.

Q. If you have a look at paragraph 26 of your statement, please?
A. Mmm-hmm.

Q. Here you've mentioned concerns being raised by staff in the Westmead ED in October and November 2022. Are these the events that you were thinking of when you just gave me that answer?
A. Yes.

Q. I take it from your earlier answers, you didn't have

any direct involvement in these incidents?
A. No, it was just another member reporting to me that they were experiencing these issues and not getting much in the way of information back.

Q. Can you just elaborate on that?
A. So in this - I think these are some of the other incident reports from the ims+ system that I annexed in here.

This was a member up in Westmead, who had been experiencing a personal threat requiring a code black, and they had relied upon their duress alarm, which was the same model, and however they triggered it - I couldn't tell you without going to read the incident report - they did not get a response and it didn't seem to give any feedback other than that they had pulled it themselves and didn't receive any sort of assistance until another method of calling for help had occurred.

Q. I'll just ask you a couple of questions about the documents you have attached. If we can have a look at annexure H, please, and for you, Mr Howson, that's tab 47
A. Tab 47. Yes.

Q. If you just look on the second page?
A. Mmm-hmm.

Q. Which is the substantive email, it's from someone named Steven Westbrook Sr. Who is that?
A. He was the work health and safety representative who was working for the district covering the emergency department space at the time.

Q. In the first paragraph in that email, he refers to the "MH pod". Do you know what that is?
A. Mental health pod. It's a bit of a colloquial term for the six-bed space in the Westmead emergency department where the mental health patients who have been assessed as having a mental health concern rather than a physical health concern are bedded until an appropriate ward bed is found for them.

Q. In the third paragraph, Mr Westbrook says:

I have already briefed Wade Norrie on these [issues] ...

Do you know who Wade Norrie is?
A. So Wade Norrie was the director of mental health services - director of nursing for mental health services at the time this email was sent.

Q. Do you know whether his role related to the Westmead ED or the Cumberland Hospital or both?
A. Both. Mental health services in Western Sydney Local Health District are a district-wide service and they have a district-wide director of nursing, and that was Wade Norrie at the time.

So working in ED, in that space, it was supposed to be a collaborative, co-located model of care between both Westmead and mental health services. So it would have been both sides getting involved. That would be the general manager and director of nursing for emergency as well as a director of nursing and our executive for mental health services.

Q. And so to your knowledge, Mr Norrie would also have been responsible for Blacktown; is that right?
A. Correct.

Q. Do you know when he started as director of nursing?
A. February 2020 I believe.

Q. So it would have been prior to the rollout of AiRISTA at Blacktown as well, is that right, to your knowledge?
A. It would have been prior to, but I would imagine it would have already been in process when he arrived.

Q. Can you just explain how it came about that you were forwarded this email by Mr Westbrook?
A. I had been doing a lot of work health and safety work with my role as an HSR and in my capacity as the branch president there, and I had worked quite closely with Steven Westbrook, both in his role as a work health safety person for the mental health service prior to his role as this, and also worked clinically with him when he was a security officer in the mental health intensive care unit.

We both share a strong passion for keeping workers safe, so if we're safe we can provide safe and effective care, and he said, "I'm not getting much traction with these issues. My hands are a little bit tied. Here is the

information, do with it what you would normally do", which is speak to the association and get some help from their work health and safety officers and come in from - come in from a different angle.

Q. So it was raised with you in your capacity with the NSW Nurses and Midwives' Association?
A. Correct.

Q. I will just ask you about the second document you attached in relation to this, which is annexure I, which should just be the next tab for you?
A. Mmm-hmm.

Q. Again, this is an email that has been forwarded to you?
A. Correct.

Q. By Neethu Maria Babu?
A. So Neethu was a nurse working in the mental health pod space at Westmead Hospital at the time.

Q. That's again the mental health pod in the ED?
A. In the Westmead ED, the co-located space that we share.

Q. How did it come about that you were emailed about this?
A. They were again discussing safety concerns and I said, "Look, we've been working on these for a while as a branch. If you have a concern that you've put in writing, please send us a copy so we can put it all together and try and get some sort of action on this."

Q. In this email, Ms Babu refers to the "acute side". Do you know what that is?
A. So Westmead ED is divided into acute A and acute B. It's just a way of dividing the large amount of beds into two separate teams, and the mental health pod space bridges both. It is a little corridor between the two, both side A and side B. So she would have said "acute" as in to leave the mental health space and go to one of the acute sides.

Unfortunately it doesn't say which side, A or B, but she would have gone to one of the primary staff stations there to seek help.

Q. You've also provided an ims+ report, which I won't ask that you be shown, but relating to these incidents. I take it that that's not a report that you submitted; it's again --
A. No.

Q. -- one that was provided to you?
A. Yeah, no, it was provided.

Q. Are you aware of in any response to that ims+ report?
A. So you are allowed to request - yeah, if you look - actually look at one of them, one of the very last sections in the ims+ report is a feedback to notifier. When you submit one, you're allowed to choose yes or no, you want feedback. Even when you choose yes, you very often get no feedback in there.

Q. In paragraph 28 --

THE COMMISSIONER: Q. Sorry, just sticking with that annexure for a minute, the email?
A. Mmm-hmm.

Q. From - it is Ms Babu?
A. Correct.

Q. Where it says "I activated the mobile duress and no staff responded, I pressed the wall mounted one, no staff responded", do you know, yourself, whether that was because the alarms didn't work or whether the alarms worked but no-one responded?
A. It did turn out that the alarms in that situation were deemed not working. So she had pulled her mobile - meaning personal - duress, the AiRISTA Flow tag, and then gone to press a button near where the mental health nurses sit in that space, and that fixed duress alarm that was labelled "code black", did not function.

Q. All right. So if neither the fixed one or the mobile one works, who would be responsible for having them fixed?
A. So that actually is the "Donna Robinson" referred to in the email there, that's the nurse manager for education - nurse manager for, sorry, for the emergency department at Westmead. That fixed code black button was repaired and deemed working after this.

THE COMMISSIONER: Thank you.

MR FULLER: Q. Do you know whether there was any response to the issue about the personal duress alarm not working in this situation?
A. I believe it turned out to be that there was a wi-fi blind spot in the area where the mental health nurses were sitting, and that was also rectified after much backwards and forwards.

Q. You have attached as annexure K a letter that you sent to Wade Norrie in your capacity as president of the Cumberland branch of the NSW Nurses and Midwives' Association, which raises these issues, in summary?
A. Yes.

Q. You say that, to the best of your knowledge, the branch did not receive a response to that letter; is that right?
A. To the best of my knowledge, we wouldn't have received a timely response. We quite often didn't get responses to correspondence for months at a time.

Q. Do you know whether any response was received to this letter?
A. I would have to go back and check my records with the branch secretary. All communication goes through the branch secretary, not my role as president. I'd have to double-check with her to see if we ever got an adequate response to this letter.

Q. Did you have any discussions with Mr Norrie or anyone else about the subject matter of this letter?
A. None that I would be able to get minutes or - none that I would be able to get minutes for or any other thing. They would have been just brief conversations about, "We're working on it" or "This is where we're up to."

Q. Do you have a recollection of those conversations?
A. Unfortunately no, I don't. They were some time ago and many things have happened since then.

Q. It sounds like the particular issues that this nurse experienced were rectified?
A. Yes.

Q. Do you remember how long it took for that to happen?
A. It was not quick. I believe some of them were also

mentioned by Steven Westbrook Sr in that other email about the fixed duress alarms not working and they were a follow-up to that situation that Neethu, Ms Babu, had spoken about in that email.

Q. The next event chronologically is in paragraph 22 of your statement, if you can just have a look at that, please.
A. Yes.

Q. You refer there to a resolution passed by the Blacktown branch of the NSW Nurses and Midwives' Association. Did you have any involvement in the passing of that resolution?
A. No, so because we're all a separate list of branches, Blacktown Hospital has one, Blacktown mental health has one, Westmead Hospital has one, Cumberland has one, but we do all work closely together as a district because again, we are sharing at that level, when you're talking about hospital-wide issues, you're also sharing a district-wide executive structure.

So we quite often sort of talk about the larger issues affecting the hospitals as a group. So it's a group of union representatives from Mount Druitt Hospital, Blacktown, Westmead, Westmead Children's, Cumberland and Auburn hospitals, all speak quite regularly on larger issues, like violence and aggression, duress alarms, staffing.

Q. You have provided an email chain relating to this issue which is annexure G, if you can just have a look at tab 46, please?
A. Thank you. Yes.

Q. I'll just ask for that to be put on the screen as well. If we just start at the end of the document, obviously the email is going backwards in time. At page 5 of the PDF, you see an email there from Kirstie Kwiatkowski?
A. We just call her KK.

Q. Good. Who is she?
A. So she is the Blacktown branch secretary for the main hospital at Blacktown, hence the correspondence coming from her because all correspondence for branches is in and out via secretaries.

Q. Have you seen a copy of the resolution that was passed by the Blacktown branch?
A. I may have at the time. But I don't have a copy of it. I believe it was all just discussion about what they had sent in the email. I believe at the time, KK did put a copy of the email into our group chat, which is pretty much what she has written here.

Q. So just looking at what she has written in her email, do you recognise that as something you were informed of being the substance of the resolution that was passed?
A. Yes. So that refers to an incident where I believe a doctor was assaulted in the Blacktown emergency department and the duress system wasn't really working at the time.

Q. On page 6, in the second-last substantive paragraph of the email, it is said that staff will be forced to consider refusal of admission on a case-by-case basis if the concerns are not addressed. Is that something you're aware of actually happening in any of the areas where you have worked?
A. It does happen, only on occasion. It's a pretty strong indicator or industrial action type event where refusal to admit unsafe people into a space does happen. It does happen in my workplace. There are some people who are, unfortunately, considered too much of a risk to themselves. There are others who, for example, are not managed in the acute wards; they are instead managed wholly within the mental health intensive care units that we have. It's just an assessment of risk. You know, Blacktown ED can refuse to treat somebody and send them somewhere else if there's a history of violence. It doesn't happen all that often but it's not unheard of.

Q. Are you aware of it happening within the Western Sydney district because of duress alarm issues?
A. No, it's not directly because of the duress alarm issues, it's more of the lack of safety posed by them. But that lack of safety could also be because somebody was considered quite dangerous.

Q. Just going up to page 3, which is the next email in the chain. This is from Marie Baxter, and her signature identifies her as director of nursing and midwifery for Blacktown and Mount Druitt Hospitals. Does that accord

with your knowledge?
A. At the time, yes.

Q. And where does that position sit in the chain of management, as far as you know?
A. Within nursing, there's another report above them, which is the district director of nursing, and then above them, it's the chief executive officer. So it's reasonably high up in the chain of command as it were.

Q. How would Mr Wade Norrie's position have related?
A. Equal.

Q. Equal. And is that because he was focused on mental health nursing?
A. Yes. So some of the larger departments, like emergency departments, may have their own director of nursing, so then the mental health service has their own director of nursing, ICU may have their own director of nursing as well, but they're all sort of at an equal level, and then all report to their direct report which is their district director of nursing.

Q. In the third paragraph on page 6, Ms Baxter - I'm sorry, that's my fault, page 3, in the third paragraph - Ms Baxter says she can confirm 200 replacement mobile duress alarm been ordered, 95 of them being delivered. Are you aware of whether the remaining duress alarms were delivered?
A. No, I couldn't say that I was aware that they were delivered. The only information I would have on those is what's in this email.

Q. Do you have any sense of how many mobile duress alarms in total there would have been - in other words, is this 200 replacing all of them, a large proportion? Do you have any idea of that?
A. Large to all. They are generally situated in banks of 10 and just with a quick visual memory of what Westmead's looks like, it is about 20-odd banks for the emergency department and the Westmead and Blacktown emergency departments are quite similar in size.

Q. Are you aware of whether there were any new duress alarms ordered for other facilities within Western Sydney Local Health District?
A. In this instance, no, I couldn't say within this time

frame. I would imagine they are regularly reordered as they do break quite regularly. Especially if you end up restraining somebody, the scuffle can break them, they get torn off, dropped on the floor, stepped on, 6 L whatever --

Q. Using the same model of duress alarms across --
A. Yes.

Q. -- all facilities. All right. Further up the chain, starting on page 1 is an email from Graeme Loy, Mr Loy is the chief executive of Western Sydney Local Health District; is that right?
A. That's correct, yes.

Q. At the bottom of page 1, Mr Loy refers to a routine duress alarm testing program being introduced 12 months ago - so around 21 February 2022. Are you aware of that program at all?
A. I am not, no. I do not recall anybody coming to physically check the alarms, only ever to check that we were wearing them.

Q. So you don't know what Mr Loy is talking about there?
A. Not from a maintenance point of view, no. This may have only been referring to Blacktown Hospital, too. I'm unaware of if the program was rolled out anywhere else.

Q. Just going over the page, Mr Loy lists four steps that he says are being implemented from "tonight". I should note that this is the same day that the original email from Blacktown was sent, so it is a quick response, in this instance; you agree with that?
A. Yes.

Q. Item 2 is Mr Loy saying he has directed:

> *... our asset management team to attend site tomorrow to perform a full assessment of all duress in the ED, fixed and portable.*

Do you know whether that occurred?
A. I can't confirm that it was done or not - or not done.

Q. Do you know whether any similar testing occurred at Westmead ED or at Cumberland Hospital?
A. No.

Q. Is that you're not aware or it didn't happen?
A. No, sorry, I'm not aware. I couldn't say either direction.

Q. How did it come about that you were forwarded this email?
A. So again, like I mentioned earlier, we do discuss these issues and I had reached out to our organiser at the time, which is the very first email on those pages, because - in the reverse chronological, from Mark Murphy, who received a copy from Kirstie after all of these emails had been done. We quite often send these things back to our organisers as a sort of central point of contact, and so the association is aware of what has been said and what has been done for their own record-keeping purposes. So it was forwarded out to us because we were also - had been speaking about our duress alarm issues for quite some time in the mental health services.

Q. Three days after this you send an email yourself about duress alarm issues, which you refer to in paragraph 9 of your statement?
A. Yes.

Q. If you can just have a look at that.
A. Yes.

Q. And I might just, sorry, ask that you be shown a copy of that email, which is annexure B, and that's tab 41 for you.
A. Yes.

Q. You're familiar with this email?
A. Yes, I sent that email.

Q. What was the trigger for you to send that? Was it the issues at Blacktown?
A. They were fresh in my mind. We had a similar issue in the C4A, C4B wards at Westmead Hospital which as I said yesterday are part of the mental health service, even though they are physically in Westmead Hospital. There was an issue that had occurred there where a nurse was injured on a night shift, in the older persons mental health unit, and their duress alarm was not functioning.

Q. Can you just elaborate on what you recall about that

issue - the incident, I mean?
A. The incident? I believe - it's in one of the other annexures for details a bit further down, I would have to look it up. From my understanding, someone was attacked, grabbed from behind, knocked to the floor and the duress alarm just did not function properly.

Q. I'm sorry to jump around. I'll just show you that --
A. Sure.

Q. -- which is what I think you are referring to. If we look at annexure C, which is in the next tab for you, Mr Howson, and on page 2, down the bottom, there is an email from Janine Van Bruinessen?
A. Yes.

Q. That's B-R-U-I-N-E-S-S-E-N. Who is Janine, do you know?
A. Janine is normally the nurse manager for recovery services at Cumberland Hospital. She may - yeah, so she was acting up into the deputy director of nursing role at the time. We have a lot of acting positions.

Q. We see right at the bottom of page 2, a heading that says "Effect on staff", and then there's an account of an event that happened with a 70-year-old lady. Is that the event or the incident you were referring to?
A. Yes, that's the incident that I heard that prompted me to test the alarms and then sent that email.

Q. You didn't witness or experience that incident yourself; is that right?
A. No.

Q. But you were informed of it and that's what prompted you to test --
A. The alarms in the C4A/C4B space at Westmead, yes.

Q. Did you personally test the alarms in C4A and B?
A. I did. I took the photo that's on page 2 in the email that I sent, of all the duress alarms flat down on the desk. They are my shoes in the photo.

THE COMMISSIONER: Can I just go back - sorry. Don't let me interrupt you. Did you want to just follow on?

MR FULLER: No, please.

THE COMMISSIONER: Q. Can we just go back to annexure G, I think it was. I can't give a page reference because I have --

MR FULLER: It is tab 46 for Mr Howson.

THE COMMISSIONER: It is Mr Loy's email. Is that it? Yes, it is. This is a question for you, Mr Fuller. Just looking at point 2:

> *I have directed our asset management team ...*

Et cetera. Safety is obviously incredibly important and, I mean, there are assertions in these emails from management that it's paramount, as it should be.

Safety isn't directly in the terms of reference. Is the procurement issue, though, that - tell me if I'm wrong - the procurement issue here is that the kind of assessment that Mr Loy is alluding to or suggesting is going to take place regarding functionality, quantity, location, et cetera, is the sort of thing that should have happened before any of these alarms were purchased and in consultation with the staff and the clinicians that the alarms are meant to protect, including with the people that represent those staff and clinicians like the union? Is that the procurement issue?

MR FULLER: That's certainly part of it, Commissioner. I think possibly the other part of it, or another part of it, is that you're hearing evidence from this witness and you have obviously heard evidence from other witnesses about issues with same and different models of duress alarms that are arising in various locations and various districts, and the fact that you are hearing evidence about issues with duress alarms that are very similar in those situations might make you think that there is a broader procurement issue that is at least worthy of investigation.

THE COMMISSIONER: Yes. I suppose almost anything gets within term of reference I, which I always forget about, but they are the procurement issues.

MR FULLER: That's right, Commissioner. Commissioner, I think, as Mr Muston says, it's potentially a workforce

matter as well.

THE COMMISSIONER: Yes, it is, yes. That's right.

MR FULLER: Clearly, issues of safety are relevant to the workforce term of reference, even though they are not referred to explicitly in the list of items in that term of reference.

THE COMMISSIONER: Yeah, look, it would - you are right, it also fits within, probably, multiple Roman numerals of F. Thanks.

MR FULLER: Q. Mr Howson, just coming back briefly, if I can, to annexure B, which was tab 41 for you --
A. Yes.

Q. I'll just ask that the photo be put on the screen so that we know what you were talking about. So we see there a number of duress - 11 duress alarms laying flat on a table, and you told us earlier that that is a situation where the man down alarm should be triggered; is that right?
A. Correct. The man down alarm should be going off on all of those.

Q. In this case, is it the case that just nothing at all happened?
A. Nothing at all happened.

Q. Was this all or only some of the duress alarms for C4A and B?
A. They were the ones that were in the docking bay, the charging port that is available in the nursing station area.

Q. If we then go back to annexure C, I'm sorry to --

THE COMMISSIONER: Sorry, I was distracting myself.

Q. That photo of all of those alarms, did any of those alarms work?
A. With the man down functionality, no.

MR FULLER: Q. Did you otherwise test those alarms to see whether they otherwise worked?
A. At that point, the self-test indicated that they were,

based on previous experience where the self-test didn't work and then all three methods failed, I didn't test further than the man down, as that was what that nurse who was brought to the ground was relying on in that specific incident. That individual was unable to reach for the button or to pull the tag themselves. So in the incident that all of this occurred from, the man down functionality was the functionality that would have alerted people.

Q. Just going back, then, to annexure C, which should be in the next tab for you, Mr Howson, if we just scroll up from Janine's email, or if you look at the bottom of page 1, Mr Howson, you see a response from Mark Bolst. Do you know Mr Bolst personally?
A. I have worked with him on a few times with various IT-related issues over the district.

Q. What's his role, to your knowledge?
A. Digital Health Solutions manager and technical lead for a few projects around the district.

Q. Is Digital Health Solutions a team in the district at the district level; is that your understanding?
A. It is. I also believe it does have a span across the whole of - whole of health.

Q. The upshot of Mr Bolst's email - tell me if I have got this right - is that the man down function just wasn't enabled on the duress alarms in C4A and C4B
A. Yeah, it was not enabled, according to his email.

Q. And it subsequently was enabled. That actually happened, to your knowledge?
A. Yes. I was informed that it was turned back on.

