

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Wednesday, 12 June 2024 at 10.00am

(Day 033)

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

Also present:

**Mr Hilbert Chiu for NSW Health
Mr Simon Fitzpatrick with Ms Summer Dow for St John of God
Hospital
Mr Oliver Jones for St Vincent's Hospital**

1 THE COMMISSIONER: Good morning.

2

3 MR MUSTON: Commissioner, the first witness this morning
4 is Benjamin Edwards, but before we start with him,
5 I understand Mr Fitzpatrick probably wants to announce his
6 appearance but also has an application he wishes to make.

7

8 THE COMMISSIONER: Let's take some appearances and also
9 hear the application.

10

11 MR FITZPATRICK: May it please the Commission, my name is
12 Fitzpatrick and I appear for the St John of God Health Care
13 and the first witness this morning, Mr Edwards.

14

15 THE COMMISSIONER: Thank you. And you have an application
16 you wish to make?

17

18 MR FITZPATRICK: I do, Commissioner.

19

20 Today's witnesses are concerned with a case study
21 concerning St John of God Health Care's public-private
22 partnership in relation to the Hawkesbury District Health
23 Service. This is an arrangement which is very shortly
24 coming to an end at the end of this month, and there are
25 commercial aspects of the unwinding of that arrangement
26 which are still being negotiated and put into place.

27

28 THE COMMISSIONER: All right. Following on the discussion
29 we had in my chambers, is this consented to or not opposed?

30

31 MR MUSTON: Not opposed.

32

33 THE COMMISSIONER: Not opposed.

34

35 You want, first of all, an order under section 7(4) of
36 the Act to have the hearing in private.

37

38 MR FITZPATRICK: Yes.

39

40 THE COMMISSIONER: And for the live stream to be killed,
41 obviously.

42

43 MR FITZPATRICK: Yes.

44

45 THE COMMISSIONER: And an order as I understand it under
46 section 8, which obviously, unless extended, expires at 5pm
47 tomorrow, Thursday, 13 June, preventing publication of any

1 of the evidence heard.

2

3 MR FITZPATRICK: Yes, that's our application.

4

5 THE COMMISSIONER: All right. I'm satisfied that those
6 orders should be made and that it's desirable that it is
7 done.

8

9 I will make that order under section 7(4), that the
10 evidence we have from this witness and any other relevant
11 witness that it should apply to be held in private.
12 There's no need to exclude anyone that is currently in the
13 room?

14

15 MR MUSTON: No.

16

17 THE COMMISSIONER: And I will also make an order, as
18 I said, which expires, unless extended, at 5pm tomorrow,
19 13 June, that the evidence - that is, the transcript and
20 any documents tendered in relation to this evidence - not
21 be published.

22

23 Is there anything further I need to do?

24

25 MR FITZPATRICK: No.

26

27 MR MUSTON: I think, if I could jump in for Mr Chiu, the
28 same order might sensibly be made in respect of
29 Ms Clements, who is the next witness, and Mr Gregory, who
30 is the witness that follows her, and that covers off the
31 St John of God group of witnesses.

32

33 THE COMMISSIONER: All right. Based on what I was told in
34 chambers, again, I am satisfied that it's desirable to make
35 a similar order, and I will make those similar orders.

36

37 MR MUSTON: Thank you.

38

39 **IN CLOSED COURT**

40

41 <BENJAMIN EDWARDS, sworn:

[10.04am]

42

43 <EXAMINATION BY MR MUSTON:

44

45 MR MUSTON: Q. Thank you, Mr Edwards. Could you state
46 your full name for the record, please?

47

A. Yes. Benjamin Edwards.

- 1
2 Q. You are the chief operating officer of St John of God?
3 A. Correct.
4
5 Q. That's a position you've held since January 2023?
6 A. Correct.
7
8 Q. And prior to that, or prior to taking on that role,
9 you held a range of different roles associated with the
10 delivery of healthcare services by the St John of God
11 organisation in Western Australia, as I understand it?
12 A. Yes, that's correct.
13
14 Q. You have prepared a statement to assist the Commission
15 with its work dated 4 June 2024.
16 A. Yes.
17
18 Q. Have you had an opportunity to read that statement or
19 review that statement before giving your evidence today?
20 A. I have.
21
22 Q. Are you satisfied that the contents of that statement
23 are true and correct?
24 A. I am.
25
26 MR MUSTON: Thank you, Commissioner. In due course, that
27 will form part of the bulk tender.
28
29 Q. Mr Edwards, since 2015, you tell us that St John of
30 God has operated the Hawkesbury District Health Service
31 pursuant to a series of arrangements with the Nepean Blue
32 Mountains LHD. That's correct?
33 A. Yes, that's correct, yes.
34
35 Q. Just because it is a bit of a mouthful, I might refer
36 to it as "Hawkesbury hospital" going forward, if that's
37 okay?
38 A. Yes, that's a lot easier.
39
40 Q. But prior to 2015, Hawkesbury hospital had been
41 constructed and was operated under a public-private
42 partnership between Catholic Healthcare New South Wales and
43 ACT, and the LHD; is that correct?
44 A. That's correct, and then we stepped in and effectively
45 took over from the other Catholic provider at that time.
46
47 Q. Could you describe the services which, at least at the

1 moment, or over the last, say, 12 to 18 months, have been
2 delivered through Hawkesbury hospital? Just talk us
3 through what it offers as a facility?

4 A. So it is a fairly general medium-sized public
5 hospital. It has an emergency department which is quite
6 significant, and provides a typical range of medical and
7 surgical services, maternity services and some community
8 services as well.

9

10 Q. You've described it as a "public hospital". Are there
11 private patients treated through that hospital or is it
12 exclusively public?

13 A. Yes, okay, so within the hospital, there is an area
14 which is nominally dedicated for the treatment of private
15 patients as well, which are typically surgical patients who
16 are listed for procedures as opposed to being acute
17 patients who turn up through the emergency department, and
18 that's always been in part of the arrangement, yes.

19

20 Q. Is there a standard range of procedures which
21 historically have been offered to those patients through
22 that part of the facility?

23 A. Yes. So it typically tends to be planned procedures,
24 so that would include things like endoscopies and surgery
25 within specialties like ear nose and throat, ophthalmology,
26 orthopaedics, soft tissue surgery, but probably at that
27 medium level of complexity, so it's not a very large
28 hospital with significant, you know, ICU infrastructure
29 which means we would undertake more complex operations so
30 middle-tier planned procedures.

31

32 Q. Would it be right that equivalent middle-tier planned
33 procedures are also offered to public patients on public
34 lists through the hospital?

35 A. Absolutely. Yes, there is an option - so the majority
36 of the hospital serves public patients and there is a small
37 proportion of private patients which are treated there as
38 well.

39

40 Q. Do you have a sense of how the services offered
41 through Hawkesbury hospital fit into the broader mix within
42 the context of services which are delivered more widely by
43 the Nepean Blue Mountains LHD to its community?

44 A. I couldn't give you a definitive answer on that. I am
45 aware that there are a series of larger hospitals within
46 the LHD, within fairly close distance, and other hospitals
47 that are being constructed, and they form part of

1 a network, as you would expect, but I'm not familiar with
2 the service delineation at those other hospitals.

3
4 Q. You may have just answered this question, but in the
5 time that you have been in your role, have you been
6 involved in any planning processes where consideration has
7 been given to how the services offered at Hawkesbury
8 hospital might fit within that broader matrix of services
9 offered within the LHD?

10 A. No.

11
12 Q. Are you aware of whether anyone else from St John of
13 God has been involved in any such planning process?

14 A. I couldn't say definitively no, but I am not aware if
15 they have.

16
17 Q. In your view, would there be value in taking
18 a system-wide approach to the services delivered in the LHD
19 and by St John of God through their respective facilities?

20 A. Absolutely, yes.

21
22 Q. Would it enable you to identify areas of overlap?

23 A. Yes, and also to understand the kind of - the optimum
24 location for services across different hospitals.

25
26 Q. So when you talk about optimum services, you might
27 identify areas of overlap and there might be two responses
28 there: overlap might be appropriate if you're dealing with
29 procedures that are in heavy demand and need to be
30 delivered or can sensibly be delivered through a range of
31 facilities - yes?

32 A. Correct.

33
34 Q. And then other areas of overlap which might be
35 identified might actually point in the direction of
36 a change in the sense that it may well be that a particular
37 service being delivered at both could far better be
38 delivered only at one or other of the facilities?

39 A. Yes, effectively a consolidation, yes.

40
41 Q. That sort of system-wide approach to service planning
42 would also enable St John of God and the LHD
43 collaboratively to identify any gaps in the delivery of
44 service to the community that they collectively serve,
45 wouldn't it?

46 A. If it was undertaken in the correct manner, yes,
47 I would expect so.

- 1
2 Q. When you say, "the correct manner", what do you think
3 would be a - I'll use your word. What would be the correct
4 way to go about that task to produce the best outcomes from
5 a planning and delivery perspective?
6 A. Well, if I think about what we would do in areas
7 where - like in Western Australia, in Perth, where we have
8 several hospitals, we start that process by looking at the
9 population that we serve, how it's changing over time, what
10 the demand of that service, of those patients, are for
11 services, where the location of the hospitals are, the
12 current infrastructure of those hospitals, and that informs
13 decisions around, effectively, in simple terms, which
14 services should be provided at which locations. That's
15 a bit of an oversimplification, but a process in that sort
16 of sequence.
17
18 Q. Sorry, I should say, I'm about to ask you another
19 question, but to the extent that you might be seeing the
20 back or side of my head, it's because I'm looking at you on
21 a screen which I suspect is in the opposite direction to
22 the camera that's facing me, so I don't intend any
23 disrespect to you.
24 A. No, none taken, none taken.
25
26 Q. I gather from the answers that you've just given that,
27 at least insofar as you are aware, this collaborative
28 planning process involving the LHD, St John of God and
29 potentially any other deliverers of health services within
30 the LHD is not, insofar as you're aware, happening?
31 A. It would be hard for me to say that it's not happening
32 at all. I think probably the furthest I could go is to say
33 that our involvement in that process has been very limited.
34 I would assume that that sort of planning process is
35 occurring. I think our involvement in it has been limited.
36
37 Q. The involvement of a provider like St John of God in
38 that process is important, is it not?
39 A. I would think so, yes.
40
41 Q. From the perspective of St John of God, it would give
42 an organisation like yours an ability to understand the
43 services that it could best be delivering to the community?
44 A. Yes, and I also think an ability to plan for what the
45 best future for that hospital is, so yes.
46
47 Q. When you talk about that planning, obviously there's

1 a significant financial element to that. When you talk
2 about the planning for the future, other than the
3 financials, what did you have in mind?

4 A. So again if I use an example from another geographical
5 location where we have more of a presence, these sorts of
6 discussions would inform things like, you know, the
7 location of services. To the point that you made earlier,
8 often there's a critical mass for some specialist services
9 where you need sufficient volume of patients to make that
10 service safe and so you would make a decision about and
11 consolidate it on to one site or another, and ultimately
12 that typically leads into things like building plans - you
13 know, do we need to expand, do we need to change the nature
14 of a facility, and then that would also feed into staffing,
15 looking - longer-term staffing/recruitment plans as well.

16
17 Q. And so that longer view and an ability to adapt the
18 services that might be delivered through a facility like
19 Hawkesbury gives you a greater capacity within an
20 organisation like St John of God to provision or to make
21 adjustments to your services in a way which they are able
22 to be accommodated financially as opposed to, say,
23 something which needs to be done within a very short time
24 frame?

25 A. Yes, effectively, I think, like any large complex
26 business, long-term planning is critical to future success.

27
28 Q. You've touched on this, but that collaborative process
29 and planning of the services that might be usefully
30 delivered through a facility like Hawkesbury could also
31 inform discussions around capital expenditure at the
32 facility relative to other facilities within the LHD, could
33 it not?

34 A. I would think that it could, yes.

35
36 Q. Hawkesbury hospital is an ageing facility. Would that
37 be an apt description?

38 A. It would.

39
40 Q. I think it has been in operation since 1996, at least
41 in its current iteration, without any significant upgrades
42 or renovations; is that --

43 A. Correct.

44
45 Q. In term of the position that St John of God found
46 itself in at the point where it was having to make
47 a decision about whether or not to extend the contract,

1 what challenges did the ageing nature of the infrastructure
2 of Hawkesbury present, commercially?