Q. Mr Bolst refers to "as long as you're comfortable there has been adequate training in how to use it" - do you know if there was?
A. Yes, because C4A and C4B is one of the mental health spaces, we were all given the same training, which I had received, which discussed all these concerns on how to activate it, how the man down functionality worked, how to cancel a man down alarm and so on.

Q. Was that after the date of this email?
A. Training would have been before. Meaning that the C4A and C4B nurses were operating assuming the man down

functionality was enabled.

Q. So as far as you know, there was no further training provided after the function was in fact enabled?
A. No, we were trained before this incident and, as I said, the nurses in question would have assumed that the man down functionality was enabled because we had been trained, and all of the Cumberland sites had it enabled, and it should have been across all of mental health, and they were excluded by virtue of being attached to Westmead Hospital physically.

Q. Do you know whether the man down function is enabled at Cumberland Hospital?
A. It is.

Q. What about the Westmead ED?
A. No.

Q. Including for mental health --
A. Correct.

Q. -- pod of beds? Are you aware of why that is?
A. I am not aware of why.

Q. Do you view it as important to have a man down - a functioning man down mechanism?
A. I do.

Q. Why is that?
A. It's evident in that incident report, if somebody grabs you and you are by yourself and you fall down on the ground and you're unable to get to your alarm, the only thing that is going to alert people if, say, someone has their arm around your throat and you're unable to yell for help is that man down functionality. I do speak of a pretty serious event but they are, unfortunately, all too common in nursing and more common in the mental health space.

Q. Your views about the importance of the man down function, do those extend to just working in the ED, leaving aside mental health nursing?
A. It does, yes. There are a number of incidents where you may be, as a nurse, escorting somebody from the emergency department to imaging or up to a ward where it's just you and one other staff member, and you should be

wearing a duress alarm that you got from the emergency department, and if something happens, you should be able to rely on that alarm wherever you are in the facility.

Q. You've said that issues with duress alarms have been ongoing. I assume you mean since this February 2023 email; is that right?
A. Yes.

Q. What issues have you continued to experience?
A. Similar to what has already been raised, alarms not sending alerts when they have been triggered.

Q. Have you escalated those issues?
A. As an incident report, that has been submitted, yes.

Q. On each occasion when --
A. I can't say if it was every occasion, but there's certainly some people who take these safety failures more seriously than others and they do quite often put in an incident report. We tend to find that individuals who have been injured in the past, in one way or another, are far more likely to report these failures because they see the importance of these in keeping them safe.

Q. Have you put in any incident reports personally since February 2023?
A. Personally, no. I've only just returned back to a clinical space from being on secondment for nearly two years.

Q. Do you have any knowledge of how many incident reports have been submitted in relation to duress alarms since then?
A. Only ones that I have been alerted to by the individual who submitted them. That would be a question you'd have to direct to the district to have a look through their own system to see things that mentions security alarm and duress alarm failures.

Q. You have provided one other incident report as annexure L to your statement - I won't take you to it - and that relates to an issue in the Westmead ED. Do you know what I'm talking about?
A. If that's the one from early February this year, yes.

Q. So that was an incident, 14 February 2024?

A. Yes.

Q. So about two days before you signed your statement?
A. Correct.

Q. And I take it, again, you didn't have any direct involvement in that incident --
A. No, again, it was a member reporting those failures to me, knowing that these things were being looked at.

Q. You have said, then, in paragraph 30 of your statement, "The current procurement arrangements do not support me in my role in providing care" and so on. Do you have any involvement in procurement in your role?
A. No.

Q. Can you just explain why you characterise the issues you've identified in your statement with duress alarms as procurement issues?
A. Given that we've been able to identify numerous incidents where something does not do what it says it's supposed to do, I would classify that as a procurement process failure, because these things should be consulted on, discussed, researched and implemented in a way that makes sure these problems don't exist. If you've bought something and it doesn't work, you send it back.

Q. And perhaps you've partly answered this, but what do you think could be done better from a procurement perspective in relation to the duress alarms?
A. More consultation with the people that actually use them. Not that I'm aware of the exact decisions made to do it, but the chances of the people wearing one of these alarms who make the decision that people have to wear these alarms is very slim.

Q. So you don't know the extent to which, if any, consultation occurred before these alarms were introduced?
A. No. I do not.

Q. Just finally, you have referred to some other procurement issues from paragraph 32 onwards. I think what you say is fairly self-explanatory so I'm not going to take you through that. Is there anything you want to add to what you have said in those paragraphs about the other procurement issues?
A. No, just as a quick summary, for the record, is that

we have a lot of people in acting roles. Procurement is spread out across a variety of roles, you know, the kitchen buys some parts of food, ward buy other parts of food, NUMs approve some parts, general services managers approve other parts. It's actually quite hard to work out who you need to ask to get something.

We quite regularly order things like toothbrushes and toothpaste and combs - we get mental health consumers who may be living on the streets before they come into hospital - those simple little things that we like to get to, you know, make somebody feel human, to brush your teeth. Quite often we will, say, order 20, and we will get the order form back with the 20 crossed out, 10 written in, saying "Low stock", or "Unavailable."

Q. Is that a particular experience that you have had - is that an example of something that you've actually experienced?
A. Yes, I have receipts of those exact transactions, too.

Q. And who was it who crossed out the 20 and put 10?
A. I couldn't tell you. It's just crossed out on the version that comes back.

Q. Do you know where it comes from?
A. General services.

Q. So that would have been an order form that you submitted to --
A. Yes. Yeah, it's just a standard requisition form. You just write out a quantity, what it is, and it gets sent up.

Q. How does it get sent up?
A. So generally it's the ward clerk who sends that out for you.

THE COMMISSIONER: Q. What does a ward clerk do?
A. The ward clerk is the - for anybody who has walked into a public hospital recently, it's generally the person in the purple shirt that you see at the front of house. They're the ones that take all the phone calls, take all the paperwork. Yeah, they're that real first point of contact into a ward. They answer the phones, they answer the doors, they answer patient queries when clinical staff aren't around, so they're support services.

MR FULLER: Q. Is a part of their formal responsibilities to do this work of facilitating --
A. It is --

Q. -- orders?
A. -- part of their responsibility. We generally just relay, "Hey, look, we're out of", X, Y, Z, "Could you please order some", and they will get on to it if they have the capabilities to do so.

Q. How many ward clerks are there at Cumberland Hospital?
A. There's supposed to be one for each ward but quite often they are doing the duties of not only the ward clerk role but also a number of other administrative positions within the wards due to absences and unfilled positions due to recruitment issues.

Q. Do you have any knowledge of the DeliverEASE initiative?
A. I have never heard of that, no.

MR FULLER: Those are my questions, thank you

THE COMMISSIONER: Mr Dawson?

MR DAWSON: No, thank you.

THE COMMISSIONER: Mr Gyles?

MR GYLES: Thank you, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Mr Howson, did I hear you say that you've been on secondment for a period and not in a clinical role?
A. Not in direct clinical contact as in working in a ward. I was working as a CNC, which is sort of a referral-based position, so when there were more difficult cases or more difficult situations, I would be asked to go to the ward to provide support to those staff.

THE COMMISSIONER: Q. What's a CNC?
A. A clinical nurse consultant.

MR GYLES: Q. When we look at your statement, you have annexed some contemporaneous documents being emails that

you have been taken through this morning?
A. Yes.

Q. Including some, I think you have described, as being provided to you by way of comradeship from some of your colleagues in other LHDs?
A. That's correct - other hospitals, same LHD.

Q. Sorry, thank you, so it's within the same LHD. Thank you. So was it part of the process you undertook in preparing your statement to find for the benefit of the Commissioner some examples where issues had been raised about duress alarms?
A. Issues that I was made aware of at the time, yes. I did not dig further than what I knew about already.

Q. All right. But each time that you incorporated these emails, you weren't then tracking through the particular email concern or request to see what had happened with that concern or request?
A. Only in the feedback that I received from the person, as I would follow it up myself, "What happened with that issue in the ED?" "What happened with that issue in the pod."

Q. But you weren't intending, in the material that you annexed to your statement, to provide the full story from complaint to how it was dealt with, were you?
A. Being not the manager involved in the decision-making that they proceed from, no, I would never have been privy to all the decisions in that chain.

Q. But essentially what you were doing was giving contemporary examples of complaints being raised?
A. Yes, issues being raised, not necessarily complaints.

THE COMMISSIONER: Mr Loy's email is a response, isn't it?

MR GYLES: There are some responses. What I'm really trying to get across, and I think the witness won't be disagree:

Q. This has been a selective exercise to show - I'm not being critical of the exercise - essentially to show to the Commissioner that some of these issues have been raised?
A. Correct.

Q. But you weren't intending to say to the Commissioner nothing was done because you haven't annexed further correspondence?
A. No, absolutely not. Look, I don't believe this process is about laying blame anywhere, it's about discovering where things can be improved. And anything that I've included here is not to lay blame on a particular individual or system or process, it's just to highlight that there are issues with our duress system, and I personally do not believe that the money that has been spent on them is worth what has been spent on them.

Q. And you're drawing upon your personal knowledge of those things plus you've received information from others about that?
A. Yeah, I sort of see the position that I'm in in the branch, it is an equivalent managerial position, you are aware of issues even if you are not directly involved.

Q. But you appreciate that things are being done about duress alarms, but your concern is that they're not being done in a way which is achieving outcomes at a clinical level on the ground dealing with particularly mental health patients?
A. Given that, as was said, the most recent email was in February where we're still experiencing the same issues of alarms not functioning, yeah, I do believe there are still issues.

Q. But you would accept that it's a challenging --
A. Absolutely, it's a challenging environment.

Q. And, for example, the man down function, now, correct me if I'm wrong, but the man down function will activate where the person with the personal duress alarm is lying flat on the ground and is not moving; is that your understanding?
A. I could not tell you the exact angle required to trigger those alarms.

Q. But if the alarm, whilst activated, was put on someone's desk, it may activate?
A. Definitely if it's on a desk, it will alarm.

Q. If someone lay down voluntarily, obviously nurses - it's a difficult job and occasionally you do go and have a rest during a shift or between shifts or when you get

a moment - that would be an occasion that might set off the man down alarm?
A. Duress alarms are supposed to be worn on your chest so unless you're fully lying down, as in having a sleep on the job, the alarm should not be going off.

THE COMMISSIONER: Q. Is there an on and off button?
A. There is not.

Q. There is not. So if you're going to have a lie-down, there is no button to push it off, knowing that you might set it off if you're just going to --
A. Not that I can say I've ever had time to lie down on shift, but no, there is no off button.

MR GYLES: Q. You also said that, to your understanding, if someone is not moving, the duress alarm - sorry, the man down alarm, would be set off. Is that in combination with it being at a particular level that is when you are horizontal or is that just not moving generally or don't you know?
A. These alarms don't have a no motion sensor, they are man down only, and as I said, I am not aware of the angle required to trigger the man down functionality.

Q. You are obviously a repository from some information from others about these duress alarms. Do you understand that there is a view of some people who are using these alarms that the man down function is not something that they need - that is, it goes off so much that you're better off without it?
A. I would disagree with that. You're still better off with it.

Q. That wasn't my question. My question was: are you aware that there are persons who are nurses who are familiar with these systems and using them every day, that would prefer not to have the man down alarm functionality because they believe that's not necessary?

THE COMMISSIONER: What kind of nurses? Mental health nurses or --

MR GYLES: Yes. Well, the one we heard from yesterday, for example.

THE WITNESS: I'm not aware of any mental health nurses

who had expressed that view.

MR GYLES: Q. But obviously in your role, if people were expressing that view, then that would be something you would need to have regard to, wouldn't it?
A. I would consider their opinion, yes. I would also point out to them that it's a requirement of the "Protecting People and Property" manual that the man down functionality is there and is unable to be turned off, and if they are saying that it is too sensitive, the "Protecting People and Property" manual also says that excessive alarms must be adjusted.

THE COMMISSIONER: Q. Sorry, just remind me, if you want to operate it, you know, there is an aggressive incident unfolding and you feel there's a need to activate the alarm, leaving aside this slightly antiquated term "man down", you have to push the button and, did you say, hold it for a certain number of seconds?
A. Yeah, I believe it's about five seconds to hold the alarm button down or do the pull cord.

Q. So that's doable if the incident doesn't actually involve a very sudden physical confrontation where you might be needing to use both your arms to defend yourself?
A. Yes, correct, and I mean, as I say --

Q. So the benefit of the man down - "person down" - function, is that the alarm will go off in circumstances where you haven't got the physical opportunity of pushing the button and holding it for five seconds?
A. Any situation where you don't have the ability to call for help is an extremely serious situation, yes, Commissioner.

THE COMMISSIONER: Okay.

MR GYLES: Q. But that would only be if you were on the ground as compared to being in a position where you were unable to either pull the alarm or push the button, if you were in a standing position?
A. Correct. If someone grabbed you from behind and held you up, there is no alarm that would work and that is, unfortunately, a risk we are exposed to as nurses.

Q. And in terms of fixed alarms that are on the wall, which don't have these issues because they're hard-wired,

in effect --
A. If they work.

Q. -- your experience is that in mental health units - the mental health units you've worked in, they don't have them?
A. In the patient clinical care areas, no. They do not have them in the ones that I have worked in.

Q. Can I suggest to you that in other parts of the system and in other wards --
A. Yes.

Q. -- whether EDs or mental health wards, there are fixed duress alarms which are able to be accessed?
A. Yes, as mentioned in one of the incidents there, there is - was a fixed duress alarm in the mental health space in ED, however, it was not working.

MR GYLES: Those are my questions, thank you, very much, Mr Howson, and thank you, Commissioner.

THE WITNESS: No problems, thank you.

MR DAWSON: Might I just ask a couple of questions arising?

THE COMMISSIONER: Sure.

<EXAMINATION BY MR DAWSON:

MR DAWSON: Q. Mr Howson, what happens - or does anything happen - to the tag that you're wearing when the man down activates?
A. You get a warning beep and a little message pops up that says, "Are you okay?" If you fail to dismiss that by holding the button, then the alarm is triggered.

Q. Is that warning beep very audible?
A. It is quite audible but hospitals are noisy environments, there's a lot of beeps, there's a lot of dings and machines that make assorted noises. By the time you tune in to that first beep, like, you'll hear the first "der-der" of it, and you go looking for it and you're trying to look at it on your chest, is it mine or is it my colleague's, is it someone sitting down in the nurses station over here - you have maybe only got one second to

dismiss that alarm before it triggers the man down.

Q. And rather than turning it off, the function off, have you got any suggestions as to how that function might be improved?
A. I do.

Q. What are they?
A. A slightly longer delay. I think that functionality is important and it should be there, but the sensitivity does need to be tweaked to be appropriate to the circumstances. If you are --

Q. In your role, have you had any conversations with people directly where they have indicated to you that they're in favour of it being turned off because of that problem of the audibility and the quick time response?
A. In the mental health service, no. We have discussed the concept of alarm fatigue, which is quite a common thing in a clinical setting, but even then, people say, "We do see the importance of it. It just needs to be tweaked."

In my role as the acute CNC at the time, I did pose the question to them that perhaps this does need to be looked at as people hear that man down and see that alarm and they do go off that frequently that they become akin to a car alarm. When was the last time anybody in this room walked out to a car alarm when it went off? They are accidental triggers most of the time and with the man down functionality a lot of them are also accidental triggers, so it leads to some sort of apathy. Reducing the number of false alarms would increase the response rate and the safety.

Q. And do you think that if you and some of your colleagues were consulted about that sort of issue, you would be able to make those constructive suggestions about how the man down function might be improved?
A. Yeah, as I said, by the time you grab the alarm and try to read something that's this far away on your chest (indicating) and work out what's going on, which button to press, acting those out before approving the approval of something, we may have been able to adjust the timing on them to be more appropriate.

Q. Do you get to lie down often on your shifts, Mr Howson?

A. Literally never.

Q. Any of your colleagues get to lie down very often on their shifts?
A. Not that I am aware of, no.

Q. Ever heard of anybody that you work with setting off the man down because they're having a lie-down on their shift?
A. Only if they were sneaking into the toilet in whatever 30 seconds that they had.

MR DAWSON: Thank you.

THE COMMISSIONER: All right. Mr Gyles, did anything come out of that?

MR GYLES: I wasn't thinking to besmirch the hard-working nurses if that's --

THE COMMISSIONER: I didn't take it that way.

THE WITNESS: I didn't take it that way either.

MR GYLES: No further questions, thank you.

THE COMMISSIONER: Thanks. Anything, Mr Fuller?

MR FULLER: I just have one matter, Commissioner.

THE COMMISSIONER: Yes, go ahead.

<EXAMINATION BY MR FULLER:

MR FULLER: Q. Do you know why it is that there are not more fixed duress alarms in mental health units?
A. Yeah, like I said, simply - we can't put them in clinical spaces. We have too many people who are unwell, buttons, things to pull on, things to press, they're just not in those environments. Clinical spaces in mental health wards are fairly bland, simply for safety reasons and to prevent those sorts of issues, pressing call bells incessantly.

Again, you know, it comes back to that concept of alarm fatigue. If someone is pressing your call bell every 30 seconds, you are going to ignore that. It's just human

nature. You can't walk to a room, find nothing's going on, cancel the alarm, walk back out, get the alarm again and walk back in. It already happens with the old ones that we have that don't make an alert beyond a light that flashes on in the nurses station and they're constantly being pushed already as it is.

Q. I take it in your experience that's different from the situation in an ED, for example?
A. Mmm. People in ED are a lot more mobile, they're a lot more on their feet and those fixed alarms are more widespread because it is a primarily medical space and people are often more in bed than anywhere else. But we do obviously have as a single entry point to services, a significant number of mental health consumers do present through ED and, you know, there is part of - I think it's in Steven Westbrook's email where they mention a consumer injuring themselves with equipment that is available in ED simply because it has to be there. So we have to remove these things from mental health spaces.

MR FULLER: That's all. Thank you, Commissioner.

THE COMMISSIONER: Thank you. All right. Now, Mr Howson, you are excused. Thank you very much for coming. It's greatly appreciated.

THE WITNESS: Thank you, Commissioner.

MR FULLER: Commissioner, Mr Muston will take the next witness.

MR DAWSON: May we also be excused?

THE COMMISSIONER: You can, certainly. Thanks for coming.

Mr Gyles.

MR GYLES: Perhaps before we move to the next witness, just to reflect on where we are with the duress alarm issue and having regard to the issue that you raised, Commissioner, with my learned friend, and perhaps I can have a discussion with Mr Muston about this, but it is one thing where - we're essentially here looking at overall governance, funding models, strategies, high-level strategies --

THE COMMISSIONER: Opportunities to improve NSW Health procurement process is one of the terms of reference we're dealing with.

MR GYLES: Quite. And then dealing with particular items obviously it's not irrelevant to know what's occurring. This, for example, is essentially a capital item which is no doubt, as to selecting, you know, the appropriate duress alarm, looking at the capabilities, whether, for example, it should - the man down function should be tweaked or should be on at all or - no doubt there are a whole lot of different views about this.

We have this witness's personal views about it, which are no doubt relevant and he is someone who uses the alarms and that would be something you could take into account, if there was to be what might be described as a deep dive into duress alarms. If you were going to seriously embark upon that issue, there would have to be a whole lot of information that would be put before you, before, for example, there was to be a recommendation made about a particular type of alarm.

If one is dealing with you, Commissioner, making a recommendation that it is important that clinicians, nurses on the ground, be heard in respect of procurement of these sorts of items which are very important items in the system, that's one issue, which --

THE COMMISSIONER: Look, why don't you have a discussion with Mr Muston, but I think what would be important for me is whether this evidence is an indication of something systemic or something that is more specific in relation to what's happened here in relation to duress alarms. I won't say no to anything, but I think it's probably unlikely I'd be making recommendations about particular duress alarms without actually expert evidence about it. I mean, there is a level of expert evidence already given by the people that have to wear them - you could call that a kind of expert evidence. But I would need to hear from, you know, manufacturers, I suppose, and how these things exactly work.

So I'm not sure that that was the basis that the evidence was called; it was more as to whether this is indicative of a procurement process where something is procured for a safety reason and there's evidence of,

system-wide, staff, et cetera, not being listened to or consulted. Otherwise, it just remains an individual issue, I would have thought.

MR GYLES: It may be, but it may be a particularly challenging piece of equipment as compared to, say, a suture, which --

THE COMMISSIONER: Yes, you keep saying that. It doesn't look that challenging to get this right, but maybe it is. Maybe, you know - I don't know enough about the way they work. It shouldn't be challenging, I wouldn't have thought. But to more address your question, I think it's whether there is something systemic rather than absolutely individual in relation to how these alarms operate. But maybe you can have a discussion with Mr Muston when we have a break in a few minutes.

MR GYLES: I'll do that, Commissioner, thank you.

THE WITNESS: Can I add something, Commissioner?

THE COMMISSIONER: Sorry?

THE WITNESS: May I add something, Commissioner?

THE COMMISSIONER: What's it about?

THE WITNESS: It's kind of hard to say without saying it. It is about duress alarms.

THE COMMISSIONER: Go ahead. We're not a court. Go on.

THE WITNESS: Anything that keeps somebody safe in their job and prevents an injury that can spiral into years of workers compensation claims is a - it is a good spend, but it needs to be the proper spend. A $400 duress alarm that prevents five years' worth of workers comp payouts at $100,000 a year is a good spend. I have colleagues who are still on workers comp after injuries sustained after five years a - acquired brain injury, traumatic injuries, psychological injuries. Anything that can prevent that is a good spend and it must be an appropriate device to do so.

THE COMMISSIONER: Sure.

THE WITNESS: I do not think duress alarms are a waste of

money in any way, shape or form, but the incorrect, non-functioning ones are.

THE COMMISSIONER: Thank you for that. Nothing arose out of what Mr Howson just said?

MR MUSTON: No.

THE COMMISSIONER: Thank you again, sir, for coming. Greatly appreciate it. Thank you.

THE WITNESS: Thank you, Commissioner.

<THE WITNESS WITHDREW

MR MUSTON: I note the time. It is a little bit early. We are about to move to another witness.

THE COMMISSIONER: You want to take the break now, do you?

MR MUSTON: Perhaps instead of interrupting her 15 minutes into her evidence.

THE COMMISSIONER: Yes, all right. We will take a break, then, until 11.35. We will adjourn until then. Who is the next witness?

MR MUSTON: Ashleigh Vinton.

THE COMMISSIONER: All right. We will come back at 11.35, thanks.

SHORT ADJOURNMENT

THE COMMISSIONER: Thank you. Did you want to say anything, Mr Muston, about the point that Mr Gyles raised just before we finished?

MR MUSTON: Only briefly, Commissioner. I think it's fair to say, Commissioner, no-one is going to be suggesting that you make a recommendation about a particular brand of duress alarm or that they be configured in a particular way in any particular unit or ward but obviously to the extent that duress alarms - that the way in which issues have arisen with duress alarms informs us about the way procurement policies are working on the ground and as we noted earlier, the extent to which the problems with duress

alarms might be in a genuine way potentially feeding into workforce issues and recruitment and retention type issues, obviously they are matters that will need to be considered by the Commission.

THE COMMISSIONER: Sure.

MR MUSTON: I think we all understand that it's at that more systemic level rather than the granular.

THE COMMISSIONER: Understood, thank you. Yes.

MR MUSTON: The next witness is Ashleigh Vinton. She is there ready to go.

<ASHLEIGH VINTON, affirmed: [11.38am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you give us your full name for the record?
A. Ashleigh Vinton.

Q. And you are working currently in the Illawarra Shoalhaven Local Health District?
A. Correct.

Q. What is your role there at the moment?
A. I'm the clinical nurse specialist working in the clinical products team of the operating theatres.

Q. Do you work in a particular hospital within the LHD?
A. Just Wollongong.

Q. How long have you been in that role?
A. Since 2016.

Q. So before that, have you had previous roles in the Illawarra Shoalhaven LHD?
A. No. Not in that district, no.

Q. Have you had previous roles in other LHDs?
A. Yes, I've - when I finished uni in 2007 I did a new graduate program at Sutherland Hospital, in South Eastern Sydney, where I worked in the emergency department there. And then in 2010 to 2012 I worked in a procurement type role in the emergency department. And then from 2012 to

2014 I worked for the South Eastern Sydney Local Health District procurement team as a clinical products manager.

Q. So your qualification is in nursing; is that correct?
A. Yes.

Q. And the first role you held in the emergency department at Sutherland was a clinical role as a nurse?
A. Yes.

Q. And then could you describe the first procurement role that you held in Sutherland, roughly what it involved?
A. It was a start - it was a new position that they created. So I was in charge of making sure we had the correct stock on shelf to look after the patients, maintaining equipment, making sure we had the proper equipment for the service we needed to provide and just the day-to-day stocktake and management of stock through the emergency department.

Q. You may have told us, but was that in a particular hospital?
A. Just Sutherland Hospital.

Q. In a particular ward within Sutherland Hospital?
A. Emergency department, yeah.

Q. And the role that you then moved into within South Eastern Sydney within the procurement team, what was that role?
A. It was a clinical products manager, so it was overseeing all the hospitals in South Eastern Sydney looking at state contracts, making sure we were complying with products on state tenders, looking at product initiatives to save money, and meeting with company representatives.

Q. So were you working as part of a team in that role?
A. Yes. Yes. We were in under the Department of Finance, in our district, and there were two clinical product managers working in that team.

Q. Did you have interaction with clinicians in that role?
A. Where needed. With new products coming in, we would meet with the appropriate people at hospital sites.

Q. I will bring you to your current role.

A. Mmm-hmm.

Q. What does your current role involve at Wollongong Hospital on a day-to-day basis?
A. So on a day-to-day, I look at the theatre list for that coming week and book in the required equipment required for those procedures, so liaising with surgeons to make sure that - what they need for each procedure, making sure we have the stock on shelf for those cases, dealing with any equipment issues that may come up throughout the week, prioritising equipment to different theatres and meeting with company reps to talk about new products or initiatives.

Q. So do you work as part of a team within your current role?
A. Yes.

Q. How many people are in that team?
A. There are five of us. Yes.

Q. What are the roles of the other team members?
A. There are two clinical nurse specialists, myself and another member, then we have two store people, and then we have a prosthetic billing clerk, who does a bit of admin as well.

Q. Working through each of them, perhaps from the admin clerk up to you, what are the particular roles that they play within the team from a procurement point of view?
A. So our prosthetic billing clerks, they look at the data that is entered into SurgiNet to make sure that what's in the patient is correct, they've got lot numbers, the right companies. Then I believe that information goes to Medicare and private health insurers to work out the prosthetic billing of those patients.

They also help with the day-to-day admin in the team, answering phone calls, booking in appointments, helping write briefs to executives. Then we have store people who use systems and Oracle, to order stock and non-stock.

Q. Pausing there, what sort of stock? You've told us a little bit about the stock that you order or have on hand for the procedures?
A. Yes.

Q. Is it that stock that they are ordering or is it different stock.
A. No, it's mainly the bread and butter stuff, so the stuff that you use, like bandages, syringes, things that are used day-to-day with most procedures, not so much the specialised equipment. So they will weekly or bi-weekly order via DeliverEASE where they will barcode the day-to-day stock that's required and then that will come from the Onelink warehouse. Then that stock will be received by the loading dock and they will put that stock away.

Q. Just pausing there, and we'll go back a few steps. Do the store people report to you within the team?
A. No.

Q. Who do they report to?
A. Our nurse manager.

Q. Who do you report to?
A. The nurse manager as well.

Q. Can I ask, in terms of your role - I'll come back in a moment to the process that the store people carry out. You hold your role at Wollongong Hospital. Do you have any involvement in procedures performed at other hospitals within the LHD?
A. No, just Wollongong.

Q. Do you know which other hospitals within the LHD perform surgical procedures?
A. Yes. So Shellharbour and Shoalhaven hospital within our LHD.

Q. Are there people, to your knowledge, in equivalent roles to yours within those hospitals?
A. There are people doing the - I'm not sure of the exact - if they align directly with our role but they have teams in those hospitals.

Q. But in terms of the procurement of medical consumables for surgery and the more specialist equipment and devices, there are people within those hospitals --
A. Yes.

Q. -- who take care of that?
A. Yes, yeah.

Q. Do you have any dealings with those people as part of the performance of your current function?
A. Not on the day-to-day, but if we have issues, if a surgeon hasn't done this procedure at our site we may liaise them and ask them what his preference is at Shellharbour hospital and get the information from them, or if we're having issues with stock we can sometimes borrow in between sites, but we've also recently set up a meeting where we're liaising, I think once a month, with those key people just to talk about issues that we're all having together.

Q. Can I take those things in two parts. The first, I think you said, is a surgeon who might operate at Shellharbour --
A. Yes.

Q. -- and then comes to do a procedure at Wollongong?
A. Yes.

Q. You will liaise with the equivalent people at Shellharbour to work out what the surgeon's particular preferences are?
A. Yes.

Q. In what respect, what sort of preferences are we talking about?
A. Mainly what type of implants he might require. Like, we'll have the day-to-day stock that he would need for that procedure, like drapes and the day-to-day stuff, but it's what implants he may require. So say if it is a procedure that we don't do all the time at Wollongong, but it's a Shellharbour procedure, Shellharbour do more of the day procedures, patients that don't really need overnight stays.

Q. Are you able to give us an example of where this has occurred, perhaps talk us through.
A. Yeah, so we had a surgeon actually this week who at Wollongong will mainly do hip replacements or knee replacements. But this was an arthroscopy case where he would mainly do at Shellharbour but, for some reason, I'm not too sure why, it was put on to our wait list at Wollongong. So we liaised with our colleague there to then send a preference card over, which is just basically a list of the set-up that is required for that procedure from

gloves, gowns, drapes, bandages, syringes. And then it drills down to also the patient positioning that's required for that case and then the implants that would be required. So then she sent that over to us, we liaise with that relevant company representative to organise the stock to be delivered for that procedure.

Q. So do you, in your role, or have you in your role, been involved in any discussions around standardising some of those things as across the different hospitals?
A. Is that implants or --

Q. Well, let's take it step by step. In terms of the medical consumables that are used, is it the case that different surgeons within your hospital have different preferences about the medical consumables that they use in the same procedure?
A. For the consumables, no. They generally come from the Onelink warehouse and they're standardised across the district. So things like drapes, gloves, gowns, they're basically - they're generally standardised.

But for the prosthesis, as far as I'm aware, I know that HealthShare have discussions with our district procurement team about market shares, so we get notified if we come outside of that agreed market share. But that's my understanding of what I - yeah.

Q. Do you have discussions or have you been involved in discussions with your counterparts at other hospitals about standardising those specialist devices?
A. No, no.

Q. I think you told us then - you have told us that there is a practice whereby you can borrow equipment from another facility --
A. Yeah.

Q. -- if you don't have it. Do you have an example of where that has occurred?
A. Like, it was sponges that we ran out of at some time last year but Shellharbour had a better stock than we did, so we organised a hospital car to borrow those and then once stock came back in, we replenished them.

Q. Dealing with that example, how did you find out or how did you become aware that Shellharbour had a good stock of

sponges at a time when you needed them?
A. Making a phone call and asking them what their stock situation was like.

Q. Are you aware of how, as between the facilities, the billing and invoicing, the payment for those sponges, works, if you borrow some from Shellharbour?
A. We have a book that we keep which has a carbon copy, so when we lend stock, we write that down, that goes with the stock, and then we have a copy, so we just follow it up. Once the stock comes in, that will just be returned back to them.

Q. And we'll probably come to it in a little bit more detail in a moment, but to the extent that stock is purchased by you or your team for your facility, how is it linked to your facility? Is there a coding or a --
A. I believe there is. It is built into Oracle. We don't see that side of it. We have all of our account codes built into our profile in Oracle, so we don't really need to change those details when we place an order.

Q. You told us about some meetings which I think have recently been initiated between yourself and equivalent people at the other facilities within the LHD?
A. Mmm-hmm.

Q. Who initiated those meetings?
A. Our district procurement team.

Q. Can I come first to deal with the process for procuring the medical consumables, I think you described them as the "bread and butter" items. You told us, I think, that it's the store people within your team who are responsible for that?
A. Yes.

Q. I think you've also told us that twice, roughly - is it twice a week they conduct an inspection?
A. Yes. They will - yes, yeah.

Q. Starting from that, could you tell us exactly what it is they do as part of that inspection process?
A. Yes.

Q. To the extent that you know?
A. So from my understanding, we have a storeroom that's

kind of just off our office, which has the boxes that come from the vendors which have our supply of - our - how do I explain it? Like, just the bulk of our supply. So they'll go into that storeroom, check the levels that are on there and we'll have labels that have "min" and "max", so they will base the count off that, get their iPad and just scan the stock that's required.

Q. Just pausing there, the boxes of consumables, are they still sealed-up boxes or are they -- -
A. Yes. Oh, some may be opened but generally they're sealed boxes on the shelf and then that stock, as required by the theatre staff, they will pull stock from there to their own areas.

Q. So in terms of the items that are in the storeroom, how do they actually physically work out how many of them are there? Do they do a physical count?
A. Yes.

Q. Or is there some other process?
A. There's a physical count, yeah. I'm not a hundred per cent over the delivery system but I believe there's a function in there where it kind of forecasts what we should have on shelf based on our forecasting. I don't have visibility of that, but to my understanding, they physically look at the stock on shelves and count.

Q. You mentioned using a barcode?
A. Yes.

Q. What is the scanner that they use to scan the barcode?
A. It is an iPad.

Q. So they take their iPad?
A. Yes.

Q. So they take their iPad and they --
A. Yeah.

Q. What do they actually - where is the barcode that they scanned?
A. It is on the shelf, underneath the product. So they're all labelled with what they are and where they come from.

Q. Having scanned it, what does the iPad tell them? What

comes up on the screen of the iPad?
A. The product and I believe the unit of issue, so how many they will get each time they place that order.

Q. Now, in terms of what items of those medical consumables should be stocked in the storeroom, who makes decisions around that?
A. I guess my team. We know what we need to run the operating theatres, and also we get input from the nurses and surgeons on the floor as well. So we will go to them with new product requests or they will - if a product is not satisfactory, they'll let us know and we'll work with our procurement team to source an alternative.

Q. Do you have an example of where that, just in the last case, where someone's not been satisfied with a particular product in that medical consumable area?
A. Yes. I'm just trying to think of a good example that we might have. I believe we had stockinettes, which are a drape that's used for joint replacements, and the ones coming from the Onelink warehouse were too small to fit the patients. So we fed that back to our procurement team and they helped us source an alternative on the state contract.

Q. So that first piece of information about the stockinettes being too small, that was fed back to you from surgeons and theatre staff?
A. Yes, yes.

Q. You then took that information, passed it on to who?
A. Our clinical products manager at the district level.

Q. And they made some arrangements with someone that you're not - that you weren't involved in?
A. Yeah, and they came back to us with some alternatives.

Q. So when you said you and your team decide what should be stocked, is that based largely on your experience working in that particular --
A. Yes, yes, and just to know what the day-to-day needs are.

Q. Again, do you know whether the day-to-day needs in your particular hospital are the same or different to the day-to-day needs in other hospitals in your LHD for the procedures?
A. I'm not too sure but I do believe that each site has

their niche procedures that they do, so I know that Wollongong kind of do a bit of everything, where Shellharbour and Shoalhaven have a smaller caseload. So their needs probably would vary.

Q. I don't know how to ask this, but as between different surgeons who are operating in your operating theatres, in terms of those medical consumables, is there any real difference, in terms of what they prefer?
A. No.

Q. In terms of stocking levels within the storerooms, who makes decisions about how much stock of individual items should be held within the storeroom?
A. That's the store people. So it's basically on the physical amount of stock we can keep. The storage is very tight where we are at the moment. So we keep the maximum required to get us through that week, really.

Q. And how is that assessment made in terms of what is needed for the week? Is it based on experience or --
A. Based on experience. We also do - we can have foresight into the procedures coming up for the following couple of weeks as well.

Q. So, let's assume they've been through the storeroom, they have made a physical stocktake of what's there and they identify that there are items that need to be purchased. What's the next step that they take?
A. So they'll use the iPad to place the order and once they have finished that order, that order is generated into iProcurement, I believe, and then it goes to the Onelink warehouse to be filled.

Q. Again, taking it back a step, how do they use the iPad to place the order?
A. So physically go to the shelf, count the stock, and if they believe it is needed to be ordered they will scan it. That will generate that order. That will build an order which goes into Oracle to be placed.

Q. Scan a barcode for a particular item?
A. Yes.

Q. And that will - what, that automatically generates "Buy one box of that item"?
A. Yes, so we have a set par level, so it will base it

off of that. So it will have a set amount, like an order each time.

Q. You then I think said it goes into iProcurement?
A. Yes.

Q. Is that an automatic process that it goes into iProcurement?
A. Yes.

Q. Can you explain what iProcurement is?
A. It's an online system that's used to create purchase order numbers. There's also an accounts payable side and receiving side as well.

Q. So in terms of iProcurement, is the iPad the interface between you and your team and the iProcurement system or is - do you access it in some other way?
A. I don't honestly put those orders through. I'm on the other side of it. The store people manage that side of things so I don't see the process on how they get from the iPad to Oracle.

Q. Do you have any experience of using the iProcurement system on Oracle?
A. Yes. Yes, so on my side of things, it's a lot of ordering the more specialised products that are required.

MR MUSTON: Could the witness be shown the document which is B023.145, which is [MOH.0001.0446.0001].

Q. We can probably get you a hard copy if it helps. Is that a document that you are familiar with? It is the ISLHD purchasing manual?
A. Yes, I have seen this before, yes.

Q. Is that a document that you use or have reference to as part of your day-to-day --
A. Not my day-to-day, no, but if I needed to get clarification on something, it's something I could refer to.

MR MUSTON: Could I ask, perhaps, for the witness to be shown hard page 3, which I think is .0004 in the electronic version.

Q. Do you see there the blue band in the middle, it looks

like a screenshot, the dark blue band?
A. Yes.

Q. Is that something which is familiar to you?
A. Yes.

Q. Is that what comes up on the screen when you open up --
A. Yes.

Q. -- Oracle?
A. Yes.

Q. So what its telling us there is first you need to log into Stafflink?
A. Yes.

Q. Can you tell us just from your perspective what Stafflink is?
A. To my understanding, it is a HealthShare system that has - we can view our pay slips, our leave accrual, and we can go into the iProcurement system as well.

Q. You can get this on your computer?
A. Yes.

Q. At your desk?
A. Yes, correct.

Q. It then goes on to say "Select the procurement app", or button, the red shopping cart button up there?
A. Yes.

Q. That's the button, is it, that you press when you want to procure something?
A. Yes.

Q. Then it seems to suggest that another item or another icon that says "Shop" comes up. Is that one you are familiar with?
A. Yes, at the top, yeah.

Q. So you press that?
A. Mmm-hmm.

Q. So presumably, it seems from what follows, you then get a dialogue box "What do you need to buy today", that

you start typing something into?
A. Yes.

Q. Could you just talk us through the process of when you start typing your item in, first of all, what do you type?
A. Yes. So for the specialised items that are purchased, so not consignment or loan, we would start with the product code, and then, if that's in the master catalogue, it will drop down with some options.

Q. So pausing there, you type a product code in after the "What do you need to buy" question?
A. Yes.

Q. What do you physically see on the computer?
A. It will have a drop-down, which will hopefully show that item number that you've put in. If the item number pops up you just click on that number and it should - and it populates with all the product details.

Q. Could I ask you to turn over to page 10 in the hard copy, which I think is likely to be page 0011 in the electronic version.
A. Yeah.

Q. Do you see in the middle of the page there's a heading "Related and Additional iProcurement Information"?
A. Yes.

Q. And then immediately below that, "How to Raise an Inventory Order"?
A. Yes.

Q. Can I ask you to just read that paragraph immediately under that. Does that - I will let you read that.
A. Out loud?

Q. No, no, just to yourself. To yourself.
A. Yes.

Q. Does that describe the process that you have just --
A. Yeah.

Q. -- been through with us, where you start typing something in to the dialogue box and then it will give you a range of options and you click one --
A. Yes.