3 A. Yes, so if that question relates specifically to the
4 ageing infrastructure, we were aware from a review that we
5 had undertaken, a broader review, that there were, you
6 know, a significant range of issues with the facility which
7 required investment to get them to a standard that we would
8 be happy with, and that included the building itself but
9 also equipment, and it was not clear to us, because of the
10 way that funding flows through the system, that that
11 funding would be available to us, and so clearly, that
12 caused some concern about the ongoing operational risk of
13 continuing to run the facility.

14
15 Q. When you say bringing it up to a level that you would
16 be happy with, what were the particular sources of
17 unhappiness, to use your words, in respect of the
18 infrastructure?

19 A. Yes, I think - so just like any building that's as old
20 as the one that you've mentioned, that's used heavily, as
21 hospitals tend to be, there's general wear and tear and
22 part of running a hospital business is that you need to
23 invest what we call kind of routine - into routine
24 maintenance every year just to stay on top of, you know,
25 the parts of the building that you see, the corridors, the
26 ceilings, the floors.

27
28 But then beyond that, there is all of the elements
29 that you don't see, like the piping, the pipe gases, the
30 heating, the airconditioning. And then, beyond that,
31 health care is an increasingly resource intensive business
32 from an equipment perspective as well, which is great,
33 because medical technology is constantly evolving. So
34 we'll often find that there's new equipment to be purchased
35 or that existing equipment needs to be maintained well.
36 I would say in all of those areas, we had some degree of
37 concern, largely due to the nature of the way that the
38 capital funding flowed from the LHD to us.

39
40 Q. What were the practical ramifications of the lack of
41 capital investment? Let's start with in terms of the
42 delivery of health care to patients of the hospital. Were
43 there any practical ramifications from that perspective
44 which derived from the absence of significant capital
45 investment?

46 A. Yes. I think probably the most obvious would be that
47 occasionally, pieces of equipment would not work, and we

1 were not able to get them either repaired or fixed quickly
2 enough, and those pieces of equipment are kind of critical
3 to performing the clinical work that we undertake, and that
4 obviously has a direct impact on patient care because if
5 you don't have the correct equipment, then you cannot
6 proceed with the work. So I think that's probably the
7 point where it affected things most. I mean, the building
8 looking shabby, et cetera, is not great, but it's not
9 a huge operational problem. But we did experience some
10 infrastructure problems with things, you know, like pipes
11 bursting and breaking and behind-the-scenes issues, which
12 we were typically able to manage, but had the potential to
13 cause disruption.

14
15 Q. What about from a workforce perspective, did you find
16 that the lack of significant capital investment had any
17 impact on your ability to attract and retain workforce
18 within the hospital?

19 A. Look, it's impossible to definitively state that
20 point, however, what we do know from running a large number
21 of hospitals across the country, which are at various
22 stages of their development, is that typically, our - we
23 call our employees caregivers, our caregivers are happier
24 when they're in new, purpose-built buildings, and we can
25 see that through the regular satisfaction surveys that
26 we've undertaken often.

27
28 We do have other facilities which are ageing as well,
29 and you do tend to get a strong theme through those surveys
30 about people's views of the environment that they are
31 working within and what that says to them about how they're
32 viewed by their employer. So I think it definitely does
33 have an impact on ability to recruit and retain staff.

34
35 Q. Were the challenges associated with the absence of
36 significant capital infrastructure something that was
37 discussed with the LHD?

38 A. Yes.

39
40 Q. And in terms of the timing of those discussions, did
41 those discussions occur in the context of negotiations
42 around the prospective renewal of the agreement to continue
43 running the hospital into the longer term?

44 A. They were - they happened in two contexts, so they
45 would happen throughout the year as issues popped up, you
46 know, concerns around specific items would be raised as and
47 when, and then, as we were in the process of negotiating

1 the new contract, we were seeking to get further clarity
2 around how capital funding would work going into the
3 future, and because the current arrangement was, in my
4 opinion, fragmented and hard to understand, and therefore
5 hard to plan around.
6

7 Q. So in terms of that first category, raising capital
8 investment issues with the LHD as and when needs arose, was
9 it your experience that the LHD responded by providing
10 capital funding to deal with whatever issue had arisen?

11 A. I would say it varied. I mean, what I would say was
12 that the LHD were always very pleasant and collaborative to
13 deal with, so the relationship - there was never
14 a relationship problem. It often felt like they were not
15 the decision-makers, so things would typically kind of get
16 referred and then we would find ourselves asking for
17 updates, and the type of response that we would get is that
18 that was being, you know, considered at a level higher and
19 we would have to wait and see. That is not unusual when
20 you're dealing with government, to be frank. So that -
21 yes, but that did - that did occur. So what that meant was
22 we didn't have the same certainty around funding as we
23 would do in our private hospitals, for example.
24

25 Q. So in terms of those decisions that had been referred
26 up the chain, did you get a response quickly, typically, to
27 the request for further funding, or was there some delay in
28 receiving an answer to whether or not funding would be
29 provided?

30 A. Occasionally we would get a quick response, but also,
31 there would be delays or, alternatively, we would be told
32 that there wasn't any available funding.
33

34 Q. When you were told that there wasn't any available
35 funding, were you given any explanation as to why?

36 A. That that was a system-wide issue and that budgets
37 were tight.
38

39 Q. At that time, were you given any - did you receive any
40 sense as to whether or not the decision not to fund was in
41 any way referable to a view formed that the funding was not
42 actually required, as opposed to not available?

43 A. No.
44

45 Q. Earlier you talked about a new hospital which is being
46 constructed within the broader catchment of Hawkesbury
47 hospital. Is that the Rouse Hill Hospital?

1 A. That's correct, yes.

2

3 Q. Is it right to say that that facility is being
4 constructed within the broader catchment currently served
5 by Hawkesbury hospital?

6 A. Yes, my understanding is that it's fairly close by.
7 I can't remember the exact travel time, but it's
8 a relatively short car journey from Hawkesbury. So it
9 would be within the network, yes.

10

11 Q. Is there a perception, or was any view formed within
12 St John of God, as to the potential impact that the opening
13 of Rouse Hill Hospital might have on the services being
14 sought and delivered through Hawkesbury hospital?

15 A. Look, we could only speculate, which I don't think is
16 helpful, but we did wonder what the impact would be and
17 what the plan was for Hawkesbury with having what appeared
18 to be, you know, a very large, very expensive hospital
19 built so close by. But we were not clear on what the
20 impact would be.

21

22 Q. So I gather from some of your earlier answers and the
23 fact that you were left speculating around the impact of
24 the opening of Rouse Hill Hospital, that there was no
25 process whereby anyone from the LHD or the ministry sat
26 down and discussed collaboratively with St John of God just
27 how all of the services to be delivered across the various
28 facilities, including the new one, might fit together?

29 A. So I was not involved in any discussions like that.
30 It is possible that that could have happened at the more
31 junior level earlier on, so I couldn't definitively say no,
32 but certainly in regard to myself and my predecessor, who
33 had this role before me, we were not involved in those
34 discussions.

35

36 Q. Are there any particular operational challenges
37 insofar as you were speculating and making decisions based
38 on that speculation - any particular operational challenges
39 that you felt the opening of Rouse Hill Hospital might
40 present?

41 A. Not really, because I think it was because it was so
42 unclear, and it was in the early stages, around what that
43 hospital or what its service profile would be and what it
44 would look like, it was almost - it would be unhelpful to
45 hypothesise about what the impact would be. So our view
46 was, you know, we had a contract to run Hawkesbury, which
47 was really clear, and that our role was to continue

1 providing that contract, providing the best possible
2 clinical services and patient experience that we could, and
3 so short answer, no, it didn't affect what we were doing,
4 other than being aware that it was happening.

5
6 Q. Do you have a copy of your statement handy?

7 A. Yes.

8
9 Q. Could I ask you to turn to paragraph 26 of your
10 statement?

11 A. Yes.

12
13 Q. In fact, in paragraph 23 and 24 you give us, at
14 a highlight level, some of the strategic and local factors
15 which informed the decision to hand back St John of God
16 hospital. I just want to work through some of those
17 considerations. Starting with what you tell us at
18 paragraphs 26 and 27, in a way, are they not really largely
19 the same thing as the considerations which you've
20 identified, at least at a headline level in 24.1?

21 A. Yes, I guess they are. They are probably a clearer
22 articulation of how the macro conditions that I articulated
23 in 23.1 were impacting us at Hawkesbury.

24
25 I think probably the key difference that I would pull
26 out - so what I tried to do was say that overall,
27 nationally, there appears to have been an inflection point
28 coming out of COVID, for reasons I'm happy to go into if
29 you want to talk about them, and that has affected some
30 areas more than others, based on a range of different
31 factors, kind of location, population, willingness of
32 people to work there. But what we saw at Hawkesbury is
33 that the cost pressures which I was referring to more
34 broadly were more significant there, and that misalignment
35 between the cost of providing service and the available
36 funding was more significant than we were experiencing in
37 other hospitals.

38
39 Q. So we'll come back in a moment to invite you to expand
40 a bit on your views as to why the health care environment
41 is changing, but the fundamental proposition is, there's an
42 increase in the cost of delivering health care which has
43 been experienced nationally, but acutely at Hawkesbury; is
44 that right?

45 A. Yes.

46
47 Q. And a problem that derives from that is - lies really

1 in the fact that the funding being provided for the
2 delivery of that health care hasn't kept up?

3 A. Correct.

4
5 Q. You offered a moment ago to expand a little bit on why
6 you think, in the post-COVID era, there's been an
7 inflection in terms of the cost of delivering health care.
8 What are the real key drivers, as you see them?

9 A. Yes, look, I think the pandemic probably provides
10 a useful focal point to state there has been a change
11 since - I suspect there have been other factors as well.
12 So if I think about it largely from a cost perspective, the
13 cost of most things has gone up, and that's not, you know -
14 that's not restricted just to health care. So the cost of
15 most of the things that we purchase has gone up, as global
16 supply chains have become strained, and you'll understand
17 with the context there, that's affected us.

18
19 The cost of building things has become hugely more
20 expensive, whether it be houses or hospitals or whatever.
21 Utilities, et cetera, have gone up as well. So those are
22 all kind of our non-pay costs, but where there has been the
23 most significant increase in costs has largely been around
24 staffing. There are a number of reasons for that, but
25 obviously Australia relies upon immigrants to work in a lot
26 of sectors, and health is no different. So across the
27 country, we rely heavily on importing doctors, nurses,
28 allied health professionals from around the world, but
29 particularly from Europe, from Asia, from India, and we
30 obviously had a period for whatever it was, you know, two
31 and a half years, where it was very, very difficult to
32 bring those people in, and on top of that, we found that
33 a lot of people from those countries decided to go home to
34 be with their families.

35
36 So we lost a lot of people and we weren't having the
37 annual influx of new people, and so what that led to is
38 some fairly acute staffing shortages, initially just
39 generally across the board, and then more recently in kind
40 of specific areas. Typically, it's kind of back to supply
41 and demand, right, so when you have lots of available
42 workers then the cost of employing people tends to be less;
43 when there aren't enough people, you tend to end up paying
44 more money, and the main reason for that is that many of
45 those people will work through locum agencies rather than
46 being employed directly, and in simple terms, if you employ
47 someone directly, you know, you're paying their wages. If

1 you employ them through a locum agency you're paying the
2 same wages and you will be paying an additional element on
3 top to fund the agency as well.
4

5 That was a particular problem for us in several of our
6 hospitals, but particularly at Hawkesbury, and particularly
7 with doctors, where there was, to my understanding,
8 a statewide struggle to recruit junior doctors, and our
9 costs in that area increased substantially.
10

11 So, yes, I would say those were the main reasons, and
12 just to kind of repeat what you said earlier, I think the
13 culmination of that was that it meant that the cost of
14 providing services was not in line with the funding
15 increases that were being provided. So, you know, by
16 FY23/FY24, we saw a very profound change in the
17 performance - the financial performance of the hospital
18 that was reflected by that gap.
19

20 Q. In terms of the workforce challenge and the particular
21 challenge presented by the need to resort to locums where
22 it's not possible to recruit staff, did you find that you
23 were in competition with, amongst others, the LHD for the
24 staff that were available?

25 A. Absolutely. Yes.
26

27 Q. Was there any collaborative approach, insofar as
28 you're aware, taken between St John of God and the LHD to
29 try and avoid a situation in which they were in direct
30 competition with one another for the delivery of health
31 care within the public system to the same community of
32 people?