Q. -- is what that's -- -
A. Yes.

Q. As best you understand it, that's what that's dealing with?
A. Yes.

Q. An inventory order is a master catalogue order?
A. And also, like, it's not just inventory items that works for, it's also non-stock items too.

Q. Okay.
A. Yeah. So when we type in the product code, it will come up with the - then after that it will show us if it is in the inventory or if it is coming directly from the supplier.

Q. Can you explain the distinction between the two for us?
A. So my understanding is inventory comes from the Onelink warehouse, and then if it's a supplier item it comes directly from the supplier's warehouse.

Q. So I think you started to tell us about a situation where you typed something into the "What do I want to buy" dialogue box and nothing comes up?
A. Yes.

Q. Which I assume is something that can happen?
A. Yes.

Q. Perhaps if we go back to page 3, do you see there immediately above the dialogue box - the screenshot at the bottom, there is a reference to "Once you have confirmed the item is not available"? Would it be fair to assume that that's an occasion when you've started typing in your product code or a product name and you haven't been given any options?
A. Yes.

Q. Or not the one you want?
A. Yeah.

Q. You then click on the "EBS Quick Links", and if you look at that screenshot, which appears at the bottom of the page --

A. Mmm-hmm.

Q. -- is that what you physically see on your computer once you have clicked on it?
A. Yes.

Q. Can I ask you to just take us through each of the items on that little screenshot and tell us how you go about populating the information in each of those fields?
A. So in the "Item Description" field, we would put in the description of the item.

Q. So pausing there, an example, perhaps, that you would use regularly, what would you type in?
A. Say a 10 mil syringe would be an item that we would maybe order.

Q. Again, to make sure I have understood it, a 10 mil syringe is not, in this case, on the master catalogue or on the inventory?
A. It's probably not a great example to use, actually. Something like a specialised stent that we would use that wouldn't be in the inventory, that we would use and it's just - yeah, just a really specialised piece of equipment.

Q. So working through the process, you have typed the part number for this specialised stent into the - or product number --
A. Mmm-hmm.

Q. -- into the dialogue box. It hasn't come up with what you wanted?
A. Yes.

Q. You have clicked through to this screen and then in terms of item type, what do you type there?
A. So we would type in, say, a Terumo stent, the sizing of it, all the information that we have available. The category is our internal accounting code, so we would go in to our spreadsheet which has all the categories listed. But this would be a vascular prosthesis so we would type in the number for vascular prosthesis.

Q. Pausing there. Is that just so it gets classified in a particular way for record-keeping purposes within your --
A. Yes, I think revenue as well, and expenses. They're

all categorised into different types of prosthesis for budgeting. The quantity.

Q. It's self-evident?
A. Yeah, we put that in. And then the unit of measure - it's a - depending on what it is, so this would be an "each", so we would type in "each" and have to select from a drop-down menu to make sure we've got the right format.

The unit price is - so we have spreadsheets of each specialty which has all the information already there. So we would sometimes just copy and paste from that spreadsheet, so all the information is in front of us ready to go.

Q. Just pausing there. Where do those spreadsheets come from?
A. They are our internal spreadsheets that we keep and manage. They are kept on our share drive. So all of the CNSs of each specialty can go in there, print off the spreadsheets and provide to us to place orders.

Q. Where does the information about the unit price that's put into those spreadsheets come from?
A. It's all on that spreadsheet.

Q. Where does it come from?
A. Initially from the vendors, so once we get a quote from them, they'll give us the unit of measure and the pricing.

Q. Is it you and your team who populate those spreadsheets?
A. Yes.

Q. So am I right in saying you will have dealings with a vendor. They will give you a price for a particular item?
A. Yes, yes.

Q. You put it into the spreadsheet?
A. Yes, that's after liaising with our procurement team to ensure the item is on contract and the pricing is correct that they've given us. Yeah.

Q. Sorry, I interrupted you.
A. That's okay.

Q. Currency, I think is --
A. Currency is automated in there. The supplier name, we'll start typing the supplier name in and it will bring a drop-down box so we have to select the correct vendor. Then the rest of the information, including site, contact name and phone number will pre-populate once that vendor has been selected, then we enter the supplier number in.

Q. Where does the supplier number come from?
A. From the quote given by the vendor or from the contract.

Q. So in terms of the process, is that something that's in the spreadsheet or is it something that you have got --
A. Yes.

Q. -- from a discussion with someone?
A. It's on the spreadsheet. So that's the product code that's listed on that item. That's the identifying product code number.

Then the other items - it's if the order that we've placed is over, I believe, $30,000, those drop-down menus will become mandatory to fill out, and it says, "Have you obtained three quotes for this purchase", and "Have you finalised a tender for this product". Generally most of our orders are under $30,000 so that doesn't need to be populated.

Q. If we can move back to deal with our medical consumables, the bread and butter items. A nurse or a store person within your team has identified and placed the order, I think you've told us you are not sure how that goes from your iPad to iProcurement. What's the process after that? So it has found its way into iProcurement.
A. Yes.

Q. What happens after that in terms of the order?
A. I believe - so are you talking about Onelink items, like the inventory items?

Q. The bread and butter items.
A. Yeah. So they will come, get packed by Onelink, be sent on a truck down to Wollongong, unloaded at the loading dock and that stock arrives into theatres.

Q. Can I take you back a step before that. Is there an approval process for the order?
A. For the items coming from Onelink that are ordered via that barcode scanner, no. That order is generated directly through Oracle. There is no approval process. They're all pre-approved items that we can order. But for the items that don't go via the Onelink warehouse, there is an approval process in iProcurement.

Q. So in terms of what was described as the "bread and butter" items, are any of them not coming through the Onelink warehouse?
A. Yes. Yes.

Q. In relation to - what sort of items?
A. It's just items that are more specialised to Wollongong Hospital or to the procedures that we're doing, that Onelink don't have the capacity to stock.

Q. What's the arrangement in existence between the supplier and the hospital in relation to those items, insofar as you are aware of it?
A. Sorry, can you explain that again?

Q. So in terms of an arrangement - an arrangement has been entered into between the LHD and those suppliers?
A. Yes.

Q. For the provision of those items?
A. Yes.

Q. Do you know what that arrangement is?
A. Most of those items are listed on New South Wales state contract. There's not many items that we purchase not on - not covered by state contract. So we liaise with the companies to provide them forecasting, get pricing, to find the best value for us, and then those items - all the information's kept on those spreadsheets that I mentioned before.

Q. And so in relation to those items, what is - what, if anything, is the approval process for orders that are made directly to or through iProcurement to the suppliers?
A. So once the item is put into iProcurement and we've submitted that order, it goes via our delegation manual. So anything under $5,000 is approved by our nurse manager, our line manager. Anything between 5 and 10 goes to the

operations manager, and I believe anything over 10 goes to our general manager for approval.

Q. In terms of the levels of delegation and the number of items which are available through the inventory, do you find that the need to obtain approval is slowing down your work in any way or do you think --
A. In some cases, yes. Most of our orders, when we place, will sit under that $5,000 or $10,000 value, so things do move, we can call our manager and say, "I've just put an urgent order in. Can you please keep an eye out and approve if you are happy to." But it is for the orders that are slightly larger, it does slow down the process.

Q. By how long?
A. Sometimes it can take two weeks for some items to be approved. But in saying that, these orders that are being placed are for stock already used, like, so a loan stock situation, so we're not waiting for the stock - that approval is not pending stock being delivered to us; it's more paying that vendor.

Q. So are delays in the approval process causing any logistical problems within your operating theatres or not, not really?
A. It does at some - at some capacity, yes.

Q. Could you give an example of when that happens?
A. So we have standing purchase orders that we use to get the niche products that are required to be resupplied next day, so those standing orders are approved by a high level of executive, because their values can be up to $150,000. So sometimes, due to those delegations, it can take several weeks to sign off. So if we don't have money left on the previous standing order, it can delay stock, the capacity for us to reorder stock.

Q. And what impact does that have on the scheduling of procedures, if any?
A. We manage it internally. We'll talk to the companies and let them know of a situation, they can generally resupply us with stock, but it's not ideal.

Q. I'll come back to those specialist items. Just finishing up with the bread and butter medical consumables, order has been placed, approval has been given. What's the next step in the process?

A. I believe the order is then created into a purchase order number by HealthShare. That goes to the vendor. Then they issue us with the stock.

Q. When you say, "issue" you with the stock, it gets delivered to a loading bay at Wollongong Hospital?
A. Yeah, to our loading dock, yes.

Q. And from there, what happens to the stock? Who collects it at the loading dock?
A. There are staff on the loading dock, so they sort through the orders and divvy them into trolleys and designate them to each department, so then that trolley will come up to us for us to - well, for the store people to unpack.

Q. Could I ask you to go to page 11 in the document that we were looking at a moment ago, the purchasing manual, which is, I think, page 0012 in the hard copy. Do you see at the very foot of that page - if perhaps the operator could scroll down - under the heading "Receipting a Purchase Order" --
A. Yes.

Q. Just if you read to yourself that paragraph very quickly.
A. Yes.

Q. First of all, is that receipting process something that you're familiar with?
A. Yes.

Q. Is that receipting process something which someone in your team does in relation to the bread and butter items that have been ordered?
A. Yes. We all - everyone in our office has a role in that receipting process.

Q. So in terms of the bread and butter items that have been put on the trolley and brought up to the theatre from the loading dock, whose responsibility is the receipting process for those items?
A. That's our store people. So they will unpack the goods, the packing slip will be popped in a tray and then they will mark off what is received versus what we ordered. Yes.

Q. And in relation to higher-value items that you might have ordered, would I be right to assume that you do the receipting for those items?
A. Yes. So any item that we raise as a requisition in Oracle, ourself, so if the store person hasn't receipted that item themselves when the stocks arrive, we'll get a notification on iProcurement to say, "This hasn't been receipted", and that flags us to make sure, to double-check the stock has come, has a step been missed?

Q. Do you have experience of goods that have been ordered not arriving?
A. Yes.

Q. What is your experience of that?
A. Especially at the moment, after COVID, there seems to be a lot of items still recovering from back orders. So if an item, a packing slip comes, most of the time the vendors will send the packing slip, which will have items received, but then they'll also list items that have gone on to back order and the quantity, and sometimes it may have an ETA of when the stock will arrive.

Other times, we will just wait, be waiting for that stock, no communication, and it'll come to us having to ring the vendor, with the purchase order number, asking for an ETA.

Q. So starting with that first category, the back order, to make sure we have understood it, you order an item through the system, or order a number of items through the system, a delivery arrives, some of the items are there, some of them are not there, but the packing slip says in respect of those that are not there, they're placed on back order, which means to you what?
A. That they don't have enough supply to fulfil our order.

Q. And in terms of the fulfilment of that order or the concept of back order, am I right to assume that that means that they're telling you that they'll send it when they do have the supplies?
A. Yes, correct.

Q. And sometimes but not always, I think you told us, they will give you an ETA for them?
A. Yes, where they can yes.

Q. Have you found that the items being placed on back order or the immediate unavailability of items has caused any issues in terms of the scheduling of procedures in your facility?
A. Yes. Yes.

Q. What have they been?
A. An example I have is at the moment, one of the vendors who we use for a lot of ENT - ear, nose and throat - procedures, I'm not sure of the reasoning behind it, a lot of their product range has gone on to back order. We have to liaise with the company representatives. They have provided alternatives in some situations, but for some procedures, we've had to liaise with the ENT surgeons to see - to let them know that we cannot get this product, and there's been instances where we've had to tell the wait list team they can't book any of these procedures due to these products not being available.

Q. Now, the second category that you told us about was items that just don't show up at all and no indication that they're placed on back order?
A. Yes.

Q. Is that a common occurrence?
A. It is. I feel - I think the system is set up, so HealthShare obviously send that purchase order number to the vendor on our behalf and in instances, they will let us - HealthShare will come back to us and say, "We've tried to place this order", they've advised us, "This has gone on to back order." They recommend us to reach out to our clinical products manager to discuss alternatives.

That does happen half of the time, maybe a bit more, but other times it will be that they'll have placed the order and the staff will come to us to say, "This hasn't arrived yet". Then we look through and we give the company a call and they will let us know then that it is on back order.

Q. To make sure that we all understand what we are talking about, these are items which have been ordered directly from suppliers?
A. Yes.

Q. Do these problems also emerge in relation to items

coming through the one share [sic] warehouse?
A. Yes. We receive from our internal district team an internal stock report.

Q. Sorry, I think it is the Onelink warehouse, I'm corrected.
A. So we get a nil stock report from the Onelink warehouse, which does show us visibility of items from that Onelink warehouse which have gone on to back order, and generally they will offer us a substitute item to order instead.

Q. To the extent you have been offered substitute items, are there cost consequences of having to substitute items?
A. Not to my - I'm not over - I couldn't comment on that one, yeah.

Q. In terms of those items that either are placed on back order or simply don't arrive, do you have any interaction with - do you report that to anyone, other than the company in the case you've just told us about?
A. If it's going to affect services and if we can't manage it internally we'll reach out to our clinical products manager to let her know of the issues and also our internal management to say that this may affect procedures.

Q. If non-delivery has occurred but it's not going to have an immediate impact on procedures, does that get reported to anyone or is it something you manage internally?
A. We definitely do raise it with our procurement team but probably not on that urgent basis. It will be in our monthly meeting, we may mention that this has gone on to back order.

Q. Do you keep any running record of who's consistently late in their deliveries and who is not?
A. We do have a running back order spreadsheet, which is only a new initiative that we put together just because of all the back orders that we were experiencing. So it's a live document where we track the product, the vendor, the ETA, and then we will make our own notes of - if we've found a good alternative or a substitute, we'll add it on to there, and that information is visible to all theatre staff. So if we've got a nurse who wants - is going to do a procedure and notices that the stock is low, she can look on there to say, "Okay, that's on back order. I'm going to

use this product instead."

Q. Does that spreadsheet get shared with people outside of your little working unit and your theatres?
A. It's still a work in progress but it's visible to anybody who wants to log into it in the theatre complex, but we would be happy to share. As I say, it's only been started in the last month, so - yes.

Q. Do you have any visibility of KPIs or performance requirements that might exist under the contracts that these suppliers have with HealthShare?
A. No.

Q. So in terms of things like the percentage of deliveries that need to arrive on time, to the extent that there might be some arrangement --
A. No.

Q. -- with HealthShare, you don't know about that?
A. No visibility on that, no.

Q. You mentioned a little while ago the DeliverEASE program or reform. Could you explain to us how that has worked or how that operates in the context of your working environment?
A. As I mentioned before, I don't use that system, I don't have any functionality or - it's the store people that do that. From speaking to them, it's working well. There have been teething issues, but that's, I guess, with most new systems that come through. They're requiring to do weekly stocktakes of 20 items, I believe, which gets loaded into the system, which I believe generates forecasting and then min/max levels.

Q. Are you aware of whether the forecasting is something - let me rephrase that. Is it your understanding that by entering the stocktake of these 20 items, it's giving some indication of what might be expected to be used within your hospital over any given period?
A. That's my understanding. I'm not sure how it works in practice, but that was my understanding.

Q. Are you aware of whether the system is actually able to record in real time what the level of stock in a storeroom for any particular item is without having to do a physical count?

A. No, I'm not aware.

Q. Can we move on quickly to procurement of those higher-value items, the prostheses, which I think you've told us is more your area?
A. Yes.

Q. What type of prostheses are we talking about?
A. Orthopaedic, so elective hips and knees and shoulders; also trauma orthopaedic products, spine, elective and trauma products, and vascular prostheses.

Q. So for any particular item, say a knee replacement or a replacement knee joint, would it be right to assume that there are different brands and models out there?
A. Yes.

Q. And do you, as part of your theatre's operations, purchase different brands and models of the same item?
A. Yes.

Q. So say knees, for example?
A. Yes.

Q. Do you know how decisions are made about which of those items to use? So whether to use replacement knee joint A or replacement knee joint brand B, how are those decisions made to the extent that you are aware of it?
A. So we have surgeons that work in Wollongong public that we know their preferences, so this is historically the systems that they use.

When I first started in the role, we met - a lot of the surgeons were using multiple different products and different companies, so we, with the district procurement team, liaised with them to try and narrow down what we used. So we came to an agreement based on I think it was the 16/18A state contract, where we would use 70 per cent one vendor, 30 per cent the other vendor, which kept everybody happy. It was basically what we were doing beforehand. So when a surgeon books in a knee, we know that surgeon A will require this product from this vendor.

THE COMMISSIONER: Q. Sorry, so there are two vendors for knees?
A. That we use at Wollongong. There's multiple, but in Wollongong we --

Q. And one you use 70 per cent and one you use 30 per cent?
A. Yes.

MR MUSTON: Q. So before this process, there was a wide range of different prosthetic devices that were being used by different surgeons?
A. Yes.

Q. Multiple brands?
A. Yes.

Q. And after this process was gone through, it was narrowed down to two brands?
A. Yes.

Q. 30 per cent one, 70 per cent the other?
A. And there is a bit of leeway there. So if there is a patient who has a different anatomy that would require a different prosthesis or a different company, then that will go through a different approval process, but for general hips and knees we have a set list of what each surgeon will use.

THE COMMISSIONER: Q. When did that narrowing take place, do you recall, approximately?
A. I believe it would have been 2017/2018.

MR MUSTON: Q. In terms of a change management, what was the process that you and your team went through to encourage surgeons to buy into this change?
A. Ernst & Young were involved in that, because they took on that role, so they went through our data and then presented that to the surgeons to show them, "This is what we're spending. If we can narrow it down, this is what we could be spending." But as I mentioned, it was basic - we didn't have to change too much, it was just a few surgeons that needed to then --

THE COMMISSIONER: Q. Were EY engaged by the district?
A. I believe so, yes.

MR MUSTON: Q. In terms of those surgeons who were outliers, if I could use that term, did you find that they were open to the change?
A. Yes.

Q. Did you have a sense of what it was that assisted in getting them to buy in?
A. I believe these surgeons weren't operating a lot at Wollongong, so it was just a small business to them, the procedures that they were changing.

Q. So, to the extent that new devices become available or new alternatives to the existing 70:30 split brands, is there a process whereby consideration is given to changing brands?
A. Yes. So if a surgeon wants to use a new product, we have a process where - we have an internal clinical evaluation form. So that form needs to go to many levels of approval but the first sign-off is the head of department for that speciality. So it will need to go - for, say, a new knee, it would need to go to the head of the department of orthopaedics and then it filters down through our management sign-offs. So it'll go directly to our NUM, procurement team, infection control, and then if there is any biomedical piece of equipment, it will go to the biomeds to sign off as well.

Q. In terms of the form that gets filled out, does it have areas where you've got to identify why it is that this particular device, in the view of the person submitting the form, would be better than the existing one?
A. Yes, so there's a "Disadvantages" section where the surgeon can - and all the company can fill out why we want to trial this versus. But generally during that process, that surgeon would also have had a discussion with the heads of department to plead their case as to why they'd like to use.

Q. So you've given an example of a surgeon coming forward with a new device that they want to use. Is that the only source of one of these forms or do the suppliers of prosthetic knees, for example, come forward and make their own case, as it were, for a change?
A. It's generally through the surgeons for those types of products, that the companies will meet with the surgeons to show them the new product that they have. The company will then potentially come to us, or the surgeon will come to us, with that request, and then we will we filter it through that process to sign off.

Q. Are there occasions in relation to either high-cost

items or even bread and butter items where the representatives of the companies are coming directly to you, trying to engage with you and encourage you to change --
A. Yes.

Q. -- from one product to the next?
A. Yeah.

Q. What does that approach look like in terms of a process?
A. Sometimes via email or a phone call, sometimes they'll pop into the office to show us something new. In those instances, we always tell them to come back and make an appointment, or meet with our district procurement manager, because those decisions really need to come from them to check contracts and what-not.