33 A. Yes, look, not that I'm aware of, but that doesn't
34 mean it didn't happen, and I probably would just say we
35 operate in many states and I did not see that collaboration
36 happening anywhere. It was pretty much a case of every
37 organisation for themselves because everyone was under
38 such pressure. At that point, most organisations were
39 launching - you know, once the restrictions had been
40 lifted, we were - everyone was going heavily into
41 international recruitment, domestic recruitment, training
42 more people, and that did tend to happen at an
43 organisational level. So I'm not aware of any
44 collaboration, but there wasn't a lot of collaboration
45 really happening in many places across the country.
46

47 Q. In terms of your broader experience of delivering

1 health care across the country, do you think collaboration
2 of that type might actually be a useful step?

3 A. Yes, absolutely, and I think it's been a learning that
4 has emerged from this. So more recently, if I think about
5 Western Australia, where most of our business is, we now
6 partner with the government to actually travel to other
7 countries to recruit new people together and to work with
8 universities, you know, to set up training courses that we
9 can then get people the appropriate qualifications and
10 bring them into Australia.

11
12 I have to say, though, that is a fairly recent
13 development, but certainly I think there's - there are
14 advantages to collaborating, in many respects, between the
15 public and private sector.

16
17 Q. In the short time that the Western Australian
18 experiment has been afoot, have you found that it has
19 produced outcomes for you in terms of solving some of the
20 workforce challenges that you've been presented with?

21 A. Yes, look, too early to say. I would say very
22 positive start, but it's in that kind of
23 relationship-building/establishment stage, and I think it
24 would take, you know, six to nine months before it's clear
25 whether it is working or not.

26
27 Q. If I could ask you quickly to turn to paragraphs 28 to
28 30 of your statement, I think it's fairly self-evident what
29 you're telling us there, but just to make sure --

30 A. Yes.

31
32 Q. -- I've understood correctly. St John of God saw
33 Hawkesbury hospital as an opportunity to expand its
34 operations through public-private partnerships in New South
35 Wales, as at 2015?

36 A. Correct.

37
38 Q. It had a view at that time that there was at least the
39 prospect of a wider roll-out of arrangements of that type
40 within New South Wales which had not previously been the
41 case; is that right?

42 A. Sorry, correct. Yes.

43
44 Q. And as a result of particularly what you tell us about
45 in paragraph 30, as an organisation, St John of God has
46 come to the view that the prospect of public-private
47 partnerships being any significant part of the delivery of

1 health care in New South Wales, at least as matters
2 currently stand, is low?

3 A. Yes. I mean, so you'll obviously be aware there was
4 a parliamentary inquiry in 2019 around Northern Beaches and
5 the report that was published, I think in 2020, was very
6 clear that the direction going forward was that the New
7 South Wales Government would be unlikely, very unlikely, to
8 enter into any further PPPs. So that was a strong signal
9 to us that the kind of strategy which we had been
10 considering would no longer be feasible.

11
12 Q. When you say not "feasible", is that because one
13 hospital out here in New South Wales as a stand-alone
14 operation is not a particularly commercially desirable
15 state of affairs, whereas one little foothold which
16 potentially was the loss leader, as it were, for a wider
17 series of operations, might have been?

18 A. Yes, so just to be clear, we do have two other
19 hospitals in New South Wales, they're both privates and
20 they're both psychiatric hospitals, so a little bit
21 different. We had those hospitals before this one. But to
22 your point, yes, it's commercially very challenging to run
23 one hospital in an isolated state. You really want
24 critical mass so you can share, you know, the sort of
25 support services that feed in to hospitals and the larger
26 you become the more economically sensible it becomes. So
27 to just have a single isolated hospital certainly does
28 create commercial challenges, yes.

29
30 Q. We then come to paragraphs 34 to 38. You tell us in a
31 little bit more detail about some of the cost escalations -
32 these are the issues that we've already touched in your
33 oral evidence. Can I ask this in relation to that, though:
34 insofar as you're aware, were these increasing cost
35 pressures shared with the LHD?

36 A. Yes - so if I've interpreted your question correctly,
37 yes, my understanding is that there were doctor shortages
38 across the whole area and that most hospitals were
39 struggling to recruit the same sorts of staff, yes.

40
41 Q. That's a useful answer but my question probably wasn't
42 sufficiently clear. Insofar as Hawkesbury hospital was
43 experiencing these particular cost escalations, and the
44 consequences of that from the point of view of its
45 profitability, was that fact shared with the LHD?

46 A. Yes, sorry, now I understand. Yes, it absolutely was.
47

1 Q. How was it communicated, in what form?

2 A. So we would have monthly performance meetings where we
3 would discuss, you know, a range of performance factors
4 around the hospital, and I attended those as often as
5 I could and I was very overt and open about sharing the
6 deteriorating financial position of the hospital and would
7 explain why. So that was probably the main reason. There
8 may well be correspondence in emails as well, possibly, but
9 certainly there were meetings where we explained it was
10 becoming rapidly very clear that the hospital's financial
11 performance was deteriorating significantly.
12

13 Q. In paragraph 38 you tell us about an efficiency review
14 that was undertaken?

15 A. Yes.
16

17 Q. The outcome of which, I gather from what is set out in
18 that paragraph, is there is little efficiency left to
19 squeeze out of the hospital. Was that shared with the LHD?

20 A. The report wasn't, but when we started to have the
21 conversations about not extending the contract, we
22 explained to them that we believed that there was not a lot
23 of cost efficiencies in there. One of the first things you
24 would always look at in this situation is, you know, is the
25 facility running efficiently or are there steps that could
26 be taken to make it run more efficiently? So, yes, that
27 was explained to them. The report that we drafted wasn't,
28 but that point was.
29

30 Q. You tell us in paragraph 39 --
31

32 THE COMMISSIONER: Q. Was there a reason the review
33 wasn't shared, that you know?

34 A. Yes, so I guess the review was always intended to be
35 an internal document to inform our decision-making. Given
36 the timing, we were - I guess there was an element of
37 convenience here. So it wasn't like we were in the middle
38 of a contract with another five years to run. Because of
39 the delays of negotiation, we were effectively at a point
40 where it was simple from a contractual perspective to walk
41 away, so it seemed like a sensible time to undertake
42 a review and we undertook that review ourselves with a view
43 to advising ourselves about the best course of action. It
44 was never intended that that review would be shared with
45 them. That wasn't its purpose. But what we did do was
46 relevant elements that came from it were shared.
47

1 MR MUSTON: Q. You tell us in paragraph 39, in the
2 second sentence there, that St John of God was informed
3 that it was unlikely that further funding would be
4 available. Who informed St John of God of that fact?

5 A. So this would refer to those performance meetings that
6 I mentioned earlier, where - so typically, I would attend
7 those along with the local chief executive of the hospital
8 and the local finance director, and we would meet with the
9 management team, the relevant management team from the LHD,
10 and we would have those sorts of discussions. And look,
11 again, very politely, very collaboratively, they would
12 explain to us that that was effectively the position across
13 the whole system, so that, you know, it wasn't like there
14 was pots of money that they could just dip into and give to
15 us. That was the available funding. So, yes, that was the
16 kind of nature of those conversations.

17
18 Q. As part of those conversations, was it ever suggested
19 to you that there were inefficiencies which Hawkesbury
20 hospital could overcome in order to deal with the deficit
21 that it was facing?

22 A. Yeah, I think occasionally there were comments made,
23 so there might be a comment around something like, "Oh,
24 your length of stay looks a bit longer at the moment",
25 which is a KPI for us, like, how long people stay in
26 hospital, or, you know, the number of procedures. So we
27 would go away and look at that, and typically, the length
28 of stay point was because of the case mix of patients that
29 were coming into the hospital was changing, and that's
30 another really significant factor.

31
32 We were seeing generally an older and more complex
33 group of patients with, you know, multiple comorbidities,
34 which typically means that they will end up staying in
35 hospital for a lot longer, and often will then kind of go
36 home for a while and then come back into hospital. So that
37 inevitably has an impact on your length of stay when you
38 compare it to people who are fit and healthy coming in for,
39 you know, tonsils out or a knee replacement or a gall
40 bladder. So that case mix changed.

41
42 There were reasons behind the areas where it could be
43 said that there were efficiency improvements. The review
44 that we undertook found - and, you know, it was an internal
45 review but it was an objective one. The review that we
46 undertook found that the hospital was running very
47 efficiently when we compared it to other benchmarks and

1 other hospitals, in terms of kind of like levels of
2 staffing. It was running very efficiently and we did not
3 feel that there was really anywhere we could make
4 additional savings that would potentially not risk patient
5 care, and so that was not something we would be willing to
6 do.

7 .
8 THE COMMISSIONER: Q. I assume from the answer you've
9 just given that the people that may have been suggesting to
10 you, as an example, that your length of stay looked a bit
11 long had not done the analysis of the case mix that you've
12 just explained?

13 A. Yeah, in their defence, though, I would say what
14 typically happens is people get hold of datasets and data
15 kind of gives you an initial view and it's like anything;
16 you need to pick - you need to go levels below that. So
17 I suspect in the data that they were seeing, it would show,
18 "Oh, length of stay has increased over a period of time."
19 But typically, it would require that kind of more detailed
20 level of service knowledge to understand the "why", and
21 that was our job, to be able to go away and explain that.

22
23 So those points were never put to us in a, you know,
24 confrontational or accusatory manner; it was more like,
25 "Well, you might want to look at X, Y and Z", and we would
26 say, "Yes, we will do", and then we would come back and
27 say, "Here's our rationale for what's happening", or, "Yes,
28 maybe we could change this a little bit."

29
30 MR MUSTON: Q. At the time, so having been through this
31 process of discussing potential areas for improvement and
32 your organisation looking into it and reporting back on
33 what it had found, did any of those discussions result in
34 any increase in the funding that was being proffered?

35 A. Sorry, did it result in any increased funding?

36
37 Q. Yes.

38 A. No.

39
40 Q. So the discussions are happening about funding.
41 You've said to them, "We need more because the funding
42 that's being provided is insufficient to meet the cost of
43 delivering the services"?

44 A. Yes.

45
46 Q. They've said, "You might want to have a look at some
47 of these inefficiencies, potential inefficiencies." You've

1 gone away and looked at it and come back and reported your
2 findings, which were that nothing more can be found there
3 in terms of efficiencies. My question is: at the end of
4 that process, was there any increase in the level of
5 funding that was being proffered by the LHD?

6 A. No. No.

7
8 Q. At any point, was it suggested to you that - well, let
9 me take it back a step. Are you comfortable that you
10 communicated clearly to those who you were speaking to at
11 the LHD that the amount of funding being provided was
12 inadequate to meet the cost of delivering the services at
13 Hawkesbury hospital?

14 A. Yes.

15
16 Q. And in response to that, did you get any sense or did
17 anyone tell you that they didn't believe or agree with
18 that?

19 A. That's a good question that I need to consider
20 carefully. Look, I think - I would say they were
21 sympathetic, and the impression that I got was that there
22 had been a general - there would need to be a general
23 tightening of budgets across all of the Department of
24 Health, and so what we were experiencing was happening
25 elsewhere, and therefore, it was no different for us than
26 anywhere else. So I didn't get the impression that they
27 didn't believe us; it was more of a case of, "Well, just
28 the money isn't there."
29

30 I think the other thing I would call out is - and
31 I know we've touched on it earlier - the complexity about
32 the capital funding was particularly - its nature was
33 fragmented and hard to understand. So what that meant was
34 that we didn't really have any level of certainty around
35 what capital funding would be coming, and that - and for
36 the reasons that we've described around the condition of
37 the buildings and equipment, et cetera, that became
38 a concern for us, because if I think about our private
39 business, we're very clear about how much money we can
40 invest into our buildings and our equipment, et cetera,
41 from a capital perspective, so to step into a new contract
42 where that was unclear represented a risk to us.
43

44 Q. Whilst it may have been happening everywhere, or you
45 may have been told it was happening everywhere, an
46 organisation like St John of God is in a subtly different
47 position to the ministry, is it not, insofar as the

1 obligations owed by its directors are concerned?

2 A. Sorry, can you just rephrase that question?

3

4 Q. Let me be more blunt about it. As a private entity,
5 albeit a not for profit entity, the directors of St John of
6 God have obligations under the Corporations Act including
7 not trading whilst insolvent?