Q. So to the extent that a representative might come to you and say, "You really should be using this stent and not another type", that's not a decision that you make?
A. No. No. No, we may ask them for - if they have spoken to the surgeon about it and do they have buy-in from the surgeon. Generally, we won't proceed with any new products without talking to that surgeon first to make sure there is an actual need for it.

THE COMMISSIONER: Q. Can I just ask - and please don't feel as though you should know the answer to this: you mentioned EY doing some work about procurement. When the decision was made to narrow the suppliers of hips and knees to two, was HealthShare involved in that at all?
A. I believe they were involved. That was - it was built off the back of the 16/18A state tender. So the data came, I believe, from that tender.

Q. I've just got a memory, without having the document, that HealthShare procurement, based on the better value in healthcare policy were encouraging all LHDs to narrow the number of suppliers for knees and hips hopefully down to two, I think. But I thought that post-dated this by quite - I thought that was with a surgical task force maybe only in 2021 or 2022, rather than this far back.

MR MUSTON: I might have to take that on notice, I think.

THE WITNESS: I believe hips and knees --

THE COMMISSIONER: Q. Sorry, you go ahead.
A. Also hips and knees, there was a new tender I believe in 2022, where hips and knees then came under the 864 state contract, so it may have been around that time.

THE COMMISSIONER: I'm not familiar with that contract, but I'm sure, in line with the better value health care general policy of NSW Health, there was a more specific recommendation from HealthShare procurement, I think, in conjunction, maybe, with the surgical task force, saying, "Look, we've got too many vendors. We should encourage narrowing down to two. It will save costs", but I could be quite wrong about everything I've just said.

MR MUSTON: It's all ringing bells but exactly which once, I'll have to come back to you on that.

Q. Can I ask you in relation to the high-value items just to take us step by step through the process. So in terms of purchasing prostheses, what's the arrangement that you have?
A. So if we use the example of knees, so we have two avenues for procuring those joints. So for general hips and knees we have consignment stock on shelf, which is the company leave the stock required to do those procedures on shelf at a set amount. Generally we could do three procedures in one day so we generally have enough equipment to do those three procedures.

So we will liaise with the company to say that "Dr X has three knees on, on next Monday. Can you please provide or ensure we've got stock for that procedure?" The company will then reply to us saying, "Yes, we've got enough consignment stock on shelf to do those procedures", and then we have a running spreadsheet of the week ahead, so we'll document on that spreadsheet, "Dr X has A, B and C patients, we're going to use three consignment sets for this procedure."

When there are procedures, if we don't have enough consignment stock, the company will let us know that we'll need to send in a loan set for this procedure, because we don't have enough on site.

Q. So let's start with the consignment stock. What is the process at your end in terms of making arrangements for

the consignment stock to be on hand, starting from the - do you tap something into your computer or what do you do?
A. So it's already on shelf. So the stock's here.

Q. Can I take you back one --

THE COMMISSIONER: Are we talking knees?

MR MUSTON: Knees.

Q. I'll take you back one step earlier. No stock sitting on the shelf?
A. Okay, yeah.

Q. An arrangement is being entered into for some consignment stock to be made available.
A. Yes.

Q. What are the steps that you go through in order to get the stock on to the shelf?
A. So we provide the vendor with the NSW Health consignment agreement, it is a template that we use, that goes to the company. They will sign it on their behalf, provide a listing of the items they wish to add on consignment and the dollar value. There's usually a dollar value on that agreement as to what the available stock they are leaving on site is. We get that back.

Then we prepare a brief that will go to the relevant person on the delegations manual as to the value of that stock. Generally it's the general manager or the chief executive, depending on the value. So we provide a brief which outlines who - what surgeons will be using it, what procedures, and then we will outline the financial burden of that, which is generally we only pay for that stock once it's used.

Then there will be a note - sorry, I will take a step back. Before we do that consignment agreement, provide that briefing note, the consignment agreement will go to our procurement team. So they will check that agreement, and all the items listed, to make sure that they're on contract and the pricing they've provided is the state contract pricing.

So once it goes from procurement, that briefing note will go up the chain for sign-off. Once that - the

agreement has been signed by the relevant person on the delegations manual, that agreement goes back to the vendor and then they provide - they'll supply the stock.

Q. Is that agreement for a particular value of stock or a particular number of items across the term of the agreement?
A. Yes. So it'll list each implant, how many implants will be provided and the instrumentation as well and the value of that instrumentation.

THE COMMISSIONER: Q. Just out of interest - and it is just out of curiosity - what does a knee cost the state?
A. Anywhere between 4,000 to 8,000, depending on the patient's anatomy and --

Q. What about a hip - the same?
A. Yes, slightly - a little bit more, up to --

THE COMMISSIONER: I cracked a tooth and it cost me eight grand to get that replaced. No wonder there is no "denti-care". SO 4,000 to 8,000 for a knee.

MR MUSTON: Yes, 4,000 to 8,000 for a knee

Q. But the agreement that you enter into is for a particular number or total value of them?
A. Yes.

Q. In terms of the approval process through the delegations, obviously someone senior needs to sign off on that?
A. Yes, yes. And that's based off the whole value of that consignment stock. So once we get that pricing from the vendor as to how much the instrumentations were and the implants, we will go via our delegation manual to work out who the approver - appropriate approver is.

Q. Once that approval has been given, what does that generate? Does that generate a purchase order for you?
A. No.

Q. No?
A. No. So then we will send that to the company, and then for consignment stock, we - well, you're probably right. I know what you - so we have a standing purchase order number. So we will create a standing purchase order

number to a certain dollar value, which goes into iProcurement. So we will raise - it will say standing order for the certain company and the time period that we wish to have that for.

Q. So just to make sure that I understand how those two things link up, you have a standing purchase order for a particular value, say $150,000 for a particular time?
A. Yes.

Q. So a year?
A. Yes.

Q. And then that matches up, does it, with the agreement that has been entered into with the supplier to supply $150,000 worth of knee joints on consignment?
A. No. So the consignment agreement is the total stock kept on site. That - the standing order, that 150,000, that was just a number that we were given internally as the maximum we could create those for. So sometimes that 150 will only last a month, a couple of months. So then each time we - that one gets drilled down, we'll raise a new one.

Q. So am I right in understanding that the consignment agreement might last for a much longer period than the $150,000 hypothetical purchase order?
A. Yes, yes. Yes. Generally the agreements are five years for the consignment agreements.

Q. How long does the process of generating the purchase order and getting the relevant approvals take?
A. It can take a couple of weeks, depending on the dollar value. But we, in our team, have running spreadsheets of each procedure that's been accounted to that standing order. So when we get to, say, $30,000 left, we'll start that process in generating a new one. So generally, there's no lag, but there's some times where we have been caught out where we've just used so much of that standing order we haven't had time to pre-empt processing a new one.

Q. I'll come back to that in a moment. In relation to the purchase order that you have for your $150,000, is that what enables you to continue to have a consignment stock replenished?
A. Yes.

Q. As three knees are used in today's procedure --
A. Yeah.

Q. -- three more come in?
A. Yeah.

Q. Until you get up to that $150,000, the purchase order that you've got is what covers --
A. Yeah.

Q. -- all of them?
A. Yeah.

Q. Then, as you get towards the end of that $150,000 on your spreadsheet, you know you need to make an application for a new purchase order --
A. Yes.

Q. -- for the next round of money?
A. Yes, correct.

Q. And in terms of the procedures in your hospital - let me come back to that. I'll come back to that. The process whereby the company is charged for the consignment stock - how does that physically work?
A. So for hips and knees, most of the time we will have a company representative in the theatre with the surgeon to support them. So they will send a copy of what was used to their customer service, and then we will be provided with a pro forma invoice for the stock that was used during that procedure. But also, in the theatre, our staff also keep a record of what is used. They will attach the stickers from the box of the implant to an implant sheet. That comes out to us to double-check, and also they enter those items into SurgiNet, which is EMR, electronic medical records. So they will enter the items there and on to the prosthesis sheet, which comes to our team to review.

Q. And having been reviewed by your team, does it then go on to the supplier in some way or has the supplier already got it via their representative?
A. From the company rep. So they will take a picture of the same sheet that comes to us. So then we get that bill or pro forma invoice from the company we go and cross-reference all the information that we have to make sure lot numbers and products match what was used in that procedure.

Q. I think you started telling us about occasions when you needed some loan stock?
A. Yes.

Q. In what circumstances would that need arise?
A. It's mainly if we have more than the expected stock on consignment or for niche procedures that we don't do regularly that we'll need to get loan stock in for.

Q. So the consignment arrangement might say, just dealing with hips and knees again, you are entitled to have a particular amount of stock on site?
A. Yes.

Q. At any given time, unpaid for?
A. Yes.

Q. If you have a procedure - let's say it's for three procedures worth of stock, if you have four procedures in any given day --
A. Yes.

Q. -- you need a fourth device. What's the process for getting that fourth device?
A. So in those emails that we would send to the company representatives to book in those procedures, they will let us know that loan stock will be required for this. They will send a loan kit in, which will include instrumentation and the implant, similar to what's on consignment but just an extra add-on set. That will come via our CSSD or sterilising department. They will sterilise the instruments required and check in the implants and they will come down to us with that patient's name on it ready for that procedure.

Q. In terms of the actual procurement process or the billing process, how does that one work in terms of --
A. It's similar. So the reps will be in the room, they will provide - either provide their customer service with what was used or we will get the sheet from the theatre, and if we know - because some of these procedures that require loan, sometimes the rep doesn't attend, it's because it's done regularly here, so we will email that customer service the next day or the same day with the products used, including the lot numbers and reference codes.

Q. Does that then just get built in to the same purchase order as you might have on hand at that L particular --
A. For loan stock, we generally won't use those standing orders because we don't rely on that resupply to come next day. We don't need the item resupplied because it was loan. So we would wait for that - that pro forma invoice from the company and enter that into iProcurement that way, so then they will generate a separate purchase order number.

Q. Just as a one-off?
A. Yes, that one-off, yeah.

Q. Even though the item has already been purchased, that one-off purchase would then go through the chain of --
A. Yes. So that's the invoice only order. So we don't actually need the stock resupplied, it's just to pay that invoice that has come through.

Q. Can I ask you quickly in relation to some questions I asked earlier around the master catalogue and the free text ordering, do you - to what extent are items that you need available now on the master catalogue?
A. It's definitely improved over the last couple of months. I believe probably 80 per cent of the items that I've had to order on there have been in the catalogue, which has been helpful.

Q. And the other 20 per cent you still are required to do via a free text order?
A. Yes, yes.

Q. Can I ask these questions: in relation to the delegation and the approval of ordering, do you know whether there is any oversight at a wider level than the individual purchase of purchasing patterns and the like by those who are approving the orders within your LHD?
A. So our manager signs off all of our - so she has visibility on everything that we order. So if she's noticing a trend, she will usually reach out to us and ask what is happening and we have to explain to her, or if a specialty nurse has requested more product than normal, then we would liaise with them and ask, "What's with the trend?" "Is there something that's coming up that we're not sure of" or "You're going on leave, you might need more stock ordered." And I - as far as outside of our

department, I'm not too sure. Yeah.

Q. And bread and butter items - does the same apply to the medical consumables? Is there anyone at any level within the LHD or within your team making an assessment of whether the purchasing behaviour is the same as expected or different?
A. I should say, we do have communications with our district procurement team, so we have category managers who manage different tenders from HealthShare. So every quarter, they do receive feedback from HealthShare as to where we're tracking on our market shares that have been built in to that tender. So say for orthopaedics or vascular, they'll reach out to us and say, "We've noticed in the last quarter you are using more of X company than B company", and then that usually involves a discussion of heads of department to say, "What's the trend?" "Do we need to look at changing our market shares?", the other way to identify better cost savings.

Q. At your level, do you have visibility or a dashboard or ability to see what your own purchasing behaviour --
A. Only from that quarterly report we receive from our procurement team. They'll usually send us a copy of that and they'll ask us - if there is any huge shifts, they'll ask us to explain, provide a bit of feedback as to why that's happened.

Q. That's a report that has been prepared locally within your LHD?
A. I believe it comes from HealthShare, yes.

MR MUSTON: That's all the questions I have for this witness, Commissioner.

THE COMMISSIONER: Thank you.

MR GYLES: Just a couple of questions, thank you, Commissioner.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. Ms Vinton, just dealing with that last matter, have I got it right to say that, to your understanding, each quarter, HealthShare will communicate with the procurement team at LHD level and give them feedback about the extent to which various products are

being used and whether it might be abnormal or what may not have been expected; is that --
A. For items that are listed on any state contracts, they will provide reports about market share to say whether we're meeting our market share or we're outside of those.

Q. So there is an expectation that you will order a certain number of a particular product maybe based on historical use?
A. Yes.

Q. And if in a particular quarter you are procuring more of that product or less of that product, that might be something that HealthShare raises at a district LHD level?
A. Yes.

Q. And then the district LHD procurement team will then reach out to the hospital procurement team, ask questions about that?
A. Yes.

Q. And that may then cause you, in the local procurement team - that is the hospital based procurement team - to speak to the clinicians or the head of department to get some feedback as to why it is that there may be different --
A. Yes.

Q. And then it would be passed back up the line to HealthShare?
A. Yes, correct.

Q. You also, I think, said that there was a monthly meeting that is occurring which involves the district procurement team and the procurement teams within some of the hospitals in the LHD?
A. Yes.

Q. I think you also said that there are - was it brand managers within the district LHD team for particular products?
A. Category managers.

Q. Category managers. All right.
A. Yes.

Q. So if there was an issue within a particular category

of procurement - let's say that there were some issues about supply or whatever - the category manager would be a means by which you could raise issues?
A. Yes, yes.

Q. For example, if it was sutures or whatever, the person was managing that contract in an LHD level --
A. Yes.

Q. -- would be someone you could go to if you wanted to?
A. Yeah.

Q. It could also be raised at the monthly meeting that occurs with the district procurement team?
A. Correct.

Q. And an advantage of that monthly meeting is that you also are able to get some feedback on what's going on yourself at the other hospitals?
A. Yes, correct.

Q. Particularly those hospitals that are doing similar work to you --
A. Yes.

Q. -- that is, they've got theatres?
A. Yes.

Q. And you've got your own procurement team, which you have said - you've used that expression a few times, which essentially are there when you are ordering to make sure that there is appropriate delegation authority for products that have been procured and ordered?
A. Yes.

Q. And so where, for example - I think you said that the master catalogue had improved in the last little while?
A. Yes.

Q. And when you say "improved", do you mean that the master catalogue now has more items on it?
A. Yes.

Q. So when you are ordering product, it's easier for you to order because there is a drop-down box which will identify a particular product --
A. Which pre-populates.

Q. -- and makes it easier for you to carry out that ordering?
A. Yeah, correct.

Q. And then for the 20 per cent of - sorry, we've got to a level where you have given a rough estimate of 80 per cent/20 per cent?
A. Mmm.

Q. So the 20 per cent of the free text items, when you're ordering those items, they need to go through your local procurement team to make sure that they're the subject of a contract --
A. Yes.

Q. -- that is, they are being provided, those goods are being supplied pursuant to a contract?
A. Yeah.

Q. And the local procurement team will make sure that the price that you are paying is consistent with that contract?
A. Yes. And if we have the pricing incorrect, generally when that order goes to HealthShare and they liaise with the vendor, they can - they will come back to us at times with the price variants. Say if the price we have typed in is incorrect, that will come back to us to approve. Generally it's approved by the first sign-off on that delegation, it will come back to them to approve.

Q. And there may be an explanation in a certain case for the pricing to be different for some particular reason?
A. Yes.

Q. But someone is reviewing that?
A. Yes.

Q. And making sure that that's appropriate in the particular circumstances?
A. Yes. Yes.

Q. And I think you've covered this, but just so I'm correct about this as well, in terms of implants or prostheses, if there was to be, for example, a new surgeon came into the system and there was a request to use a particular - some different type of implant, that would ultimately be a call that is made by the head of

department, say the head of orthopaedics?
A. Yes.

Q. And that would be a carefully considered decision before there was an approval to --
A. Yes.

Q. -- add? And I think you were asked about a process that took place back in 2016 or 2017, in which there was a reduction to the number of implants that were available?
A. Yes, yes.

MR GYLES: I have no further questions. Thank you very much, Ms Vinton, and thank you, Commissioner.

THE COMMISSIONER: Anything?

MR MUSTON: Excused. Unless, of course, you have any questions.

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

THE WITNESS thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: Is it convenient to have Mr Dale next, meaning after lunch?

MR MUSTON: It is. It is not Mr Dale. But it is probably convenient to not start someone in their evidence eight minutes before lunch. We are entirely in your hands, Commissioner.

THE COMMISSIONER: On the sheet it says Mr Dale 2pm. That's not fixed, is it? Someone is shaking their head. Mr Fraser is shaking his head. Whatever the next witness is, we will have at 2 o'clock.

MR MUSTON: Someone will be here.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: For what it is worth, the project - it is called a study - that I was thinking of when the last witness was here is - there was a new statewide orthopaedic hips and knees contract on 1 March 2022, where HealthShare led a team of engaging clinicians, surgical services task force and the better value care program and encouraged - didn't force but encouraged - LHDs to bring the number of suppliers of these prostheses down to two, and some LHDs had eight.

The media release says that HealthShare negotiated a best price offer to encourage hospitals to take up the option to select two suppliers from a statewide list, so I think I was remembering generally correctly.

MR FRASER: I think you were, Commissioner, and as you can probably tell by the fact that I'm standing at the lectern, the next witness is to be Mr Dale, and it is touched on in his statement.

THE COMMISSIONER: Oh, is it?

MR FRASER: So we will address it briefly through him.

Before I call Mr Dale, I'm told that the third tranche of evidence, of documents, is yet to be tendered, and there are some documents that Mr Dale might be taken to.

THE COMMISSIONER: Someone has left two Post-it Notes with a whole lot of --

MR FRASER: I'm not aware of the Post-it Notes, Commissioner.

THE COMMISSIONER: Sorry, go ahead.

MR FRASER: In terms of an index, I hand up an index. It's tabs 54 to 66 - B.054 to B.066.

THE COMMISSIONER: Is this for Mr Dale or is this --

MR FRASER: There are a few documents within that which Mr Dale may be taken to - 61, 62 and 59.

THE COMMISSIONER: So that's tendered, is it?

MR FRASER: Yes.

THE COMMISSIONER: B.054 to B.056 is tendered, is it?

MR FRASER: Yes, Commissioner.

I call Paul Dale.

<PAUL DALE, sworn: [2.04pm]

THE COMMISSIONER: Mr Fraser will ask you some questions, just listen carefully and answer those then Mr Gyles for NSW Health may also.

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Mr Dale, you are employed by the Medical Technology Association of Australia; is that correct?
A. That's correct.

Q. Often referred to as MTAA?
A. That's right.

Q. And what is your role within MTAA?
A. I am the policy director.

Q. How long have you been in that role?
A. Five years.

Q. Just in terms of your general experience other than that five years, could you briefly describe it?
A. Yeah, my experience extends across the pharmaceutical and medical device industries. So working on the private side, they include roles in Australia and also internationally across a range of areas - policy, government relations, pricing, commercial role and, yeah, those - that's probably the main areas.

Q. In terms of MTAA, it is a representative body; is that correct?
A. That's correct.

Q. And it represents - in shorthand, is it correct it's the peak body for medical technology companies?
A. Yeah, it is the primary peak body for medical technology, yes.

Q. I will just have you taken to your statement. It is

tab 16, operator, it is [SCI.0003.0001.0022].

Mr Dale, for you, there should be a hard copy behind tab 16 in that folder?
A. Yes.

Q. I believe it is signed by you at the back. Is that your statement?
A. Yes, that is my statement.

Q. Just going back to your membership body, roughly how many members does MTAA have?
A. Nearly 130 members, of which about 85 are device suppliers.

Q. And when you say "device suppliers", medical devices?
A. That's right, yes.

Q. And does that cover - if you could give some examples of medical devices?
A. Yeah, a medical device, I mean, the way the Therapeutic Goods Administration would describe a medical device is really anything that's used for a diagnostic or therapeutic purpose that doesn't have a pharmacological or immunological mode of action. So it really could range from anything, from a scalpel right up to an MRI machine. You can broadly group them into categories of consumables, implantables or prostheses and, you know, larger capital equipment that do a range of things. So our members cover all of those areas.