8 A. Correct, sorry, yes.

9

10 Q. So to the extent that there might be a deficit, and
11 perhaps a significant deficit, in the funding going
12 forward, which creates a hole in a budget, that has
13 consequences in the hands of the directors of an
14 organisation like St John of God which might not be shared
15 by others working more broadly within the ministry who are
16 under the same budgetary pressures; would that be right?

17 A. Yeah, I think private and public health are
18 completely - are different in that respect. So overspends
19 that occur in public hospitals are resolved one way or
20 another through additional funding top-ups. We don't have
21 that ability. Although we are a not for profit, we run as
22 a business, so if we start to run at a deficit in a
23 hospital, that's a big problem for us because there aren't
24 other funding pots that we can go to to get that money. So
25 it's a very different operating environment and I think
26 that is one of the key challenges of running PPPs.

27

28 MR MUSTON: Could I ask the operator, is Mr Edwards going
29 to be able to see the documents that get brought up on the
30 screen if I refer them to him?

31

32 Q. I might go briefly to some documents, Mr Edwards. The
33 first is [SJ0.0001.0005.0046].

34

35 THE COMMISSIONER: Do you have a G number for that as
36 well?

37

38 MR MUSTON: I do have a G number. It is G.014, at least
39 in my folder.

40

41 Q. Do you see that document, Mr Edwards, and recognise it
42 as the Hawkesbury District Health Service pricing proposal
43 for FY2023/24, dated April 2023?

44 A. Yeah, I can see it. I'm not hugely familiar with that
45 document but I can see it.

46

47 Q. Insofar as you are familiar - and tell us if you're

1 not in a position to answer any of these questions - that's
2 a document, at least on its face, that would appear to have
3 been prepared by St John of God and submitted to the LHD?

4 A. I'm trying to have a look at it now.

5
6 Q. If you need us to scroll through it in any way just
7 sing out. The operator can roll through to any page that
8 would assist you.

9 A. So based on what I'm seeing in front of me, it appears
10 that --

11
12 THE COMMISSIONER: Q. Perhaps go to the next page. You
13 will see 1.1 "SJGHC propose"?

14 A. Yeah, okay, so - yes, so, having read that, it does
15 look like a document that we've put together to propose
16 pricing for those two financial years, yes.

17
18 MR MUSTON: Q. So that, at least as you understand it,
19 is the document or a document through which St John of God
20 was seeking funding for the 2023/2024 financial year?

21 A. Correct, and I think there were several documents and
22 correspondence exchanges relating to that matter, yes.

23
24 Q. Just in terms of the document itself, and accepting
25 that it might be loosely alluded to in that
26 paragraph commencing "The pandemic" on page 2 that's up on
27 the screen, the document doesn't explicitly spell out any
28 of the matters that you've identified in paragraphs 34 to
29 38 of your statement - the particular cost pressures. And
30 again, if you need us to scroll through --

31 A. No, it's fine. So I guess it would - my comment would
32 be that it refers to them at a high level.

33
34 Q. It seems, just scrolling through, for example, to
35 page 3, under the heading "1.2.1 Acute Services", it
36 identifies an amount of - or last year's volume of service,
37 NWAU, that was to be delivered, proposes a sum for 2023,
38 annualised and normalised, and then explains why it says
39 there should be, for that year, at the end of that little
40 piece, 9,804 NWAU attributed to acute services as part of
41 the funding allocation. Do you see that?

42 A. Yes, I guess what I can see in here is comments
43 referring to COVID, impacts on the hospitals; I can see
44 comments that refer to:

45
46 *... the volume allowed this year is not*
47 *sufficient to meet demand within the*

1 *catchment, even when not taking into*
2 *consideration addressing of the backlog of*
3 *patients ...*
4

5 therefore, we were proposing significant growth in addition
6 to the funding required and we needed more weight in this
7 money.

8
9 So I think buried within the body of this document
10 there are several points where we are calling out the fact
11 that we need more money. Even just another one here:

12 *[St John of God] also seeks your advice as*
13 *to funding allocations to Emergency*
14 *Departments to fully implement the*
15 *recommendations of the Anderson Report.*
16 *Initial calculations suggest this cost is*
17 *in excess of 480,000...*
18

19
20 Effectively asking for that money. So I'm not across all
21 the detail, but just from a quick read of this, there are
22 several points within it where we are effectively
23 requesting increases in funding and justifying why.

24
25 Q. So I guess - maybe I'm misunderstanding it - it seems
26 that the purpose of this document is to identify the amount
27 of activity which it is anticipated will be generated
28 through the hospital and seek a funding allocation linked
29 to that level of activity?

30 A. Correct.

31
32 Q. But other than in the respects that you've identified,
33 it doesn't seem to say, for example, that the state
34 efficient price or that the state price payable in respect
35 of each of those units of activity is not enough to
36 actually meet the cost of delivering that unit?

37
38 THE COMMISSIONER: Or to meet the demand.

39
40 MR MUSTON: Well - I'll come back to that.

41
42 THE WITNESS: Yeah, look, without reading the whole thing
43 now, I can't kind of comment one way or the other.

44
45 MR MUSTON: Q. There would be two issues. The first is
46 demand, and insofar as demand for services is concerned,
47 that's something which presumably is sought to be

- 1 recognised through the level of activity which is
2 identified - that is to say, if demand increases, then you
3 would seek more activity?
4 A. Correct, and I think that - I'm just having a look.
5 I think that's spelled out fairly clearly in here.
6
7 Q. Yes, it is.
8 A. Based on - yeah, so that point is made, yeah.
9
10 Q. Do we gather from that that it was anticipated that
11 there would likely be an increase in activity and,
12 therefore, more units of activity should be included as
13 part of the budget --
14 A. Yeah.
15
16 Q. -- in the service agreement that was to flow from
17 this proposal, in a range of different areas?
18 A. Yeah.
19
20 Q. And then the next --
21 A. The bit that refers to the funding rate is in 1.1,
22 which spells out some kind of stipulations around what
23 should be included within the price and refers to
24 historical pay rises and super, et cetera, so those were
25 points that, from a rates perspective, were going to be
26 negotiated as well.
27
28 Q. Would it be right to say that this document came on
29 the back of a lengthy series of performance discussions
30 that had been had between St John of God and the LHD where,
31 as I think you've told us, these particular price pressures
32 had been canvassed in some detail?
33 A. My understanding of this document is that it was
34 something that was prepared, you know, annually as part of
35 the pricing discussions, and so I think, in the background,
36 the performance discussions that we've talked about would
37 have been occurring. But I wouldn't suggest that this
38 paper would have been a result of that. This would be part
39 of a standard process of going through a negotiation.
40
41 Q. Sorry, I might not have expressed myself clearly. So
42 this was a standard document which was produced each year,
43 the purpose of which was to identify, in essence, the
44 amount of activity which St John of God anticipated that it
45 would be purchasing, or would be purchased from it by the
46 LHD during the upcoming financial period?
47 A. Correct.

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THE COMMISSIONER: G.011 is another example from a prior financial year.

MR MUSTON: Yes.

Q. But I guess the short point is there's not a detailed articulation in this document of the extent to which the state average price which was payable for each of those items of activity, which had been identified, was insufficient to actually meet the cost of delivering that unit within Hawkesbury hospital?

A. I can't see that in this document.

Q. Do you have a recollection, during any of the performance meetings, of actually going through in a detailed way the numbers with the LHD - that is to say, identifying exactly how the deficit between funding and the cost of delivering services at Hawkesbury hospital had arisen?

A. Yes. So - I mean, to your point about level of detail, it's probably harder to answer, but what we were very open and transparent about was the financial performance of the hospital. So we were - you know, we had a fairly open book around - once things started to become clear that financial performance was deteriorating quickly, we were sharing that information at the monthly performance meetings, like the size of our deficit, what we believed the key drivers were, which were a range of things that we discussed at the moment, yes.

THE COMMISSIONER: Q. Just before we leave that document, there's just one thing. Can we go to the next page, please. Can you just tell me - see under the heading "Acute - Waiting List", do you see the sentence commencing "In addition to the above"?

A. Sorry, which "Acute - Waiting List"?

Q. "Acute - Waiting List":

In addition to the above, funding is required to achieve 0-0-0 ...

Do you see that?

A. Yes.

Q. What does "achieve 0-0-0" mean, do you know that?

1 A. So that's about achieving state targets to minimise
2 the number of people who are waiting for surgery, which is
3 a fairly common target.

4
5 MR MUSTON: Q. But as at '23/24, there was - perhaps
6 coming to the tail end of it, there had been a period of
7 working through a significant backlog of a type of surgery
8 as a consequence of the shut-down during COVID; is that
9 right?

10 A. Yes, correct. It's not unusual for, in the public
11 sector, hospitals to be asked to undertake additional
12 levels of activity, usually surgical, kind of backlog work,
13 to catch up, and that would certainly happen to us at
14 certain points during the year, and we could either - we
15 either were or weren't able to help depending on how busy
16 we are at that time.

17
18 Q. Can I get you to go back to a document which I think
19 in your folder is G.013. It's [SJ0.0001.0005.0044]. It's
20 a letter dated 2 August 2023.

21 A. Is that a letter to Strephon?

22
23 Q. It is, 2 August 2023. Do you have that letter in
24 front of you?

25 A. Yes.

26
27 Q. So just looking at the first --

28
29 THE COMMISSIONER: Is this the response to G.014, the
30 prior document?

31
32 MR MUSTON: At least insofar as the documents we've seen
33 are concerned, this seems to be something of a response to
34 the pricing proposal dated April 2023, which we've just
35 gone through.

36
37 Q. Do you know whether it is, Mr Edwards?

38 A. Whether - sorry, whether it is what?

39
40 Q. Dealing with the first block of it down to the point
41 at which we get to the small bullet points, it seems to
42 talk about the deferral of the budget?

43 A. Yeah.

44
45 Q. It gives you some facts about the state efficient
46 price and gives you some facts about what the LHD has
47 received. Just dealing with those things quickly in turn,

1 the deferral of the budget, whilst perhaps a political
2 necessity, what was the impact, or what impact does that
3 have on a private organisation like St John of God?

4 A. That's a significant problem for us, because it
5 creates a big vacuum in our ability to plan. So if we
6 don't know what budget we have, it makes it really
7 challenging to understand what needs to be done to ensure
8 that the hospital can operate sustainably. It creates
9 a level of uncertainty, and that was a big factor, in terms
10 of that lack of clarity.

11
12 Q. Is that a political reality that you experience in
13 other jurisdictions that St John of God operates, or has it
14 been done differently or better in other jurisdictions from
15 the perspective of an organisation like yours?

16 A. We haven't experienced significant delays like that.

17
18 Q. So could I come down to the bullet points, just at the
19 bottom of the first page there. The letter is to formally
20 advise Hawkesbury District Health Service of the following:
21 the first is the interim allocation, which is basically the
22 same as the 2023 allocation. Do we take it from that, that
23 to the extent that the document that we've just been
24 looking at - that is, the April 2023 pricing proposal - was
25 seeking an increase in activity, that at least as at
26 2 August no increase had been forthcoming?

27 A. Correct. So we effectively had said, based on our
28 understanding of the demand that was coming through the
29 facility, that we needed to - that we would need to
30 increase our activity, and our interpretation of this was
31 saying that there was no funding to support that.

32
33 Q. Dealing with the next bullet point, could you explain
34 to us what you understood that to mean?

35 A. So I believe this is a conversation around clearing
36 backlogs on waiting lists, so people who have been waiting
37 for operations and what would need to be done to - and the
38 amount of activity that would need to be undertaken to
39 clear that backlog.

40
41 Q. And then in the third bullet point, "Non-ABF
42 components" are set at FY2023 amounts. What were the
43 non-ABF components that sat within the budget allocation
44 each year, in general terms?

45 A. Yes, so that would be things like the capital funding
46 that we discussed earlier would come out of - would not be
47 ABF; the top-ups we've talked about, so if we were required

1 or asked to undertake additional activity; and sometimes
2 there were - we would refer to things as "top-ups", which
3 were additional funding amounts that were provided
4 throughout the year which could be related to things like
5 backdated salary and wages increases or information
6 technology or unforeseen events. And so I think what that
7 was saying was there wasn't clarity, again, around that,
8 which probably, I think, was - probably all of this
9 contributed to a situation where, from our perspective,
10 there was just not a high degree of certainty around how
11 much funding we would receive for running the hospital.
12 And I recognise that public is very different to private,
13 but that's a very different sort of operating environment,
14 where effectively, from a private perspective, it's a very
15 simple calculation to understand the patients that you
16 treat; there's a clear formula that attaches a revenue to
17 them and, therefore, once you understand your activity, you
18 know what revenue you're going to get.