Q. When you say "consumables", would that include sutures?
A. Yes.

Q. Potentially --
A. Yes.

Q. -- for instance? Down to that level?
A. Yes.

Q. And implantables - pacemakers, replacement knees - are examples of that?
A. Exactly, yeah, they are the most common types, that's right.

Q. And you gave an example of an MRI machine in relation

to large capital external machines?
A. That's right.

Q. Equipment?
A. Yes.

THE COMMISSIONER: Q. So your members - some supply a hell of a lot of stuff which item by item might be quite inexpensive, up to very large machinery that costs millions?
A. That's right. Yeah.

MR FRASER: Q. You said 85 of your 130 members were device suppliers. What about the balance?
A. They're professional services suppliers. We call them associate members. So generally they are providing some sort of consulting or service, often to our members, actually. Yes.

Q. So your core membership are the 85 device suppliers?
A. Yes, they're the full members; that's correct.

Q. And presumably your membership is varied in its make-up as to size?
A. Enormously, yes. That's right. From start-ups that are pre-revenue, haven't earned a single dollar in the marketplace, you know, right through to Australian suppliers and global multinational companies.

Q. Dealing with your members, as you've set out at paragraph 1 .2, your member companies directly engage with the health system at a couple of levels; is that right?
A. That's right.

Q. So with local health districts?
A. Mmm-hmm.

Q. And HealthShare?
A. Primarily those two.

Q. As the primary interactions, particularly in terms of actual procurement of items?
A. That's right.

Q. And in terms of your organisation, MTAA, as the peak body, how does it interact with what is broadly termed NSW Health?

A. So essentially, obviously because we're not involved as a supplier directly with NSW Health, what we're doing is using committees, forums of our members to get information about how things are working, what their relationships are like, what the issues are, and then based on that, we might engage with HealthShare or with NSW Health or indeed sometimes at a political level to, you know, discuss issues that are coming up for our membership.

Q. You referred in the statement to some matters which I'll take you to in a moment, but is there any formality in relation to your interactions with NSW Health?
A. We do have, coming out of some roundtables that were held back largely in 2021, if memory serves me - we did - that did lead to an agreement with HealthShare NSW of cooperation and around our shared issues. That was signed in 2022, May, if I'm correct, and that was really just a statement of intent to cooperate on the matters that we had been talking about in our engagements.

Q. That wasn't something dealt with in the statement; is that right?
A. No, I didn't. I'm sorry. It wasn't in the statement, yeah.

Q. No doubt it is a document we can obtain from NSW Health. But the agreement is actually with HealthShare?
A. It is with HealthShare, that's right, yes. Carmen Rechbauer, the CEO, is the signatory.

THE COMMISSIONER: Q. Is the nature of this agreement "We will meet more regularly, we'll talk to each other", that sort of thing?
A. That sort of thing, that's right.

MR FRASER: Q. You've described at paragraph 1.5 and 1.6 how information from your - well, what I'll term internal procurement forums, forums with your members, and matters raised therein, at least those that relate to New South Wales, are then - feedback from those is relayed to what you've termed "New South Wales procurement stakeholders", including the achieve executive of HealthShare NSW and also the chief procurement officer; is that right?
A. That's correct, yeah.

Q. Is that done in regular meetings or in an informal way? Can you --

A. Look, it hasn't been done regularly. It has been done more informally on an issue-by-issue basis. Probably quite a bit of our contact has been in relation to what's called the standing offer agreement, which is something we see as an overall positive development, but it's essentially creating a template under which, you know, all contracts that are negotiated with suppliers can sit under, so you basically know the terms and conditions that apply to contracts in general and then you just are able to add a schedule to that. But obviously those terms and conditions are important, so - to our members, and so much of our discussion has been about that.

Q. Just lastly, local health districts, does your organisation tend to engage at the LHD level?
A. We don't tend to do that, no. We've had conversations from time to time, but generally speaking, we don't. Bear in mind, we're a national organisation, so we're already stretched, dealing with, you know, all states and territories.

Q. Yes. And I think lastly, you've indicated that at times the MTAA meets with the Australian and New Zealand Health Procurement Roundtable?
A. We have, that's right.

Q. At which chief procurement officers from all states and territories, and presumably New Zealand as well --
A. Yes.

Q. -- meet? One of the things your association does, as you've dealt with at 1.8, is you conduct a national procurement survey?
A. We do.

Q. Amongst your members, or the members of the Australian medical technology industry; is that right?
A. That's correct, just our members, yes.

THE COMMISSIONER: Q. Is an example of that B.020?

MR FRASER: Indeed.

Q. Would you turn to tab 20 in your folder, and can we display that, please, operator. These are the current results, the most recent results?
A. Most recent, that's correct.

Q. If we go to pinpoint reference 0092, operator, within that document, those are the current responses from your members; is that right?
A. That's correct.

Q. Currently --
A. Sorry.

Q. Yes?
A. I just wanted to be clear just how variations are managed. So that's one factor.

THE COMMISSIONER: Q. That's variation of contract, is it?
A. Yes. Which is a fairly common - which is a common occurrence. But it's not the only form of interaction we have. But I would say, if I may, that those results are quite reflective of what we would see generally across the board, if I could just summarise.

Firstly, this survey is primarily focused on the interactions that our members have around tendering and contracting processes routinely. What we're trying to understand through this survey is what are their experiences like, what challenges are they encountering, you know, are they working well with procurement agency staff and, in general - and we must note here that New South Wales has very dramatically turned this around since our very first survey back in 2019 - is that New South Wales would be consistently one of the best-performing in terms of their interactions with our members in those processes.

MR FRASER: Q. And that's also reflected over the page in the results which focus on the tender portals?
A. That's correct.

Q. The actual mechanics of tendering.
A. Yes.

THE COMMISSIONER: Assuming I don't make any findings, I don't think we have to notify VicHealth of these survey results, or Queensland.

MR FRASER: I don't think nationally, Commissioner, you need to make any findings in relation to that.

THE COMMISSIONER: Not on variations of contract, no.

MR FRASER: Q. Mr Dale, just before we go to some specific matters in your statement, there are some principles that are dealt with in your statement that I'd like to ask you to explain in a simple fashion, if you can. The first is "value based health care".
A. Mmm-hmm.

Q. Could you briefly explain that principle?
A. Value based health care - it's a widely discussed concept now, as I'm sure you have heard, but it really is simple. It is delivering the outcomes that matter to patients as efficiently as possible. We would say that a key part of that is patient centricity, and it must be focused on the outcome for the patient, the experience of the patient, but obviously there's an efficiency component as well, so delivering the maximum outcome for the resources that you are using.

Q. So just to drill down on that - and I think you've got a brief explanation at 5.1.2 - so a "patient centric measurement spanning the entire care pathway for a patient"?
A. That's right.

Q. So is it fair to say this cost is not irrelevant?
A. That's correct.

Q. It remains a relevant factor?
A. Mmm-hmm, yes.

Q. But as opposed to a purely cost-immediate benefit assessment that may be what's the cost of the item, what does the item do; does it give you a knee; does it close a suture or close a wound - it's a more holistic assessment; is that right?
A. That's right. You really are asking about what are the costs across the entire care of an individual patient or, indeed, the care of multiple patients. You're asking what is the cost to deliver a quality outcome and a quality experience and so you're not - it's about not focusing merely on the cost of that individual intervention or that individual piece of technology at that time, but a much more holistic consideration of what will happen to the patient afterward and the costs that are going to be

incurred, the outcomes that you're going to see, the experiences they're going to have after that.

Q. Are you able to give some examples of factors that might come into that type of consideration?
A. Yeah, I mean, when we're talking about it much more broadly as value based health care, there can be many components. I suppose from a value based procurement point of view, you know, very obviously, if you procure something that is low cost but doesn't serve the patient particularly well, and they end up needing to be readmitted or they end up needing more care in the community and they end up facing whatever distress might result from, you know, higher incidences of complications, then you clearly have only a very short-term saving in that situation, and there are a number of --

THE COMMISSIONER: Q. A stupid example would be if you bought - this doesn't happen, but if the state bought a knee prosthesis and they paid $2,000 an item but they wore out after three years, as distinct from buying prostheses that cost 10 grand but they last for 15 years, then ultimately, there's (a) a better patient outcome but, (b) a better long-term outcome for healthcare costs?
A. That's right.

Q. Probably better for the economy, too, if the person gets back to work earlier and is a productive, tax-paying member of - I don't know whether the Productivity Commission does these sorts of things, but there are those benefits as well which are probably much more complicated to work out?
A. They are, and working out the benefits is sometimes the difficult part of the process. Sometimes it might be obvious and sometimes it might not.

Q. That part I would have thought would particularly require some sort of expertise like the Productivity Commission to work out those sorts of productivity gains as distinct from an obvious health outcome gain. Tell me if I'm wrong, though.
A. No, no, if I can introduce - so I'm probably going to focus more on value based procurement here, which is probably more of an accounting exercise, if I may say, you know, linked to patient outcomes, but there is also the discipline, if we like, of what we call health technology assessment, health economics. It's a well-established

discipline.

When we talk about health technology assessment, you know, we're talking about processes of examining evidence about what outcomes are likely to be like with a certain intervention and, therefore, what should be paid for and what shouldn't. That tends to be a long, evidence-rich process, can I say, which is not always suited to the practicalities of a healthcare system on a day-to-day basis.

Q. It would be difficult for LHDs with their sort of annual defined budgets?
A. Yes.

Q. It sort of requires the system manager to maybe set up trials and engage at a more central level than - LHDs are always going to be, "God, we've got to keep within our budget"?
A. Yes.

Q. I'm not suggesting they can't engage in either value based procurement or value based health care, but it's a bit harder when you have a 12-month budget cycle, I suppose?
A. Well, I think that's a really fundamental key to what we wanted to bring to the Commission, is indeed, there is this very strong tension between working within budgets and innovating in a way that ultimately leads to a better value outcome, and I'm sure others have raised that issue and I think that tension exists in procurement as it does in other areas.

THE COMMISSIONER: Sure.

MR FRASER: Q. Can I just ask, amongst those factors that a value based approach takes, presumably, there are some quite nuanced factors that potentially arise - let's stick with the knee replacement example that the Commissioner has raised. Does that become - if it's patient centric, does that take account of perhaps when you are looking at, say, someone who might be in their mid-80s, a 25-year life for a knee, a new knee, might not be necessarily required; is that a factor that comes in?
A. Yeah, that absolutely could be right. I mean, there are even situations where, you know, a patient would prefer not to be receiving, you know, a treatment. In many cases

they do - in most cases, they do. But, yes, that absolutely is part of it.

I think that, you know, sometimes assumptions are made about what patients actually want for their treatment, or the system just works as it does, right, and it's been very focused on the episode and, you know, incredible work by the healthcare professionals to produce the best result they can within that. But, you know, it's kind of business as usual, and I think this is one of the things that we would welcome about NSW Health: they have taken, I think, a leadership position in measuring outcomes and patient experiences, and we would say that's absolutely essential. In fact, you can't do value based health care and value based procurement unless you are consistently asking the patient, "Was that what you were looking for?"

Now, ideally, you do that beforehand, of course, but at the very least, getting metrics about whether the system is doing what it's meant to be doing.

Q. In order to do that effectively, does that require getting patient opinions across the range of care settings - acute care --
A. Yes.

Q. -- primary care, sub-acute?
A. Mmm.

Q. In your assessment?
A. Yes, that's right.

Q. Just before we come off this, you said it's something that your organisation considers that NSW Health is doing quite well, or very well, I think is what you said?
A. Well, I would say that they're at the forefront of it. I mean, as I'm sure you will hear - and will hear - the healthcare system with the movement to value based health care, but also with the digitisation of health care and the connectedness of healthcare data is actually on - you know, I think it's reasonable to say - a precipice of - "precipice" is the wrong word, it sounds negative; it's really at, you know, on the verge of being able to do some remarkable things that we've never, I think, done before. You know, the use of AI to mine data - there are others who can speak more effectively than myself to this - but our ability to measure is going up very significantly and this

is going to be, I'm sure, critical to the findings of this Inquiry. Not that I wish to pre-empt that, Commissioner.

THE COMMISSIONER: Not that you wish to?

THE WITNESS: Not that I wish to pre-empt your findings, but I would imagine --

THE COMMISSIONER: Go ahead, make all the suggestions that you want.

THE WITNESS: -- that is going to be fundamental. If I may sort of add to that, you know, we have to keep people out of hospitals and we've got to get them out of hospitals faster. That's --

THE COMMISSIONER: Q. When you say - to some extent, at least, what the practical application is, not quite sure yet, but some of these concepts are now embedded, at least, in the reforms from the National Health Reform Agreement?
A. Yes.

Q. Including outcomes - paying for value and outcomes?
A. They are, yes. I think --

Q. It's easy to say that, of course --
A. -- rubber hitting the road is still there --

Q. -- to make an agreement. Doing it is different, but yes.
A. Yes.

MR FRASER: Q. We've perhaps skipped over but, just for clarity, value based procurement is really as simple as a value based health care approach to procurement; is that right?
A. That's right, yeah. Recognising that procurement is a part of the value based health care approach, you know, it's how do you purchase to enable value based health care.

Q. In your statement, you were asked to reflect - I go back to section 3 - on your organisation's impressions of advantages of the current procurement and service delivery arrangements at the local and local health district level. You have described --

THE COMMISSIONER: Q. This is what we were talking

about before, is it, with the pressures on LHDs with their annual budgets, at least in part, and that's what you are picking up in 4.1?
A. Yes, that's right. Yes.

MR FRASER: Q. So in terms of - well, the Commissioner has taken you to 4.1. 4.1 is disadvantages or limitations, as your organisation sees it, MTAA sees it, and I think you've put it simply as your members experience is that sometimes the focus for technology is on price above all else; is that right?
A. Yes, and this is probably a relatively subtle thing to describe, but I think that the vast - the large majority of purchasing that occurs of our members' devices is done through HealthShare NSW contracts. We don't know the statistic exactly, but anything that is routinely purchased would be likely to come under those contracts, and then the LHDs are required to conform to those contracts.

The LHDs may - the contracts themselves may have flexibility for the LHD to negotiate a different arrangement. I think the Commissioner made reference earlier to, you know, negotiating a smaller number of suppliers; negotiating, you know, more volume for a better price. But that volume price arrangement will be preset within the contract itself that HealthShare NSW has negotiated. So it's not like the LHD is going out and renegotiating a completely new set of terms and conditions.

So I would say, you know, at two levels, HealthShare NSW - and I'm happy to go into a little bit more about that, but HealthShare NSW has a strong focus on what I think procurement traditionally focuses on, and that is what I would say is a cost contract and compliance - getting the technology for the lowest possible cost; getting the contract terms under which it will be supplied; and then making sure that there is essential compliance with that subsequently. I mean, this is, you know, a common approach in procurement, is to standardise, is to aggregate, and these are the pathways that HealthShare NSW typically follows, and both HealthShare, as we understand it, and the LHDs, essentially have savings targets that they have to deliver on, and that obviously puts pressure on them, you know, to find more savings from current contracts, hence you get very - hence you get these renegotiations of contracts on a reasonably frequent basis. Not only to - well, they may be initiated by suppliers but

they are often initiated by HealthShare themselves.

Q. Is it your impression that that comes at the cost of implementing value based approaches in those - at least at times?
A. Yes. I think that is right. I think that - I mean, it's interesting that a study, which I'm sorry I haven't put into the witness statement, but nonetheless, there has been a study which has looked at the NHS, how procurement has responded to top-down budget requirements and, you know, one of the interesting comments from that study is that it does see approaches to innovation being set aside in order to achieve the savings goal, and that's not surprising. I mean, we would expect that sort of behaviour.

I think that innovation and value based procurement does sometimes require, firstly, the effort of resource and time to look at a different way of doing things, and that's hard to do in a system, you know, in which HealthShare is operating; and it also requires the ability to think outside the square and often to collaborate strongly with other stakeholders, including clinicians.

So I think we would say that even if sometimes the contract on the face of it looks like it is allowing for value based approaches, that when it comes to final decision-making, we don't think that that is often the case, and I think that that is unsurprising, you know, given what HealthShare's role really is, and if you look at their, you know, KPIs in their service agreement as well, which are new ones, just relatively recently been released, much of it is going to be focused on savings, it's going to be focused on how many, you know, purchase orders are raised within existing contracts, getting rid of purchasing outside of contracts, and those are the kinds of things that procurement organisations routinely do, but that's a different thing than thinking, "How can we actually get more value out of this purchasing arrangement?"

Q. You've referred at paragraph 3.1 to an innovation or the inclusion of "innovation value add offers" within procurement processes in New South Wales as a positive development and you explain what those are? They can take into account value adds of a clinical, operational, service or financial nature?
A. Mmm.

Q. You've qualified that in paragraph 4.1 to suggest that your impression is that it's difficult to see how those are - what weight those are being accorded?
A. Yes.

Q. And it would seem that value is sometimes trumping those principles. Is that a fair summary?
A. Yes. Yeah I think we can talk about it in two ways. Firstly, was value really the key factor in the awarding of the contract in the first place, regardless of what has been said in terms of the requirements that have been laid out? We obviously - well, not "obviously" - we don't have any real visibility of what ultimately the criteria are, so that's one issue.

In the case of the orthopaedic tender that the Commissioner was referring to earlier, we don't think that's where the problem has been.

Q. I'll just stop you there.
A. Yes.

Q. Is that the same as is referred to at paragraph 5.1.4 of your statement.

... HealthShare NSW value-based procurement pilot for orthopaedic hips and knees.

A. Which paragraph is that, sorry?

Q. 5.1.4, the last sentence?
A. Yes, that is the same, yes.

Q. Which you have referred to as being a positive step --
A. Yes.

Q. -- towards value based health care. So could you just explain - you are saying that that pilot, it is 2022, as we understand it, and that's been done through HealthShare, and you see, at least at that level, that has successfully incorporated aspects of value based procurement or principles of?
A. Yeah - yes. It did - yes, we're positive about how the contract was set up in terms of its ability to - it gave the LHDs the opportunity to work with suppliers to incorporate potential value adds, you know, be they

clinical, be they operational, be they patient support programs, for example, and generally speaking, the suppliers welcomed that, and we would welcome further approaches of that nature.

The challenge with that one was not in the HealthShare agreement; it was that it hasn't really been taken up at the LHD level to any great degree, according to - as I understand it from our members. And so good in the high-level execution. I think what we have emphasised always is that good procurement practices that emphasise value have to engage multiple parties, and it appears in this case that the LHDs and the hospitals didn't and haven't engaged in this.

In fact, we have an example which, you know, I won't name specifically, but a company has advised us that they went to an LHD to have a discussion about how they could implement a specific approach under this contract, but it was actually - and there was willingness at the executive level to do that from the LHD side, however, the procurement lead for the LHD did not want that to progress because they were happy with the numbers that they were getting and so --

THE COMMISSIONER: Q. So this is what you've referred to in paragraph 4.3 of your statement?
A. Yes, that's right.

Q. We can discuss it - you're not comfortable being specific about which LHD, which company; is that your concern?
A. I don't have authorisation to do that.

Q. It may not be necessary for me to know, but --
A. Yeah. I think the point we're wanting to make is not that they should be - that that should be pursued specifically, but rather, if we ask the question why is it not being taken up, you know, this is probably an illustration.

Q. Where is the resistance here - and look, we haven't heard from this procurement person, whoever they are and there might have been a really good reason why they did what they did. Where is the resistance to this change? Is it from the clinicians? Is it from management? What do you think?

A. Well, in this case it was from the procurement lead, probably because - and I'm surmising here - they were happy with the numbers that they were getting. So they thought that they were getting the devices at the price they wanted and they didn't want anything to interrupt that. I think that value based procurement, it takes work, it does involve realising benefits that might be not exactly on the bottom line or --

Q. At least for that year?
A. -- at least initially aren't on the bottom line and, look, there does have to be pull-through from clinicians, they need to champion and say, "This is something we really want to see", and this is why - we'll come to it - the community of practice is very important that it engages clinicians and clinicians see the opportunities that this presents, because they do need to be asking for it.