19
20 For the reasons we're describing here, it was more
21 opaque and difficult to understand the funding we were
22 going to get and, therefore, when we were at this point of
23 negotiating the contract, that effectively created a - you
24 know, a potential financial risk to us, particularly in
25 view of some of the new clauses within the contract which
26 had been proposed, which would - could potentially have
27 increased that level of risk.

28
29 Q. So turning over to the second page of that letter, you
30 see there's the table at the top, and then if you track
31 down three paragraphs, there's a paragraph commencing, "The
32 escalation provided to date". Are we to understand that,
33 or perhaps I should say did you understand that as saying
34 the interim allocation that was being made did include some
35 level of escalation on the 2022/2023 figures, in the amount
36 of 2.51 per cent?

37 A. That's my understanding, yes.

38
39 Q. But what it appears was being said there is that that
40 had not taken into account some wage increases which
41 were --

42 A. Yeah. I would say roughly - roughly - our costs were
43 increasing above 5 per cent at that time, across the board,
44 so --

45
46 Q. I gather from that that the 2.51 per cent increase did
47 not come close to bringing about a situation where the

1 funding reflected the actual cost of delivering the
2 services to be delivered through Hawkesbury hospital?
3 A. No, no, and that - and to get to the punch line here,
4 that became abundantly clear in the early months of this
5 financial year where our financial performance at that
6 hospital deteriorated very quickly and very significantly,
7 so it became very evident that there was a significant gap
8 between the - you know, we hadn't changed the services we
9 were providing, there was the same service at the hospital,
10 that hadn't changed. But the cost profile had changed, the
11 funding profile had changed, but the relationship between
12 those two financial, you know, inputs hadn't changed to the
13 point where the funding covered the costs, and almost
14 immediately, when we moved into FY24, which is July, we saw
15 a profound difference and were rapidly forecasting
16 a \$5 million deficit for the full year, which we did
17 explain to the LHD.

18
19 Q. Let's creep our way towards that, step-wise. The next
20 document I want to take you to is G.012, which is, for the
21 operator, [SJ0.0001.0005.0041]. Do you have that document
22 in front of you? It is a letter from the LHD to
23 Strephon Billingham dated 25 October 2023?

24 A. Sorry, I'm just trying to find it.

25
26 Q. I think in your folder it's probably G.012?

27 A. Yeah, my tabs are numbered.

28
29 Q. It should be number 12. Tab number 12, I'm told.

30 A. Twelve? Okay, cool. Yeah, got it.

31
32 Q. And just to make sure we've both got the same thing in
33 front of us, it's a letter dated 25 October 2023?

34 A. Yeah, yeah.

35
36 Q. So it would seem that this is the letter that was sent
37 once the budget had been finalised and the interim position
38 referred to in that 2 August 2023 letter had morphed into
39 a more final conclusion on the service agreement --

40 A. Yes.

41
42 Q. -- that was to be in existence as between the LHD and
43 St John of God; is that as you understand the broad context
44 in which this letter was received?

45 A. Yes.

46
47 Q. On that first page, they tell you a range of

1 interesting things about the health budget and a
2 comprehensive expenditure review being undertaken by the
3 government, but in the final --
4

5 THE COMMISSIONER: Why, I ask rhetorically. Why does that
6 need to be in this letter? You don't have to answer that,
7 nor does the witness.
8

9 MR MUSTON: Well, I can ask the witness.
10

11 Q. Do you think anyone within St John of God found that
12 information particularly useful in the context of its
13 operations - that is to say, everything up to at least the
14 subheading on page 2, "NSW Health State Price"?

15 A. I think probably the politest way to answer that
16 question is that we were interested in the information that
17 related to us.
18

19 Q. Just if I could take you back to page 1, in the final
20 paragraph, there's a reference to the "challenging
21 financial landscape". Did you understand that to be
22 a reference to the escalation factors that you have
23 identified as driving up the cost of delivering health care
24 within the wider context of Australia, or did you
25 understand the challenging financial landscape to be more
26 a reference to the amount of money that the LHD had been
27 provided for the delivery of services?

28 A. My - if you're talking about the paragraph that begins
29 "In a challenging financial landscape" --
30

31 Q. I am.

32 A. -- my personal interpretation of that is,
33 effectively - and I may have misinterpreted this -
34 a suggestion that we needed to cut costs, you know,
35 including, you know:
36

37 *... will require strong financial controls*
38 *including affordable FTE levels and*
39 *achieving Efficiency Improvement Plans.*
40

41 That's the sort of language that you use when you are
42 saying, "You need to strip out cost." By that stage we had
43 undertaken our efficiency review and we were absolutely of
44 the view that there were no further efficiency savings that
45 could be made at that hospital without creating significant
46 risks, so we did not agree that that was a way forward that
47 would help us. What our feeling was was that we needed

1 more funding in order to reflect the additional cost of
2 running the hospital.

3
4 Q. Just dealing with the efficiency review - and I think
5 you've probably answered this but to make sure temporally
6 we are right - at some point by or before 25 October 2023,
7 are you satisfied that you had communicated to the LHD that
8 such efficiencies as could be won within Hawkesbury
9 hospital had been found and secured?

10 A. So we had fed that to them verbally in the meetings
11 that we'd had, that we'd undertaken a review and that we
12 did not feel that there were further efficiency savings
13 that could be made, and I think said, "If you want to come
14 and have a look yourself and see what you can find, that's
15 fine, but we've undertaken a fairly rigorous review and we
16 cannot find any further savings."

17
18 I mean, we compared the Hawkesbury to most of our -
19 many of our other hospitals, and it was clear that it was
20 at the very bottom end in terms of cost and efficiency, in
21 the sense that it was running very lean.

22
23 Q. In terms of the invitation that you've just alluded to
24 to "come and have a look yourself", was that ever taken up
25 by anyone within the LHD?

26 A. Yes, look, so I think, yes, there definitely was
27 interactions. I would have to say the LHD were proficient
28 at looking at data and asking questions about why things
29 were happening, the length of stay example was one that
30 I used earlier, and so it was clear that they were
31 monitoring what we were doing and having a look, as opposed
32 to standing back.

33
34 Q. In terms of at least your interactions with the LHD,
35 at any point prior to 25 October 2023, had anyone from the
36 LHD actually told you, as a result of this process we've
37 just canvassed, that there were further efficiencies which
38 you could find within Hawkesbury hospital?

39 A. I think it was insinuated at times through comments
40 like, kind of, the length of stay piece, and I can't
41 remember the details but I believe - I believe that there
42 were conversations around, you know, "Are there other
43 changes that could be made here to save further money?"
44 Which we would periodically look at, because, you know,
45 often in a hospital you will find other things - that there
46 are other things that you can do. So, yes, those sorts of
47 comments were made to us.

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Q. Just tracking down to the second page of the document under the subheading, "NSW Health State Price", did either the state price or the state efficient price, insofar as you were aware, reflect the cost of delivering a unit of service at Hawkesbury hospital?

A. No, and obviously particularly the state efficient price was a concern, because it is less, and that's something that we became aware of fairly late on in the process and added to our concerns. Effectively we would - when you were asking me questions earlier about volume, I guess this is when we started to get into the rate piece here, and it became clear that we would be getting paid at a lower rate when we were --

THE COMMISSIONER: Q. When you're using the term "less" in relation to the state efficient price, you mean less than the cost, do you?

A. No, sorry.

Q. Or less than something else?

A. Yeah, yeah, what I was referring to was if you look at the paragraph that says "NSW Health State Price", it says the NSW State Price for 2023-24 is \$5,323 per NWAU23, whilst the New South Wales State Efficient Price is \$5,207", which is less, and that's the one that we were going to get funded, so it became clear that that was a reduction in price, effectively.

MR MUSTON: Q. Did you have a view about or did anyone make any analysis within St John of God, about whether the New South Wales state price - that is, the slightly higher number - accurately reflected the cost of delivering a unit of service at Hawkesbury hospital?

A. Look, not in a forensic way. I guess the way that we came - the way that we undertook our review was we looked at how the hospital was operating and because we run a lot of hospitals, we have a lot of benchmarking data that we can use that helps us understand whether something's being run efficiently or not. So we looked at that piece of work, because if you find that a hospital isn't being run efficiently, then it may well not be a funding issue.

So the first thing that we looked at was is the hospital being run efficiently and the answer was unequivocally yes, you know, incredibly efficiently - you know, the most efficient of all of our hospitals. And so

1 the fact that when you then combine that with the outcome
2 that we were losing money clearly pointed towards there
3 being a funding issue.
4

5 Q. Can I track down to the subheading "HDHS Budget",
6 immediately above the table. I will make this observation,
7 you can check my arithmetic if you need to, but with the
8 exception of the figure identified for ED, it appears that
9 all of the figures are lower than the activity which had
10 been sought in the proposal dated April 2023. Do you have
11 a recollection of whether that was the case? You may not.
12 A. Yeah --

13
14 THE COMMISSIONER: Maybe bring that document up, because
15 I want to understand this. Maybe if we can leave that
16 document on the screen but bring up the 0046 document.
17

18 MR MUSTON: Yes, 0005.0046.
19

20 THE COMMISSIONER: And at internal page 0003 - well, 0004.
21

22 MR MUSTON: Q. Start at 0004. We've got "Acute
23 Baseline", and you see at the foot there --
24

25 THE COMMISSIONER: Can you lift the page up a bit, sorry,
26 because there's a bold figure. Yes, 10,285. Should
27 I understand that that's what is sought, and what is given
28 in the prior document is 9,527; is that how I read it?
29

30 MR MUSTON: Yes. Whether it is the 10 that is sought, or
31 even if one tracks back to the paragraph at about point 5,
32 before we get into the "Acute - Waiting List", where an
33 NWAU value of 9,804 is sought for acute services. Either
34 way --
35

36 THE COMMISSIONER: That's the total acute, isn't it?
37

38 Q. I will ask you, sir, 10,285 is the total acute;
39 correct?

40 A. I'm struggling to - I can see the document on the
41 screen. I'm struggling to find the one that you're
42 comparing it with.
43

44 Q. Go back to - you see on the St John of God document it
45 has, "This leads to a combined NWAU value of 10,285 for
46 acute activity"? Do you see that, where the cursor is, if
47 you can see the cursor?

1 A. Oh, yeah, okay.

2

3 Q. And then, looking at the other document, it's got
4 "Acute", 9,527. Do you see that?

5 A. Yes. So my - I'm assuming from there that, yes, we
6 asked for a number, and we received a number that was
7 lower.

8

9 MR MUSTON: Q. The next figure that we come to is
10 "Emergency Department", the document on the screen,
11 Mr Edwards, you see that 1.2.2 "Emergency Department", and
12 if we could perhaps scroll down to the top of the next
13 page, you see there in bold, a request or proposal for
14 3,903 units of activity for "Emergency Department"? Again,
15 next to the cursor?

16 A. Yeah.

17

18 Q. If we track back to the tab 12 document that you're
19 looking at, you see the table there, it does seem to be
20 some more activity than that which was sought being
21 proffered in respect of the emergency department - that is,
22 3,942.

23

24 THE COMMISSIONER: Q. Do you see that, sir?

25 A. Yeah.

26

27 MR MUSTON: Q. I'm content to work through each of them,
28 if it would be helpful, but you can take it that having
29 gone through that exercise, it would appear that other than
30 in respect of that emergency department figure, each of the
31 NWAU allocations set out in the table are lower than what
32 was proposed for in the April 2023 Hawkesbury District
33 Health Service pricing proposal, which is that document
34 behind G.014. Do you have a recollection --

35 A. Yes.

36

37 Q. -- of whether that was or wasn't the case?

38 A. Look, not the - not in detail --

39

40 THE COMMISSIONER: Q. Just make the assumption that it
41 is.

42 A. Yeah, not in detail, but what I remember is that,
43 I guess it was a negotiation and we put forward what we
44 believed we required and then when we got the budget
45 through overall it was less than we were hoping for and
46 expecting, in most areas, as you have said, not all.
47 I think ED may be an exception.

1
2 MR MUSTON: Q. At the conclusion of that negotiation -
3 that is to say, when or shortly after the 25 October letter
4 behind tab 12 was received - did anyone from the LHD
5 explain to you why the amount of activity which you had
6 projected would come through the Hawkesbury hospital was
7 not going to be funded?

8 A. So my recollection is that the main response we got to
9 those sorts of questions just was that there was not enough
10 money overall in the health system and that every LHD and
11 every hospital would be receiving less, and therefore, the
12 experience that we were encountering was just in line - was
13 a reflection of the broader picture that was going on.

14
15 THE COMMISSIONER: Q. Do I assume from your answer, at
16 least to your knowledge, no-one from the LHD said, "Look,
17 the activity amounts in your pricing proposal are just
18 plain wrong and here's the reason or reasons for that";
19 rather, it was there just wasn't enough money?

20 A. I do not recall there being any discrepancies around
21 volume, like, disagreements around volume. What I remember
22 from the discussions was that they were focused around
23 availability of funding.

24
25 Q. And I think you've probably answered the next question
26 within that answer, but you're not aware of a document that
27 was provided by the LHD or any other aspect of NSW Health
28 that says, "Thanks for your pricing proposal, but here are
29 the written reasons why it's wrong", for whatever
30 particular reason?

31 A. I'm not aware of one. It's possible that one could
32 exist that I haven't seen but I'm not aware of one.

33
34 THE COMMISSIONER: Thanks.

35
36 MR MUSTON: Q. Can we go forward now to the document
37 behind tab G.015, which for the operator is SJ0 --

38
39 THE COMMISSIONER: I'm in your hands because this witness
40 is online as to when we take a break. If you want to keep
41 going to finish the witness, that's fine.

42
43 MR MUSTON: I'll probably be 10 minutes.

44
45 THE COMMISSIONER: Let's do that, keep going.

46
47 MR MUSTON: Q. [SJ0.0001.0006.0046].

1 A. Yeah.

2

3 Q. Just to make sure we're looking at the same document,
4 it is a letter from Strephton Billingham from St John of
5 God to Lee Gregory dated 28 November 2023. Do we have the
6 same document in front of us?

7 A. Yeah, I've got it, yes.

8

9 Q. Do you see on the first page there, if you track down
10 to the subheading, "New South Wales State Price", do you
11 see in the first paragraph there it seems that you have
12 again told them about the efficiency review that was
13 undertaken?

14 A. Correct.

15

16 Q. In respect of that, do you recall receiving any
17 response to that proposition from Mr Gregory or anyone else
18 from the LHD?

19 A. I don't recall receiving anything. There may have
20 been something, but not that I can recall seeing.

21

22 Q. Turning over to the second page, to the paragraph
23 immediately above the subheading "HDHS Activity", the
24 letter expresses a conclusion as to the financial forecast
25 and the loss which was anticipated. Again, do you recall
26 receiving any response to that letter or was any doubt
27 expressed by anybody from the LHD, Mr Gregory or otherwise,
28 at least to you, about the correctness of your prediction
29 that there would be a \$4.8 million loss?

30 A. No. I think my recollection is that they trusted our
31 calculations and that was never challenged.

32

33 Q. In relation to capital, could I just ask you to go
34 down to the bottom paragraph on the second page there,
35 commencing, "Whilst we appreciate"? Could you tell us
36 briefly what your understanding of the independent audit
37 that had been on the agenda for over 18 months comprised,
38 if you know?

39 A. Yeah, look, so I wasn't directly involved, so I could
40 only speak at a high level here. My understanding is that
41 there had been an ongoing dialogue about a series of
42 effectively infrastructure upgrades, you know, and
43 equipment upgrades, like I was referring to earlier, and at
44 some stage it was proposed that an audit would be
45 undertaken by the LHD to undertake an audit to inform that.
46 However that work took a very long period of time, and
47 I think you will see there that 18 months was referenced,

1 and I was certainly in meetings where the question was
2 asked, like, "Where are we with the audit? What's the
3 outcome?" And I think the hope from our perspective was
4 that the audit would highlight that capital funding was
5 required and that they would be forthcoming.
6

7 I think, and you can see we spell out there, that
8 based on work that we had undertaken, we had identified
9 around \$3 million of capital required urgently to progress,
10 and that was a rather circular conversation, and at several
11 of the meetings that I was at, we asked the question,
12 "Where are we with the audit? When will we get an outcome?
13 What does that mean about funding?" - yes.
14

15 Q. Just in relation to the audit, are you aware of what
16 stage it had reached? I mean, at least from the
17 perspective of St John of God, are you aware of an occasion
18 when an auditor went and walked around?

19 A. Yeah, yeah, so my - I believe the work certainly was
20 undertaken and there were people out on site having a look
21 round, et cetera, and --
22

23 Q. Who was doing that work, do you know?

24 A. I couldn't name them. I think it was relevant kind of
25 experts, either from the LHD or perhaps contracted by the
26 LHD and I think --
27

28 THE COMMISSIONER: Q. But if it was by the LHD, it's not
29 an independent audit, at least as I would understand it.
30 Was it an external firm or people within the LHD?

31 A. I can't be definitive. I thought it - I thought it
32 was overseen by people within the LHD, but I cannot be
33 absolutely certain of that. It's something you would want
34 to check with them.
35

36 MR MUSTON: Q. So at around this time, you were at the
37 pointy end of the negotiations around the potential
38 extension of the contract between St John of God and the
39 LHD in respect of the continued operation of Hawkesbury
40 hospital; is that right?

41 A. So this was November. I think, to be honest, by this
42 point we were close to making a decision. So in - I mean,
43 those negotiations had been going on for years. They were
44 very protracted and slow with, you know, terms sheets
45 bouncing between solicitors, et cetera, so they had been
46 going on for a long time. I can't remember the exact dates
47 here, but towards the back end of that year, we had formed

1 a view off the back of the efficiency review that
2 I mentioned earlier, which was it didn't make sense for us
3 to be involved, and so I think the correspondence that we
4 were receiving, like the one we've just looked at, really
5 was just confirming that where we had landed with our
6 thinking was probably the correct place to have landed.

7
8 Q. Can I just step through the chronology with you
9 briefly?

10 A. Yeah.

11
12 Q. You have your two years' worth of discussions and
13 contract extensions relating to the prospective continued
14 operation of the facility by St John of God. As we
15 understand it, on 1 September 2023, St John of God
16 indicated that it would accept a terms sheet that had been
17 produced at the conclusion of those two years worth of
18 negotiations as a way forward. Is that something that you
19 recall?

20 A. I - sorry, so we did accept a terms sheet. I can't
21 remember the exact date.

22
23 Q. Just assume for present purposes that documents
24 suggest it's 1 September. On 18 October, the LHD --

25
26 THE COMMISSIONER: 1 September 2023?

27
28 MR MUSTON: 2023.

29
30 Q. On 18 October 2023, the LHD communicated to St John of
31 God that it also accepted the then iteration of the terms
32 sheet. So it would seem that by 18 October, at least
33 a potential bargain, subject to documentation, had been
34 reached as between St John of God and the LHD. I don't
35 intend to suggest it was binding in any way, but what
36 I would like to explore with you is what changed between
37 1 September and then 5 December, when the letter you allude
38 to in your statement was sent confirming that St John of
39 God would not continue in its operation of Hawkesbury?

40 A. Yeah, so I think the simplest way I can answer that is
41 that once financial year '24 began, which was July, we
42 started to see that rapidly deteriorating result, and, you
43 know, often you'll have a month or two that's difficult,
44 but it is a blip and you come back, so kind of July,
45 August, fine. By the time we get to September it is
46 a trend and a profound and significant trend.

47

1 So whilst these discussions were happening around the
2 terms sheet, simultaneous to that it was becoming clear
3 that the financial viability of the hospital was
4 deteriorating very rapidly. That triggered the review
5 which probably would have been undertaken in
6 maybe September time and taken a while to have kind of
7 written up and revised and reviewed, and start to make
8 a decision, and then - so I believe that that review was
9 then formalised in the November, where we had an internal
10 discussion, presented - had that discussion with our board,
11 it would have either been in November or December, and it
12 was that that made the decision clear that it was not in
13 our interests to continue.

14
15 So effectively, we had two things happening at the
16 same time: you had this ongoing negotiation which had led
17 to a terms sheet, and alongside that, the work that my team
18 was doing in response to rapidly deteriorating results to
19 try and understand why, what was going on. And then
20 I think what that meant was that some of the clauses within
21 the proposed new contract, which initially didn't seem very
22 problematic, suddenly seemed a lot more problematic, and
23 changed our opinion on those clauses.

24
25 Q. That rapid deterioration in the financial position of
26 the hospital is a function of two things, I think you've
27 told us: first, escalations in the costs of delivering the
28 services. Is that one of the --

29 A. Correct, yeah.

30
31 Q. And, secondly, and importantly, a failure in the
32 funding mechanism to keep up with those increases, such
33 that the amount of funding that was being offered,
34 including through the 25 October letter that we were
35 looking at a moment ago, simply was insufficient to meet
36 the costs of delivering those services; is that right?

37 A. Correct. Yes, it's - I think it is as simple as that.
38 So in health service provision, the two big factors are how
39 much does it cost you to provide your services and how much
40 are you being funded, and if those two, you know, dynamics
41 are in line, then things work; if they start to slip out of
42 line, you have a problem, and that's effectively what
43 occurred during that period and it just happened very
44 rapidly.

45
46 Q. So to the extent that one of the factors, the local
47 factors, you've identified as driving the decision not to

1 renew was the commercial and financial performance of the
2 hospital, it really boils down to what you perceived to be
3 the inadequacy of the funding that was provided, or being
4 offered, by the LHD for the delivery of the services
5 contemplated by the service agreement? And, presumably,
6 future service agreements?

7 A. Yeah. I mean, look, if we'd undertaken the efficiency
8 review and had found that the hospital was incredibly
9 inefficient and there was lots of, you know, surplus costs,
10 then we would have undertaken a cost reduction exercise to
11 resolve that, but we didn't; we found out that it was
12 running extremely efficiently, which left us with no other
13 conclusion to draw than the issue was funding, and we saw
14 no prospects, based on the discussions that we had been
15 having, that that was likely to get any better in the short
16 to medium term. And there were clauses within the new
17 contract which we would have had to have signed which would
18 have placed us at a significant risk if that had continued,
19 just in terms of how many years of poor results we would
20 have had to have experienced before we could exit the
21 contract, which was a new clause.

22
23 Q. Could I ask you to jump forward to paragraph 53 of
24 your statement.

25 A. Yeah.

26
27 Q. You see there, you express on the part of St John of
28 God, but presumably it's your own view, that you consider
29 it will be in the best interests of the community, patients
30 and staff for Hawkesbury hospital to be operated by the
31 Nepean Blue Mountains LHD, which will allow it to be fully
32 integrated into the public health and hospital system in
33 New South Wales? Just to be clear, that's a view you
34 personally hold, I take it?

35 A. Yes, it is. Yes.

36
37 Q. In what way, or what material way, did you think
38 Hawkesbury hospital was not fully integrated into the
39 public hospital system when it was being operated by
40 St John of God?

41 A. Yeah, so I think there's probably two kind of macro
42 factors that I would pick out as being significant.
43 I think the first is just that when you have a PPP
44 arrangement, it brings in a different level of complexity,
45 so rather than it being, you know, government - state
46 government working right from the top all the way through,
47 you are dealing with another party with a different

1 working, and therefore, there is a different dynamic, which
2 I think can sometimes be unhelpful. That's the first
3 thing.

4
5 The second thing is that I observed that because the
6 hospital was not part of NSW Health, there were areas where
7 it lost out, and I think a good example of this is the
8 significant investment that has happened into IT across,
9 I believe, virtually every other public hospital in
10 New South Wales. I'm talking about an EMR, electronic
11 medical record, which is a significant investment. I think
12 most or if not all public hospitals in New South Wales have
13 an EMR. Hawkesbury doesn't, right? And so I would point
14 to that as an example of where the funding mechanisms, the
15 PPP arrangement, meant that, for whatever reason, that
16 didn't happen, and then local patients, effectively, are
17 disadvantaged compared to patients who are attending other
18 hospitals which have that significant technology investment
19 in place, and that's just one example.

20
21 MR MUSTON: Thank you, Mr Edwards.

22
23 I have no further questions for this witness,
24 Commissioner.

25
26 THE COMMISSIONER: Mr Chiu, do you have any questions?

27
28 MR CHIU: Just a couple of questions, yes.