MR FRASER: Q. Can I ask you this, Mr Dale. Just in that example - again, without needing to identify those involved - are you aware of whether there was any approach or suggested approach to bring HealthShare into the conversation, given HealthShare's overarching support of this pilot?
A. Mmm.

Q. Are you --
A. I'm not aware that HealthShare was approached or asked about it. I can say that the company believed that they essentially had no alternatives but to accept the - to accept what happened. It's worth - I'm sure HealthShare can elucidate themselves, but it's worth remembering that LHDs are effectively independent entities who are the actual purchasers at the end of the day, and, you know, as long as it doesn't conflict with an actual contract that HealthShare has set up, they are autonomous to a degree in their ability to say yes or no.

Q. And this particular pilot doesn't constitute a statewide contract or the like; it's more a set of - "encouragement", I think is the word you used?
A. Well, there would have - sorry. Yes, the statewide contract would have, I expect, mandated pricing and probably some other key terms and conditions, but in terms of these value adds, it was left to the LHDs to decide whether they took them up or not. Yes.

Q. You have gone on in 4.4, in fact, to note - you've said there in relation to a continued focus on cost and compliance, standardisation and aggregation of purchasing is limited in increasing the New South Wales health system's ability to address the challenge of providing high quality and safe care and remaining financially sustainable; is that right?
A. Yes, if I can explain briefly what I mean by that.

Q. Yes.
A. Or what we mean by that. I mean, I alluded to it earlier. Essentially, the procurement approach worldwide, really - and we think of procurement as, in a sense, a function that grew out of a finance function - its focus essentially was to aggregate purchasing and try to extract more value - you know, better prices, essentially - and to standardise, and so standardise and aggregate. And we would see that you see that principle underlying a lot of what HealthShare is still continuing to do under its service agreement and, indeed, there's a number of those features in their submission to this Inquiry, I would say.

I think the point that we would make is that that can only get you so far. You know, it's premised on the idea of essentially, yes, providing - getting some savings just through better purchasing, better systems, but also, essentially trying to drive down price overall and, you know, using purchasing power. You know, that has some success and it absolutely has its place, HealthShare NSW has done a good job at that, we would say. But that is a very different way of thinking to what we call value based procurement, and I think that at the moment, HealthShare wouldn't - while there is reference to interlinking what HealthShare does with the value based health care approach, in the end there is a disconnect because their primary KPIs are going to be focused on these areas, you know, aggregating, standardising, reducing cost, reducing outliers and getting as much under contract as possible.

Again, there's value in that. There's reasons for that. But that's a very different exercise than to step in to value based procurement, which is why that we suggest that has to involve collaboration between HealthShare and that part of the ministry which is working on, you know, "Commissioning for Better Value", for example, or "Leading Better Value Care", where it's more strongly integrated

into a clinical approach.

Q. You just referred to two initiatives there, they are in your statement, it was "Commissioning for Better Value"?
A. I'm sorry, can you help me find where it is?

Q. Yes, 5.1.4, "Commissioning for Better Value Programs" - that's what you have said in your statement?
A. Yes. I know what you're talking about, I'm just struggling to find it.

Q. It's 5.1.4?
A. 5.1.4, right, I missed the 5. Yes, absolutely. So "Commissioning for Better Value" - I mean, "commissioning" is a term that's often used for purchasing services and again, we would absolutely support that. It's difficult to know sometimes exactly what is happening on the ground and whether that matches the aspiration, but certainly the principles of "Commissioning for Better Value" programs are what we would fully support. We just don't think that purchasing of certainly our members' technologies are being looked at through the same lens in most cases, recognising that the orthopaedic hip and knee contract was an exception to that.

Q. If I can just take you to one of the publicly available documents about that, it is tab 61. This the "NSW Health Commissioning for Better Value Strategy 2021-25". Just in terms of principles, on the page ending 0004 - page 4 of the document - there is a heading "Principles Undermining CBV". I'll just let you read those to yourself.
A. Mmm-hmm. Yes.

Q. And you would agree with those principles; is that right?
A. Absolutely.

Q. And I think you've provided the Commission, both in your statement as an annexure, some guiding principles for procurement of medical technology. That's at tab 19 of your statement, of the annexures - sorry, tab 19 of the folder before you, which I believe is a document that was generated at one of your procurement forums?
A. That's right.

Q. So from the input of your member organisations?

A. Yes, that's right.

Q. There are some high-level aspects to that, there is some similarity, obviously differences in expression?
A. That's right. Yeah, we do believe that what we are proposing aligns with much of what NSW Health, both under the previous government and this one, are intending to achieve.

THE COMMISSIONER: Q. Your view is that it would assist in the full embracement of these principles if the community practice that you've talked about was set up?
A. Mmm.

Q. Is that right?
A. Yes. I think there are some elements of procurement of product rather than service that are probably unique. We understand, based on publicly available information, that there is a community of practice within NSW Health about "Commissioning for Better Value", or "Leading for Better Value Care" - I think I have got that right - but that's not available to people outside of NSW Health. We don't know what's in it. We think that - and one of the comments we would make is that as industry, we think we can be appropriately included in this conversation and have more explicit conversations, along with other stakeholders as well.

Q. So in a kind of - what do we call them - a community practice or an expert panel or advisory panel --
A. Yes.

Q. -- but involving both people within NSW Health and also people like you or --
A. Yes.

Q. -- others --
A. Yes.

Q. -- with the relevant expertise and desire for value based care?
A. Yeah, I think so. I mean, we're not suggesting that this is an overnight change. It does - I think value based health care, as a whole, requires a change in mentality, and I think there have been some really laudable attempts to change that mentality globally, in Australia and within NSW Health. However, I don't think that has been really

applied to procurement and it is going to require partnership between government, industry, clinicians, and I think patient involvement as well. So that's what we are essentially calling for.

MR FRASER: Commissioner, those are the questions I had for Mr Dale.

THE COMMISSIONER: Mr Gyles?

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

THE COMMISSIONER: Q. The Alira study that you had done, that was - you commissioned Alira to do that report?
A. We did, yeah. They have global expertise that we're hoping to bring in, yeah.

Q. When was that? That was just last year, was it?
A. It was. That's right.

Q. And some of your recommendations that you've made flow from that?
A. They do. We simplified them to a degree, yeah, that's right.

Q. And in your submission - I just want to make sure I understand your recommendations. One is - sorry, I'm looking at the document behind tab 17, if I've got the same --

MR FRASER: Tab 17, Commissioner, yes.

THE COMMISSIONER: -- as everyone else, which is the MTAA submission. We've already discussed, the recommendation regarding what you call a community of practice or a panel involving all these various stakeholders and experts, thank you for not calling it a task force; digital health - that speaks for itself, I think; and then, two, the principles you are talking about there are the ones that Mr Fraser was briefly discussing with you at B.019, are they?
A. They are.

Q. They're in relation to medical technology but that's what you are referring to in there?
A. That's what we're referring to, yeah.

Q. Is there anything further you would like to say about any of those recommendations while you are here?
A. Look, we're recommending a community of practice but we don't want - we do want to see more of the orthopaedic hip and knee approach. We don't think it needs to wait. There is a collective learning that needs to go on but also we don't need to wait for that in order to be able to continue to work on these approaches. So we do support continuation of that approach with a better engagement at the LHD and potentially clinician level on what is going to make a difference at the local level.

We haven't really talked about digital health. I just want to point out, I didn't probably canvass this at the start, but digital health technologies, medical devices - digital health technologies can be medical devices, and so generally speaking, if they have a therapeutic or diagnostic purpose, then they are a medical device. And we are increasingly seeing our own industry move from being purely a hardware industry, historically, to being increasingly a mixture of hardware and software and a data collecting - devices increasingly collect data, data that's important to the healthcare system.

Q. Can you give a specific example of that?
A. Well, I mean, one of the key samples would be - is that pacemakers, very often, have a remote monitoring function. They actually send data back to base, and that's actually very important for the clinician, usually working with a company technician, to make sure (a) that the device is working properly; but also (b) to pick up any possible signal events that might be occurring that need clinical attention.

Q. That might be predictive of something --
A. It might be.

Q. -- an adverse event?
A. That's right.

Q. Right.
A. Yeah. And so our devices are increasingly, you know, part of the internet of things, and obviously they need rigorous privacy around them, which I would say that, in the case of the example I've given, they do, but you can imagine how much data is being generated that way.

Likewise, continuous glucose monitoring for diabetes has advanced enormously.

Q. The ring I'm wearing will tell you how long I slept last night.
A. Yes, okay.

Q. I'm not going to download it, I've shared enough personal information already with that.
A. So that data then becomes, you know, if privacy is obviously considered and cybersecurity is critical, but having said that, that data can be very important to clinicians, it can be important to the healthcare system, and so --

Q. It could be really valuable?
A. Absolutely valuable if used in the right way. So we absolutely support the single patient health - you know, patient record that NSW Health is invested in; drives toward interoperability, the ability for, you know, data to be exchanged securely without, you know, technology and interoperability impediments. And also I think it's going to be tremendously exciting, the ability to remotely monitor people in their home, potentially use diagnostics in their home, even the ability of AI to sense when somebody might be potentially - an elderly person who is vulnerable to falls can potentially - this can be anticipated, even, assuming the person is willing to be monitored in that way, which is not a given.

Q. Yes.
A. But some of these opportunities are extraordinary and so that's really what we're talking about there.

I think improving procurement processes - yes, so --

Q. And the procurement processes for these, let's just call them, new technologies are going to be really important?
A. They are going to be important, yeah. And digital health is a little bit - usually it's more one off; it's usually or very often a distinct item, and so the procurement processes can be quite long and unique and we would say - I know eHealth, which we haven't really talked about, is working on improving these processes but nonetheless, you know, I have seen some fairly onerous examples of what kinds of hoops had to be jumped through in

order to acquire digital health that was going to benefit patients at an LHD level.

So it is really important that that process is effective, and so, yeah, we would certainly urge that there even be a digital health procurement framework, actually, yeah.

So that would probably summarise anything I wanted to say. I hope that's helpful.

THE COMMISSIONER: Thank you. Did anything arise out of that?

MR FRASER: Not from me, Commissioner.

THE COMMISSIONER: Mr Gyles?

MR GYLES: Nor I.

THE COMMISSIONER: Thank you very much for coming. We are greatly appreciative of your time.

THE WITNESS: Thank you, Commissioner.

THE COMMISSIONER: You're excused, thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: Consistent with yesterday I will give the people in charge of the reporting a break for 10 minutes, so we'll just adjourn for 10 minutes. We will come back at 3.15.

SHORT ADJOURNMENT.

THE COMMISSIONER: Yes, Mr Fraser?

MR FRASER: Commissioner, the next witness is Karolina Misevska. Ms Misevska is in the witness box.

THE COMMISSIONER: Thank you for coming.

<KAROLINA MISEVSKA, affirmed: [3.16pm]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Ms Misevska, am I pronouncing your name correctly?
A. Correctly.

Q. That's M-I-S-E-V-S-K-A; is that correct?
A. That's correct.

Q. Thank you. Ms Misevska, you're a business manager at the Sydney Local Health District; is that right?
A. Yes, that's correct.

Q. As a business manager, you have some particular responsibility in the procurement area; is that correct?
A. Yes, that's correct.

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

THE COMMISSIONER: You might just need to keep your voice up, for me, at least.

MR FRASER: The microphone directly in front of you, if you maybe just bring your chair in, does amplify. The sirens don't help.

Q. Ms Misevska, your team and yourself, what is it that your team does collectively?
A. So I'm a business manager in operating theatres of Royal Prince Alfred Hospital specifically. Myself and my team are looking after resupply and management of stock for operating theatres at RPA, endoscopy team at RPA and the anaesthetic team of RPA Hospital.

Q. Sorry, I just missed the last thing you said?
A. And the anaesthetic team.

Q. And the anaesthetic team; is that right?
A. Yes.

Q. So that's all operating theatres at RPA; is that correct?
A. That's correct.

Q. I imagine that's a fair number. Do you know the number off the top of your head, how many theatres that is?
A. We have 22 theatres.

Q. And your team - how many in your team?
A. There's five people. So four of them are supply officers and one is a h-trak administration officer who also does some procurement tasks.

Q. And then in addition, yourself, who supervises the entire team; is that correct?
A. Yes. So I supervise supply and business and so procurement of goods and services for those services we mentioned.

Q. In terms of what it is that you're procuring, is it anything that gets used in an operating theatre?
A. Pretty much everything. So we're basically processing all consumable products, so medical consumable products, all prosthesis products.

Q. Prosthesis?
A. Yes, and also any purchases via the Onelink warehouse or centralised supply.

Q. So firstly, if we can just work through how that happens day-to-day, how is it that your team will know that they need to order a particular item or product?
A. So they're guided by checklists, so those checklists will list every single item that is within their portfolio to order, so - and it will also include, so, details of the product, minimum and maximum par levels and stock on hand.

Q. So there is, for each item, a minimum and maximum level?
A. Yes.

Q. Stock level? And you've said stock on hand.
A. Yes.

Q. Firstly, how do you determine the stock on hand? Is that automated or does that require someone to go into the storeroom and periodically check the stock on hand?
A. It's a manual process. So physically, a supply officer will go into a given stock room, on a particular day, and check the stock across that storeroom. And then, based on the stock on hand, will know how much to order.

Q. In terms of the minimum and maximum levels, how do they get arrived at?
A. So mostly are based on previous usage. So historic

usage, and also it's also determined by the need, obviously, the type of surgeries that we're doing, the frequency of those surgeries, and always in consultation with the clinical staff, the nurse unit manager or a designated nurse specialist specifically.

Q. So there's a level of forecasting that goes on as to what you'll require --
A. Yes.

Q. -- or what the theatres will require depending on what surgeries are upcoming?
A. Upcoming and what has been happening, let's say, over the past six months period, depending on the activity during that period. So that's how we determine the par levels.

Q. Presumably, with a large facility like RPA and 22 operating theatres, there's not one storeroom, but a series of them; is that right?
A. Yes, there's multiple storerooms.

Q. And is that one storeroom might deal with a particular - a number of theatres, a particular part of the hospital; is that right?
A. So all theatres are situated within JL operating theatres, so we have specifically one large non-sterile stock storeroom, which - where we stock all our Onelink warehouse products. And then within clinical areas we have dedicated storerooms, let's say, to service specific departments or specific services. So let's say pod 1, which is cardiac and vascular or cardiothoracic and vascular, they have a dedicated storeroom which would house everything that they would need during the day, so that may be a mix of prostheses, consumables and maybe trays and so on.

Q. Thank you. And is it products dropping to the minimum stock level that triggers reordering or is it anticipated --
A. That's correct.

Q. -- over a period?
A. So let's say the predetermined par level is five, a supply officer will go into the storeroom and find that there's only three on the shelf, they will note on their checklist that two need to be ordered. And then, once they

finish with their check across that room, they would go to the computer and they will key in all these orders through iProcurement.

Q. For your staff, what proportion of their time is spent ascertaining the current stock levels?
A. So the check will occur on, let's say, the morning of a Monday, one of the supply officers will check the endo products, and then on the Monday, mid-morning, another supply officer will be checking the, let's say, sutures, and they would be also checking the anaesthetic stock, and then they would go into their office and key in those orders. So it will - I think that it would take maybe an hour to go through the room and then go back and start ordering.

Q. And for those rooms, is it done on a daily basis, the stock --
A. On various days we check various. So there's a bit of a schedule, so let's say on the Monday we always do endoscopy or endo products and sutures. On a Tuesday it's mostly receivings, and then another staff member will probably do the scanning for imprest stock, which is ordered via DeliverEASE to arrive from Onelink, so then the next day will be the stock put away.

Q. Sorry, the next day, the stock will --
A. They'll be putting away the stock.

Q. Putting away the stock?
A. Yes.

Q. Counting is done. Is it then - it's entered on to the system; is that right?
A. That's correct.

Q. Stock levels on the day?
A. Yes.

Q. Is that through a tablet or a terminal?
A. So depending on the nature of the stock, if it is a Onelink order, that's obviously done via the iPad, which is a tool that we use now with the introduction of DeliverEASE. So they would go from one, let's say, set of products to the next. They would determine, let's say, the first set of products, there's two boxes, we need to order one more to make it up to the par level, which is three.

We order - the orders are placed based on cycle counting, which is a predetermined sort of, if you like, par level into the DeliverEASE system. And that was predetermined based on a process that we went through I think with the implementation of DeliverEASE.

Q. You've just mentioned - so DeliverEASE --
A. Yes.

Q. Can you explain DeliverEASE?
A. So DeliverEASE, obviously it's a centralised NSW Health portal or a service, which provides a portal or an ordering or procurement process to occur for stock to be ordered through the centralised stock room, or storeroom, which is Onelink warehouse, for us.

Q. A relatively new system, is that correct?
A. It is a relatively new system. We've only implemented mid-December, we went live with DeliverEASE, in my area.

Q. In your local health district?
A. No, in specifically operating theatres.

Q. I see. But your team --
A. Yes.

Q. -- or your part of the hospital --
A. Yeah.

Q. -- that's when it went live? Presumably, other hospitals with operating theatres within the district have a similar team that does the job that you do for RPA; is that right?
A. I would say so. Depending on the size, I suppose, and the structure, they would have something similar, yes.

Q. So DeliverEASE is not for every item though; is that right?
A. No. So, I mean, mainly it's been, so - at the rollout it was mainly to replace the old scanning system, and obviously to improve processes across the board, to provide greater visibilities of what's available, mitigate back orders more effectively by provision of that - it has this additional feature now with the DeliverEASE, we can actually see the alternative item that is available through Onelink. Previously that wasn't visible, it was more of a manual process.

Q. When you say "alternative item", is that an alternative item within the hospital or alternative item within the --
A. Available.

Q. -- available for ordering?
A. Yes. Through Onelink.

Q. So you've recorded the stock levels on whatever item it might be --
A. Yeah.

Q. -- it requires ordering the item that you usually get, which is out of stock; the DeliverEASE system will show you if there's an alternative item that is available then and there?
A. That's correct.

Q. Without having to search around for --
A. That's correct.

Q. -- or make inquiries? So it speeds up that process for alternate items?
A. Yes.

Q. And are there any other improvements from the previous system of stock tracking?
A. So there is a visibility, so we can log in and check whether a certain item is available, whether there is an alternative, whether it has been on back order and so on.

Q. In terms of the actual ordering, is that done within DeliverEASE or a different system?
A. You mean ordering of other items that are not available through Onelink?

Q. So Onelink --
A. Yes.

Q. Can you just explain Onelink?
A. So Onelink warehouse is the centralised warehouse and DeliverEASE will - so we - with DeliverEASE system, we obviously are replacing the system that would send the orders to Onelink directly. However, DeliverEASE now also has ability to create orders directly with suppliers. So let's say if we agree or we determine that it's beneficial

to include an item that is a direct supply, directly from supplier, that is possible now with the DeliverEASE system.

Q. So through DeliverEASE you can order from the Onelink warehouse?
A. Yes.

Q. And you can see, through that system, stock levels - whether it is available in the warehouse?
A. Yes.

Q. And if it's not, what alternative items there are available?
A. Through the warehouse, yes.

Q. And whether or not products are on back order through the warehouse?
A. Yes.

Q. And then you can also, through that system, order items that aren't available through the Onelink warehouse; is that right - direct from a supplier?
A. That is correct.

Q. Is there a different process that applies to them?
A. In terms of setting up DeliverEASE, it's a very similar system, because we need to, first of all, have that item included in into our catalogue. A barcode needs to be created for, obviously, DeliverEASE to work. However, the actual order process doesn't flow through the Onelink warehouse because obviously it's a direct order. So the system will generate - so once - so with the iPad you can start scanning, let's say, a certain area, and you don't have to stop, where, let's say, you know that it's an imprest stock or Onelink stock, to then, you know, submit and continue, you can continue ordering throughout your shelving even if you have mixed products, let's say, Onelink and direct orders, as long as obviously they're barcoded.