29
30 **<EXAMINATION BY MR CHIU:**

31
32 MR CHIU: Q. Mr Edwards, my name is Chiu and I represent
33 NSW Health in this inquiry. Could I take you back to the
34 document that was G.015. This is the letter from St John
35 of God to the chief executive of the LHD dated 28 November
36 2023. Do you have that?

37 A. Yes, I've got it.

38
39 Q. You've got that document in front of you?

40 A. Yes.

41
42 Q. Could I take you to the bottom of page 2. You were
43 asked some questions earlier by counsel assisting about the
44 reference there to an independent audit. Do you recall
45 those questions?

46 A. Yeah.

47

1 Q. Was it the case that the independent audit was, in
2 fact, conducted by a contractor independent of the local
3 health district? Is that your recollection?

4 A. Yes, so I honestly couldn't say, and I wouldn't want
5 to misspeak as to that. I'm not - I'm not sure who
6 undertook it.

7
8 Q. Right.

9 A. I think it was - I think obviously it was commissioned
10 by the LHD. In the - in terms of kind of who actually came
11 out to the site to do the auditing, I'm not clear as to
12 whether that was, you know, LHD employees or an external
13 contractor. Yeah, I don't know.

14
15 Q. Do you recall that when the report came out, a copy
16 was provided to St John of God for review?

17 A. I do believe that we saw a copy of the report, yes.

18
19 Q. And do you recall when that was?

20 A. I don't, I'm sorry.

21
22 Q. Was it the case, and tell me if you don't recall, that
23 by the time the report came to St John of God, you had
24 already made the decision not to extend the contract?

25 A. It was all around - I think a lot - I can't give you
26 a definitive answer and it's not because I'm dodging; it's
27 more just because so many things were happening at the same
28 time, it felt like everything was coming together at the
29 same time. So, you know, we were negotiating the terms
30 sheet. There were - in addition to that, below that there
31 was negotiations around the funding. There was pieces like
32 this audit, there was our review - all seemed to be
33 happening at a similar time, so I couldn't - I could not be
34 clear on the exact timing of that versus our decision, so,
35 sorry.

36
37 Q. No, not at all. One final question --

38
39 THE COMMISSIONER: We note the letter you're referring to
40 is 28 November, the audit hasn't been received yet.
41 Whether it was received shortly after, I don't know

42
43 MR CHIU: Another witness may be able to give that answer,
44 Commissioner.

45
46 THE COMMISSIONER: Yes.

47

1 MR CHIU: Q. Just one final issue, Mr Edwards. When the
2 decision was made not to renew - this was, as I understand
3 from your earlier evidence, a little bit of time after the
4 final terms sheet in September 2023 - did St John of God
5 undertake an analysis as to how much more funding at that
6 time it would require in order to renew the contract?
7 A. Yes, so I think we had a view on how much funding and
8 volume would need to increase and some of that is contained
9 within the correspondence. I think the fact that that was
10 rather a moot point was that whenever we had discussed any
11 sort of either volume or rate increase, the messaging back
12 had been very politely a version of, "That is not going to
13 happen. There is no more money. There's no more money in
14 the system, there's no more money for other LHDs, there's
15 no more money for other hospitals and there's no more money
16 for the Hawkesbury." So I don't think we spent too much
17 time getting into the detail of that because it had been
18 made clear to us that there wasn't additional funding.
19
20 Q. I understand you didn't spend too much time on it, but
21 when you did land on a figure, is that produced in any
22 document anywhere?
23 A. I would have to check. I couldn't say off the top of
24 my head.
25
26 MR CHIU: No more questions, Commissioner.
27
28 THE COMMISSIONER: Thank you.
29
30 Mr Fitzpatrick, do you have any questions?
31
32 MR FITZPATRICK: No questions.
33
34 THE COMMISSIONER: Thank you. Mr Edwards, thank you very
35 much for your time. We're very grateful. You are excused.
36
37 THE WITNESS: Thank you. Have a good day.
38
39 THE COMMISSIONER: Thanks, you too.
40
41 <THE WITNESS WITHDREW
42
43 THE COMMISSIONER: We will adjourn until 10 past 12. Is
44 that suitable?
45
46 MR MUSTON: Yes.
47

1 THE COMMISSIONER: We will adjourn until 10 past 12 or
2 would you want slightly longer? I'm going to make it
3 quarter past 12 as an executive decision. We will come
4 back at quarter past 12.

5
6 **SHORT ADJOURNMENT**

7
8 MR MUSTON: Commissioner, the next witness is Vanessa
9 Clements, who is sitting in the box.

10
11 **<VANESSA JANE CLEMENTS, affirmed: [12.16pm]**

12
13 **<EXAMINATION BY MR MUSTON:**

14
15 MR MUSTON: Q. Could you state your full name for the
16 record, please?

17 A. Vanessa Jane Clements.

18
19 Q. And you're the director - planning redevelopment and
20 project management office for the Nepean Blue Mountains
21 LHD?

22 A. Yes.

23
24 Q. That's a mouthful?

25 A. Yes.

26
27 Q. You've held that role since January 2022?

28 A. That's correct.

29
30 Q. And have you had any previous roles within the public
31 health system?

32 A. In the public health system, yes.

33
34 Q. What is your public health background prior to coming
35 into your current role?

36 A. So I moved to Australia in 2006. Prior to that,
37 I worked in the NHS. By trade I'm a midwife. My first few
38 roles in New South Wales were in sort of maternity
39 services, I worked at Sutherland Hospital and then the area
40 health service and St George Hospital. I then worked for
41 the perinatal services network and then have worked for
42 a number of years in the Ministry of Health before coming
43 to the district in 2022.

44
45 Q. Could you give us just a very brief description of
46 what your role as director - planning redevelopment and
47 project management office within the Nepean Blue Mountains

1 LHD actually involves on a day-to-day basis?
2 A. Yeah. So I have two teams within the district, so we
3 have sort of the planning team, so where we sort of
4 undertake all of the clinical services and other health
5 services planning for the district. With my redevelopment
6 hat on, we have a major redevelopment on the Nepean campus,
7 so that's a \$1 billion redevelopment, and other sort of
8 associated redevelopments on the campus, so we've got
9 a child and adolescent mental health unit that we're also
10 building; we've got a community health centre.

11
12 We're also - we were fortunate to, in the last budget,
13 have money for planning and upgrades for the Blue Mountains
14 hospital. So that now sort of falls under my remit too.
15 And then the project management office, or the strategic
16 office, is - we oversee and coordinate strategic or high
17 sort of profile projects for the district, and so the
18 negotiation for the new Hawkesbury contract came sort of
19 under that banner and a number of other - basically,
20 anything that doesn't sit anywhere neatly in the district
21 tends to come to my office to look after.

22
23 Q. You have prepared a statement to assist the Inquiry
24 with its work dated 6 June 2024?

25 A. Yes.

26
27 Q. Have you had an opportunity to read or review that
28 statement before giving your evidence today?

29 A. Yes, I have.

30
31 Q. Are you satisfied that its content is true and correct
32 to the best of your knowledge?

33 A. Yes.

34
35 MR MUSTON: Thank you, Commissioner, in due course that
36 will form part of the bulk tender.

37
38 THE COMMISSIONER: Sure.

39
40 MR MUSTON: Q. Just a moment ago you told us a little
41 bit about the infrastructure funding which had been
42 received by the LHD, or has been received by the LHD in
43 recent times. Has any infrastructure funding been
44 received, or was any infrastructure funding sought or
45 received, in respect of Hawkesbury hospital during the
46 period that you've been in the role?

47 A. So last year, in 2023, so the district has an annual -

1 well, the ministry has an annual process whereby each of
2 the districts and specialty health networks can identify
3 key capital priorities for the district, and we actually
4 put up Hawkesbury district hospital, the upgrade of the
5 emergency department, as one of our capital investment
6 proposals to the ministry last year.

7

8 Q. When last year?

9 A. That would be by the end of the financial year last
10 year.

11

12 Q. So some time before 30 June 2023?

13 A. So - yeah. So we would have started working on that
14 probably in January '23.

15

16 Q. When, roughly, to the best that you can recall, was
17 the good news received from ministry in relation to the
18 funding of the upgrade?

19 A. We weren't allocated funding. So we identified it as
20 an area - as a priority area for the LHD.

21

22 Q. So you sought some funding for the emergency
23 department at Hawkesbury hospital, but at least as the
24 process rolled through in the 2023/2024 year, you were not
25 allocated any funding for that?

26 A. No. And we're submitting it again this year.

27

28 Q. In your time, has any other funding, infrastructure
29 funding, been sought with respect to prospective upgrades
30 at Hawkesbury hospital?

31 A. There are ongoing - as Ben, who was - previously had
32 mentioned, there were various items at various stages of
33 the years, I understand, that were identified as priorities
34 for Hawkesbury. My understanding is since 2019, we
35 invested about \$2.1 million in upgrades at Hawkesbury, so
36 that included a big capital investment to upgrade the
37 chillers for their airconditioning.

38

39 Q. Could I ask you, do you have a copy of your statement
40 handy?

41 A. Yes.

42

43 Q. Could I ask you to go to paragraph 10 --

44

45 MR MUSTON: Commissioner, you've got a copy?

46

47 THE COMMISSIONER: I do now, thanks. Mine has "Draft"

1 written on it but I'm sure it's the final one.

2

3 MR MUSTON: I think it probably is not, because I also
4 have one that has "Draft" written on it.

5

6 THE COMMISSIONER: I probably have it somewhere else then.
7 Don't worry, we will live. I will look at the screen.

8

9 MR MUSTON: Q. You tell us in paragraph 10 that when you
10 joined the Nepean Blue Mountains Local Health District, you
11 became responsible for coordinating the negotiations with
12 St John of God in relation to the proposed new services
13 agreement for the operation of the hospital. Just to tease
14 that out, when you refer there to the "services agreement",
15 I assume that's a reference not to the annual service
16 agreement, but rather to a proposed extension of the
17 longer-term arrangement?

18 A. Yes.

19

20 Q. Did you have any role to play in relation to the
21 annual service agreement negotiation and issue process?

22 A. No.

23

24 Q. Who was responsible for that within the LHD?

25 A. The director of finance.

26

27 Q. Do you know whether it was the director of finance or
28 someone else who had final responsibility for determining
29 the amount of funding that would be provided to St John of
30 God under that arrangement annually?

31 A. I'm not directly involved in those conversations.

32

33 MR MUSTON: Could I have the witness shown a document
34 which is at tab G.013, which is [SJ0.0001.0005.0044].

35

36 I'm sorry, I'm told the live stream is currently on.
37 I think the live stream should be off. I think the
38 intention was that --

39

40 THE COMMISSIONER: Yes, I know. I thought that was my
41 order, but maybe it was too broad brush.

42

43 MR MUSTON: I think it's highly likely that --

44

45 THE COMMISSIONER: I don't think we've covered anything -
46 in fact, the entirety of the evidence so far today, with
47 all due respect, probably hasn't required any form of order

1 but I won't revisit the order I have already made.

2

3 MR MUSTON: The people of New South Wales will be spared
4 another day of the back of my head.

5

6 Q. Could I ask you to have a look at that document not
7 yet on the screen, which is [SJ0.0001.0005.0044]. That's
8 a letter from the LHD to Strephon Billingham. Did you
9 have dealings with Strephon Billingham in your role?

10 A. Yes.

11

12 Q. If we could just scroll down to the second page of
13 that document, at the very foot, the bottom of the page,
14 the signature block there, it appears, maybe during a short
15 interregnum at Nepean Blue Mountains hospital, you signed
16 that document?

17 A. Yes. So the chief executive was on annual leave so
18 I was acting as chief executive.

19

20 Q. So in connection with this document, other than
21 signing it in your capacity as the acting chief executive,
22 did you have any involvement in its composition?

23 A. When you're acting as the chief executive, you rely on
24 your colleagues' expertise in their areas.

25

26 Q. So to the --

27

28 THE COMMISSIONER: Q. Does that mean "no", does it?

29 A. No.

30

31 MR MUSTON: Q. So other than signing that document,
32 I think the answer you have given us is that you were not
33 involved in any material way in discussions or decisions
34 around annual funding of St John of God and Hawkesbury
35 hospital pursuant to its annual service agreement?

36 A. Yes.

37

38 Q. Could we jump forward to paragraph 13 of the
39 statement. You tell us there that from September 2022,
40 regular meetings occurred with St John of God to discuss
41 the terms of the new services agreement, and again, this is
42 the longer-term services agreement we're talking about?