So then once you submit that order, the system creates requisition which goes for all of the items from Onelink, and that order obviously goes through Onelink warehouse. It also creates a separate purchase order, which then goes directly to the supplier.

Q. And is that integration a more efficient - more

efficient than the previous system?
A. I guess it is a more efficient system if you order directly in that manner, because it kind of speeds up the turnover or resupply process, but at the same time, it skips the regular approval process.

Q. Just in terms of what comes through the Onelink warehouse, are those items that are generally those that are obtained via statewide contracts; is that right?
A. Yes, that's correct.

Q. And there's a term that I think might have been used, "iProcure"?
A. iProcurement, yes.

Q. iProcurement, is that part of DeliverEASE or is that a separate system?
A. So it is the same system, in my understanding. I mean, they use the same platform to actually distribute the orders.

Q. It's the part of the system that does the ordering --
A. Yes.

Q. -- as opposed to the part of the system that is keeping track of stock; is that right - but it's all integrated and speaks to each other?
A. So keeping track of the stock - sorry, can you - you mean of what has been ordered?

Q. Well, you tell me. DeliverEASE, you're recording your stock levels in there as well as making orders; is that right?
A. Yes, yes.

Q. And the iProcurement - is that - that's the part that does the actual ordering; is that right?
A. Yes, that's correct.

Q. Thank you. Now, in terms of things that are - in terms of that ordering process, is there a sign-off procedure for items, or is that only - does that apply to all items?
A. So if it's a Onelink item, that's predetermined, so that's kind of included into our catalogue at the commencement of use of this type of a system. We do have the ability to revise that, depending on the need.

Obviously, if we need more stock or less, depending on the activity, we can amend those, the par levels.

Q. But in terms of, let's take swabs, for instance, which I assume is a Onelink item; is that right?
A. Yes.

Q. The storeroom has hit the minimum level, stock level, for swabs, you need to order swabs. Does that need to be authorised by somebody?
A. No. Not if we - I mean, it doesn't go through any particular approval process, if it's already set up to be ordered via DeliverEASE.

Q. So you have preset amounts that you order to get back to your maximum stock level?
A. Yes.

Q. And that doesn't - so there's no delay?
A. That's correct.

Q. You and your team, or your team, will see that when they count the stock and they will make the order?
A. Yes.

Q. And it doesn't go across someone's desk?
A. No, that's right.

Q. In terms of items that are separate to that, not through the Onelink warehouse, do they require authorisation?
A. So every order would probably require authorisation one way or another. So let's say if it's a general requisition, that will go through the approval process according to the local delegation manual.

Q. So if it's not something with a preset stock level, there's an ordering process that would require someone --
A. To approve.

Q. -- to approve it? Is it right, depending on the item, there's no doubt a delegations --
A. Yeah.

Q. -- a financial delegations level as to who can approve it?
A. Yes.

Q. Depending on how much it costs?
A. Yeah. So depending on the value and depending on the value of that requisition, it will go up the chain of approval. So let's say for orders - for operating theatres and the areas where I work, I'm the first approver, so when supply officers would raise an order, it will come into my work list in Oracle, waiting for approval.

Q. And what's the time range that it takes for things to be approved, that require approval?
A. So hopefully, that will be approved that same day, and then it will go up to the next person and then up to the next person, depending again on the value.

Q. Depending on the value?
A. Yes.

Q. Does that process ever take a significant time?
A. Yes, it can take a few days, yeah.

Q. For higher-value items?
A. Yes.

Q. And do you ever run out of items?
A. Occasionally, we do.

Q. How do you deal with that?
A. We escalate the approval. Obviously we escalate to the next approver and the next approver, and then even with HealthShare - with HealthShare with the buyers or, first of all, with our district supply office, to see if we can issue an urgent purchase order for the goods. We may even liaise with the supplier to see if they can deliver within the same day and so on.

Q. Presumably the aim is that what is required for the scheduled procedures is available - that's the aim?
A. Yes. Absolutely.

Q. And is that always able to be met?
A. So mostly, yes. I mean, we've hardly - and hopefully we won't have any - I mean, not availability of a product won't be the reason of cancellation. Obviously that's the last thing we would want to see.

Q. Just to deal with non-availability as distinct from

approval process, you could have an item, the ordering of which is approved internally, you've said sometimes it's not available. How do you deal with that?
A. So it often happens that a product goes on back order. Hopefully, we'll be notified early on. Suppliers sometimes do have a very quick response. They would email us or call us or they have a portal available where we can log in and have a look whether something is on back order. And then also provide alternative products which they may have, which are also available on contract. And then obviously - or consultation with the clinical staff will occur, whether the proposed alternative item is suitable for that procedure. If it's on contract, hopefully, they can match the price. That's the aim. And then there's, on very rare occasion, that "none of the above", and then we'll have to look for a different supplier, and so on. It doesn't happen often but it has happened.

Q. And presumably there are similar steps taken if things haven't been delivered that have been promised by suppliers, you escalate to the supplier; is that right?
A. Yes, that's correct. So again, it happens that, let's say, the warehouse missed packing half of the order, so they would ship an order supposedly based on our purchase order issued. The goods will arrive to our receiving dock, they will receive into the system and then alert us of that delivery. So then my staff or our supply officers will open up the boxes, check against the order and find that there's, let's say, one item missing or two items missing. So they would contact the supplier to stay, "We've received this order. We noticed that this is the case." Usually, those items aren't listed on the delivery docket. Very, very odd occasion that it will be listed but the goods won't be delivered, and often they do their own investigations, they contact their dock people and so on, and hopefully are able to rectify the situation directly with the supply officers.

If that doesn't happen, usually the supply officers will escalate to me, as their direct supervisor, which will then result probably with me contacting the representative who usually is designated to our hospital, then they try to resolve the issue. A worst case scenario, they will even send - depending on the urgency of the product, they will send a new sort of item directly to help us out in this situation. Obviously it's something that - it might be something that they have overlooked at their end, so

then they are trying to meet our needs and deliver, if not even bring it themselves, depending on the nature of the product.

Q. If there are persistent or significant issues with a supplier --
A. Absolutely.

Q. -- that has persisted despite your contact with them, is there an escalation process for you to follow?
A. Yes, I would escalate to our district supply, investigate why it has been happening, how often it's been happening, whether we've had any previous back-order issues, gather information in case they need it in their escalation, whether it's for products that are purchased via any of the New South Wales contracts or other.

Q. And do HealthShare have a role in escalation of problems under at least statewide contracts?
A. Sometimes we do raise it up with HealthShare, especially for if it's a recurring issue, if it is an ongoing supply issue, especially high specialty items. I mean, obviously there is not many, or if there is not many suppliers that are contracted, if it is one of two, that's obviously an issue, it's definitely an alert, so we will - those discussions will occur with HealthShare, yes.

Q. You have referred to "specialty items". Those are items that may not be routinely kept on hand; is that right, or they are --
A. So specialty items might be kept on hand but only used by certain specialties; or it might be products that are only used in, let's say, operations, in operating theatres; or may be specialty items that are only used by the anaesthetics; or sometimes we do get occasional, depending on patients, the surgery and so on, a request for a very special item that we might not even keep as a regular supply.

Q. Are they ordered through the same system or is there a separate system?
A. So they are eventually processed via the same system. Would you like me to give you an example?

Q. Yes, please.
A. So let's say almost always those will be treated as loan products, especially if they are prostheses. So let's

say a surgeon needs to use a very special graft for an unusual case.

Q. Yes.
A. They would probably - and the hospital will probably be alerted to this case coming through. I assume that a discussion would have been - between the clinician and either their head of department, who would then contact either the director of surgery or the nurse manager to advise them that this is coming, this case, and we need this special item, who then will pass on that information to me to say that this is coming, "What do we need to do, how can we process it?"

So if it is a loan product, they usually determine what's the most clinically appropriate and they will probably do the request for that product with the supplier or the product specialist, and that product will then be brought to the hospital on a loan basis. If it is a product that needs to be resterilised then it will be delivered to the sterilising department, it will be processed there ready for use, so then at the procedure time they will use it.

Q. Yes.
A. If it is a product that we have used before and it has been in our catalogue, the staff, or the nursing staff, will be able to scan that product into h-trak and record it that way. If not, they will wrap up the packaging, indicate the specific MRN of the patient, procedure, and bring it to our supply office so that then we can add it to that patient usage.

So then what happens next is we contact the supplier and ask for loan pro forma. Upon the issue of the loan pro forma we ensure that the price which was discussed previously, the item code, the lot number, is captured correctly and it matches, and once that is done we process - we raise a requisition which goes through iProcurement.

Q. I will come back to it in a moment well, I'll deal with it now. You have just referred to h-trak?
A. Yes.

Q. What's h-trak?
A. h-trak is our - it is a local system. It is a patient

implant and consumable usage capturing sort of system.

Q. So you have discussed a few times a replacement knee or a knee prosthesis?
A. Yes.

Q. So if you had four of them in stock, would that get entered into h-trak? Would it be the usage, or it is the stock level and the usage?
A. Yes - so the stock level, not, but as in - so the entering of information into h-trak happens at procedure time.

Q. I see. So it's done through the - it comes out of the --
A. So it's, let's say inside a theatre they would commence a case, they would - the h-trak comes with scanners, so they would scan, let's say, the patient's wristband or identification band, which would then draw the information from SurgiNet into h-trak. It will bring up the procedure name, primary procedure list, patient MRN. Then up in that sort of information or creation of that entry into h-trak, nursing staff will scan all products that were used for that patient.

Q. I see. So it allows you to see usage overall?
A. Yes.

Q. But it also allows the tracking of what has been - down to a patient level?
A. Yes.

Q. So if there, for instance, was a recall of an item or subsequently it turned out there was some contamination --
A. Yes.

Q. -- in the process, you would be able to identify --
A. Yes.

Q. -- for batch this, for a particular batch, you would be able to go to the patients it has been used in through that system?
A. That's correct.

Q. There is a project known as the SmartChain project that is on the horizon. Has that been implemented in your LHD yet --

A. No.

Q. -- or is that in the future?
A. No. Hopefully in the future. I have heard about it. I don't know how it works, whether it works the similar principle, but if it is, then it's very exciting for other areas where they don't have.

Q. I see. So it is a wider implementation of a similar system to h-trak, is it?
A. Hopefully.

Q. Your understanding is that. Just in terms of types of item, the last one I wanted to ask you about is items known as "consignment items" --
A. Yes.

Q. -- or items ordered on consignment. Can you explain those?
A. So consignment items are usually prostheses that are used on a regular basis in operations, so let's say they can be ocular lenses. The frequency of use and the need of a certain range probably calls to have those on consignment - on a consignment arrangement. So basically a range of products which has been revised or has been predetermined by the clinical team or the clinician themselves - clinicians themselves, the surgeons, would determine the range of products and the quantity, and then once that is done, it obviously goes through an approval process, again through the executive, depending on the delegation, and then that stock is placed into operating theatres to be used for future - for whatever is required.

We do have one little process. When consignment is brought in to the hospital, let's say we've gone through all the approval process and so on, we determine the quantities and the range, we enter the range of those - of that particular consignment into our catalogue in h-trak, so when the time comes for them - for the nursing staff to scan, to use that, or it's been used for the procedure, they are actually able to scan it. So they won't be able to scan it if that's not already in the catalogue. So making sure that they capture everything, and then also it gives us an overview of our catalogue to make sure that it's not everyone or anything can actually end up in the catalogue.

Q. Why are some items dealt with through this consignment process rather than general procurement processes --
A. Because --

Q. -- if you know?
A. Why we have consignment instead of --

Q. Yes, why is that process for these things such as ocular lenses and such items?
A. Because of the nature of the product, obviously. So we have to have them on shelf, because we do, let's say, 10 cataracts a day, so we need to make sure that they have the stock to perform the surgeries. Why? Because if we pre-purchase this product it will cost us a lot of money to keep so much stock on hand.

Q. I see.
A. There is a risk of those expiring, so obviously unnecessary cost. So I think that's good enough reason to have this consignment.

Q. I will just ask you about the expiry of products.
A. Yes.

Q. How are expiry dates tracked to ensure that --
A. So h-trak actually has the ability, it collects that data as well. So it collects the product item - item code, item description, the quantity used, the lot number. So if the product has a lot number, they will obviously have to scan all individual items to make sure all of the lot numbers are collected. It also captures the price, obviously, and also the rebate code. So if we happen to have a private patient, or if it happens that the product is rebatable and it is used for a private patient, there is an opportunity for revenue there, obviously, so it collects the rebate code as well.

Q. I see. All through h-trak?
A. Yes.

Q. Just lastly, I believe you have some contact at times with, interactions with, supplier representatives; is that right - in your role?
A. Yes.

Q. That might be for a variety of reasons, such as increased usage; is that right?

A. Yes.

Q. Or issues with the product?
A. Yes.

Q. Is it also in relation to potential - if a supplier has a new product, are you sometimes the person they initially make contact with?
A. They might get in contact, yes.

Q. And in terms of new products, is that always how new products are driven, from a contact from a supplier, or are they sometimes requested by a clinician, such as a particular surgeon?
A. So, I mean, representatives do promote their products, it's a regular occurrence, but that doesn't mean that we - that's the way, how we introduce new products. Usually, there is a process, but that process is usually driven by clinicians.

Q. So if there is a new product and it is not part of a statewide contract, whether you used it would be driven by particular clinicians. How would that actually happen?
A. So if they are interested for an ongoing use, they would probably go through our local products committee. So they would need to do an application for the products committee for this product to be reviewed, and usually - so the application itself calls for an approval by their head of department. So they would already have a discussion at department level to determine that this is a product that is in the interest of patient outcome across the board, so then potentially all surgeons within that department would use it, or depending on their specialties, whether they would use or not, and then that product, or that request, is reviewed at the clinical products committee and then, if it meets criteria, it might be approved or not.

MR FRASER: Commissioner those are the questions I had for this witness.

THE COMMISSIONER: Mr Gyles?

MR GYLES: I just have a few questions.

<EXAMINATION BY MR GYLES:

MR GYLES: Q. First of all just in relation to that last

matter, so if there was a proposal for a new product, whether it was from a clinician or something that had been driven by a supplier, that's a reasonably - sorry, from what you said, that's a reasonably labour-intensive process? There is a product committee which needs to look at it?
A. Yes.

Q. And ultimately the department head - the head of department within the particular specialty would have to sign off on it?
A. Not necessarily. So they would already have a discussion with the head of department. So the application itself calls for an approval by - so a requester will sign and also the head of department will sign.

Q. So the head of department has an involvement prior to the application to the product committee?
A. Yes.

Q. And the head of department would be the person who would be liaising with the other clinicians about that particular product?
A. If - within their department. So depending, let's say, what the product is, if it is a knee replacement, then it will be - they will discuss, I assume, you know, "This is a new product. It does this and these are the benefits", and they will say, "It's good to use", "Not good to use", or "It might be more expensive, we need to seek consultation with the hospital", which would then seek consultation with, let's say, district supply, who will then escalate or even - we would even escalate with HealthShare to see whether there is any - first of all, whether this product is on contract. If it is something new and revolutionary, then whether there is a plan to revise the contract to include this new item and so on.

Q. So that's a process that involves many levels of, in effect, decision-making and input from a whole lot of different people?
A. (Witness nods).

Q. Just so I'm clear about one thing you've said, when consignment items come in - say prosthetics or implants come in - and are on a shelf within the Prince of Wales Hospital in a storeroom - I'm sorry, RPA in a storeroom, if

that product is not used and it passes, its use-by - I think you said cataracts was one example - that would return to the supplier without ever having been purchased; is that right, in effect? That is, in order for you to have to pay for that product, it is used, it then gets entered into h-trak --
A. Yes. So consignment stock is usually maintained by suppliers, so if something is expiring, it is their responsibility to replace that product with the product within valid dates.

Q. So they are at risk, not the hospital, for paying for it?
A. (Witness nods).

Q. I think you said that was a sensible way to try to save some money --
A. Yes.

Q. -- that you are not responsible for?
A. Yes.

Q. And h-trak is a way in which the particular prosthetic or the particular product is then linked to the patient?
A. Yes.

Q. And as you would understand it, at the moment there is a procurement reform program being rolled out, and we see iProcurement as part of that, and we have one ordering system which comes through the HealthShare warehouse?
A. Yes.

Q. And is it your understanding that part of that process which would ultimately replace h-trak would be the SmartChain technology which would enable a link to be made between, say, a particular prosthetic and a patient, as well as having other effects, including being able to raise invoices and purchase orders to pay for prosthetics that have been used?
A. I'm not familiar with SmartChain.

Q. I see. Okay. Just moving finally to the bread and butter consumables - that is, the things that are being used in theatre all the time - it would no doubt be helpful for you if there was a system that was able to be put in in which there were a barcoding of items that went out of the warehouse and when those items got to a minimum level,

there was then an automatic ordering process - that would be easier than doing manual stocktakes, I would assume?
A. It would be easier. So if we captured the whole cycle of the product, then most definitely, yes.

Q. And if, for example, you could then hit a button and you would know how many of each product was in a particular storeroom or within the hospital, that would obviously be a benefit as well?
A. Yes.

MR GYLES: Thank you.

No further questions, thank you, Commissioner.

THE COMMISSIONER: Thank you. Anything further?

MR FRASER: Nothing arising, Commissioner.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: Has there been a witness waiting here all day?

MR FRASER: Yes.

MR GLOVER: There has, Commissioner. It's just been brought to my attention that this witness has travelled from Wollongong and has to depart Sydney at 4.30 to meet childcare arrangements.

THE COMMISSIONER: Has to depart Sydney, so has to depart this building now.

MR GLOVER: Quite - well, doesn't have to depart the Sydney region, has to depart here at 4.30. What I propose is to make a start and then, subject to where we get to, perhaps, rather than have that witness travel back tomorrow morning, finish tomorrow morning by AVL, if necessary.

THE COMMISSIONER: Okay. I don't want to risk childcare arrangements. Is the other option to have the whole of the

evidence tomorrow morning via AVL, or --

MR GLOVER: Subject to - we can discuss that offline. Yes, that is the other option. Something is happening behind me. I'm not sure what it is.

THE COMMISSIONER: Yes. People are talking.

MR GYLES: Commissioner, I think the witness is happy to start today and finish by AVL, although I do need to go, so I will be leaving my junior in charge.

THE COMMISSIONER: What about the witness? Does the witness want to start now and then leave or --

MR GYLES: I think that is her preference.

THE COMMISSIONER: Why don't we just find out quickly.

MR MUSTON: Can I say from our point of view, we are happy to accommodate the witness in whatever is going to be best. Also, of course, reporting staff and the like, for the sake of getting started with a witness, to finish on AVL tomorrow, it is a bit disruptive and has the capacity to keep more than just us and the witness here for an extra 25 minutes, probably 20 by the time we get started.

THE COMMISSIONER: We'll just find out what the preference is.

MR MUSTON: I think I have now got the full story. The two witnesses from Wollongong, the one we've just had and the one we're about to have, have come up together. The witness we've just had is the one who needs to leave for childcare arrangements by 4.30.

THE COMMISSIONER: But she is transporting the other witness.

MR MUSTON: They travelled together, which is perfectly understandable. The witness who is yet to be called has no strong preference about whether we start with her evidence this afternoon or whether we do all of it by videolink.

THE COMMISSIONER: What do you want to do? You are calling her.

MR MUSTON: I'm quite content to wait till tomorrow morning, to just get it dealt with in one hit to spare everyone --

THE COMMISSIONER: Yes, let's let them go and do it by AVL tomorrow or whatever arrangements can be made.

MR MUSTON: And can I say for the record that, having kept a witness here today and not managed to reach her, we are genuinely grateful that she has come, obviously, and genuinely apologetic that we have inconvenienced her in that way.

THE COMMISSIONER: Yes, it is unfortunate. Me too. All right, thank you. We will adjourn until - we will still just make it 10am tomorrow?

MR MUSTON: Yes.

THE COMMISSIONER: Okay. We will adjourn until 10 tomorrow, thank you.

AT 4.08PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 21 FEBRUARY 2024 AT 10AM

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