43 A. Yes.

44

45 Q. Can I ask, who attended those meetings usually?

46 A. So our legal counsel from the LHD side, St John of
47 God's legal counsel, the chief executive at the time, on

1 both sides, the LHD and St John of God's, and myself, and
2 Ben usually attended.

3
4 Q. In terms of legal counsel, were they internal in-house
5 lawyers or external lawyers that had been retained,
6 starting with the LHD?

7 A. Yes, so the LHD, we had Freehills assisting us, so
8 external to the LHD. St John of God at that time had an
9 in-house lawyer.

10
11 Q. If we move forward to paragraph 15, where you tell us
12 a little bit more about meetings that were held - this is
13 in February 2023 or in the lead-up to February 2023 - you
14 talk about meetings which were held with the deputy
15 secretary, health system strategy and planning, the chief
16 executive officer, the chief procurement officer and
17 yourself to advise on negotiations. Just so I understand
18 that first part there, these are meetings that you and
19 others from within the LHD were having with people within
20 the ministry --

21 A. Yes.

22
23 Q. -- to inform the approach that they were suggesting
24 that you should take in relation to the negotiations with
25 St John of God?

26 A. Yes. So as we started working through the terms
27 sheet, there were areas that we needed to seek ministry
28 guidance as to if the ministry were happy with us sort of
29 taking certain - or agreeing to certain terms.

30
31 Q. In relation to that negotiation process, and with
32 a view to, if possible, ultimately reaching a concluded
33 agreement with St John of God, did you have a view about
34 whether - about who, as between the LHD and the ministry,
35 was ultimately going to have the final say? Perhaps that's
36 a poorly expressed question. Let me put it another way.
37 You talked about seeking guidance from the ministry, in
38 paragraph 15, in relation to the terms that were under
39 discussion with St John of God?

40 A. Yes.

41
42 Q. At the end of that process, you envisaged that there
43 would, hopefully, be an agreed terms sheet which could be
44 reduced to writing as a formal agreement that would be
45 binding as between the LHD and St John of God?

46 A. Yes.

47

1 Q. At the point at which the LHD was going to be
2 potentially saying, "Yes, we agree with this terms sheet,
3 let's go ahead", did you understand that the ministry would
4 need to be consulted to confirm whether or not it was
5 acceptable to the ministry?

6 A. We were - we regularly had check-ins with the ministry
7 to ensure that the ministry would be comfortable with the
8 items in the terms sheet, but if we had got to the point
9 that we did have a draft agreement, we would have sought
10 ministry approval before the signing of that agreement.

11
12 Q. If the ministry hadn't approved to the terms in the
13 draft, the LHD would never have proceeded to sign it,
14 I presume?

15 A. I think we would have tried to negotiate a mutually
16 acceptable clause.

17
18 Q. When you say you would have sought to negotiate, you
19 would have sought to change the agreement with St John of
20 God in a way that made it acceptable to the ministry?

21 A. I mean, the - sorry, I am --

22
23 Q. Maybe I haven't been clear. You, as the LHD, were in
24 negotiations with St John of God --

25 A. Yes.

26
27 Q. -- about an agreement as between the LHD and St John
28 of God?

29 A. Yes.

30
31 Q. You were seeking guidance from the ministry along the
32 way in relation to that? Yes? You have to say it out
33 loud.

34 A. Yes.

35
36 Q. You have, I think, indicated to us that you were
37 concerned - you and others within the LHD were concerned to
38 ensure that the agreement that you were negotiating or the
39 position you were adopting in negotiations would be
40 acceptable to the ministry?

41 A. Yes.

42
43 Q. At a point at which you reached, in effect, an all-but
44 signed agreement with St John of God - that is to say
45 a draft agreement was produced between you that seemed
46 acceptable on its face to both - you would seek approval
47 from the ministry before entering into that agreement?

1 A. Yes.

2

3 Q. That is to say, before the LHD entered into the
4 agreement?

5 A. Yes.

6

7 Q. If the ministry had not been forthcoming with that
8 approval, the LHD would not have gone it alone and signed
9 the agreement, would it?

10 A. We didn't get to that point.

11

12 Q. I understand that --

13 A. Yes.

14

15 Q. -- but I'm just trying to understand the
16 decision-making structure and perhaps who, at the end of
17 the day, had you got to that point, you, within the LHD,
18 felt had the ultimate decision in relation to it. If you
19 had reached that point, unless and until you received
20 approval from the ministry that it was acceptable to them,
21 am I right to assume that the LHD would not have signed the
22 agreement with St John of God?

23 A. Yes, in theory.

24

25 Q. "In theory"? When you say "in theory", is that
26 because you never reached that point?

27 A. We never reached that point and I think through the
28 series of negotiations we were having with St John of God
29 on the terms sheet, we were able to negotiate a position
30 that both the ministry, St John of God and ourselves were
31 comfortable with.

32

33 Q. So I take it from that that you anticipate that had
34 you reached that point, an impasse of the type I have
35 hypothesised about would probably not have been reached
36 because you had been in constant contact with the ministry
37 to make sure you knew exactly what would be acceptable to
38 the ministry if you reached that end point of a draft
39 agreement?

40 A. Yes.

41

42 Q. Is there any reason why the ministry wasn't
43 negotiating directly with St John of God in relation to
44 this facility?

45 A. My understanding is that the Hawkesbury hospital, as
46 it's now known, is actually part of Nepean Blue Mountains
47 LHD. So it's part of our LHD in the same way that all of

1 the other facilities within the LHD are our responsibility,
2 hence why we were having the negotiations with St John of
3 God.

4
5 Q. Accepting that the LHD might ultimately have been the
6 relevant party to the agreement, I suppose my question
7 relates more to the process of negotiation. If you were in
8 between St John of God on the one hand and the ministry on
9 the other, I'm just wondering whether you have any view as
10 to why the ministry, who would need to be satisfied with
11 the terms of the agreement, didn't just step in and
12 negotiate itself?

13 A. I really can't comment on that.

14
15 Q. In paragraph 15 - do you see the final sentence
16 there - you refer to the fact that in February 2023,
17 St John of God were invited to participate in discussions
18 with the deputy secretary, the health system strategy and
19 planning, which you attended. Do you recall St John of God
20 or any representatives of St John of God attending meetings
21 with ministry representatives as part of the process?

22 A. Yes. So the chief executive and Ben would have
23 attended that meeting and the chief executive regularly
24 would reach out to the deputy secretary to have
25 conversations.

26
27 Q. What was discussed in the meeting that you allude to
28 in the last sentence of paragraph 15, to the extent you can
29 recall it?

30 A. Yeah, so to my recollection, it was talking around
31 some of the key areas of negotiation. So sort of they
32 wanted to talk about service planning, they wanted to talk
33 around the transition of their staff, if - you know, at
34 a point that the contract came to an end, and probably the
35 capital component, that generally seemed to be an area that
36 they were concerned about.

37
38 Q. You referred a moment ago to the fact that the chief
39 executive was in regular discussions with the deputy
40 secretary. The chief executive at that time was who?

41 A. So by this time, it was Bryan Pyne.

42
43 Q. And the relevant deputy secretary who Mr Pyne was in
44 discussions with?

45 A. Deb Willcox.

46
47 Q. How did you become aware of those regular discussions

- 1 between Mr Pyne and Ms Willcox?
2 A. I wouldn't say they were regular. I mean, I wouldn't
3 like to say they - but I know that there were occasions
4 where there would be - we would have a meeting and then he
5 would perhaps phone Deb afterwards to have a discussion
6 with her.
7
8 Q. When you say that, did he say to you at the end of the
9 meeting, "I'm going to call Deb Willcox and have a chat
10 with her about this"?
11 A. No.
12
13 Q. Or did you get some feedback from --
14 A. No.
15
16 Q. -- Ms Willcox saying, "Well, I've just had
17 a conversation with him and this is what he told me"?
18 A. We would be asked to provide advice.
19
20 Q. On what sort of issues?
21 A. The same issues.
22
23 Q. When you say "the same issues", what were the key
24 issues that advice was being sought from you in relation
25 to?
26 A. Oh, the capital component, the sort of transition of
27 staff, the KPI abatements - the issues in the terms sheet
28 that really we'd spent most of our time sort of negotiating
29 around.
30
31 Q. So you've identified in paragraph 17 what you describe
32 as some of the key issues. Are they the topics that were
33 the subject of regular discussions between you and St John
34 of God?
35 A. Yes.
36
37 Q. On the one hand?
38 A. Yes.
39
40 Q. And were they the same topics that were regularly the
41 subject of discussions between Ms Willcox and/or her
42 department and you, through which this advice was sought?
43 A. These are certainly areas that we briefed the ministry
44 on.
45
46 Q. I might come back to those areas, if that's okay. You
47 refer in paragraph 15, at the very end of that sentence, to

1 an invitation to undertake some joint clinical service
2 planning.

3 A. Mmm.

4
5 Q. What did you envisage, or what was envisaged, as best
6 you understand it, by that concept, "joint clinical
7 services planning"?

8 A. So for me it was really about including St John of God
9 and Hawkesbury district hospital in the service planning
10 that the district was doing. So we - in I think 2021,
11 before I started, the district had already started working
12 on a district-wide health services plan. That was paused
13 at the time, you know, because of COVID and what have you,
14 so when I commenced in the district, we recommenced that
15 piece of work and were keen to make sure that we included
16 Hawkesbury in that piece of work.

17
18 In 2023, probably sort of middle of the year, we
19 actually invited Strephon, who was the chief executive, to
20 be part of our steering committee, to oversee how we sort
21 of progressed the district-wide health services plan, and
22 unfortunately we had to put that piece of work on hold for
23 other priority reasons, and when we --

24
25 Q. Just pausing there, what were the other priority
26 reasons?

27 A. Accreditation of the LHD. We had some work to do for
28 accreditation. So we recommenced the project at the
29 beginning of this year, by which time, obviously, St John
30 of God had made their decision. So the interim general
31 manager is now on that steering committee. And that, the
32 health services plan, really is about setting the strategic
33 direction for the district, in terms of planning, including
34 Hawkesbury.

35
36 Q. Recognising that it pre-dates your time in your
37 current role, but based on what you understand or have been
38 told, is it your sense that St John of God had previously
39 been involved in any planning process around the way in
40 which services would be delivered to the community within
41 the LHD?

42 A. I really can't comment.

43
44 Q. As part of any discussion - so to the extent that
45 there were some embryonic discussions that had started in
46 relation to this service planning before the priority
47 issues intervened - was the potential impact of the new

1 Rouse Hill Hospital on the operations of Hawkesbury
2 something that was discussed?

3 A. No. So we actually had our first meeting around -
4 about Rouse Hill with the planning team at Rouse Hill last
5 week.

6
7 Q. Accepting that it's going to be an LHD issue not
8 a St John of God issue going forward, has consideration now
9 been given to where Hawkesbury hospital might fit in to the
10 mix of services delivered to the LHD once Rouse Hill
11 Hospital is up and operational?

12 A. So our understanding from the planners in Western
13 Sydney is that they're just in the final stages of
14 completing their clinical services plan themselves. That
15 hasn't been - I think they - I think - sorry. I think
16 that's in with the ministry now but they haven't got their
17 final clinical services plan. How it will impact on the
18 LHD and Hawkesbury district hospital is yet to be seen. We
19 haven't seen the detail of their clinical services plan.

20
21 Q. So would it be right to infer from that answer that
22 the LHD has not been involved in the formulation of the
23 clinical services plan for Rouse Hill Hospital?

24 A. Yes.

25
26 Q. Does Rouse Hill Hospital sit within the footprint of
27 Nepean Blue Mountains LHD or is it in Western Sydney?

28 A. It's in Western Sydney.

29
30 Q. Nevertheless, it will no doubt serve people sitting
31 within the catchment of the Nepean Blue Mountains LHD to
32 the extent that they might be on that side of it?

33 A. Certainly our expectation is that some of our patients
34 may choose to go to Rouse Hill.

35
36 Q. To the extent that the new hospital at Rouse Hill
37 might attract some patients who live within your LHD, or
38 services used or utilised by people living within your LHD
39 might more efficiently or effectively be delivered through
40 the new hospital at Rouse Hill, do you have a view about
41 whether or not it would be desirable if - for your LHD to
42 be involved in the planning process around what clinical
43 services should or shouldn't be delivered through that
44 facility?

45 A. The range of services that will be delivered at Rouse
46 Hill hasn't yet been decided, as far as I'm aware. My
47 personal opinion is there's always advantage in planners

1 coming together to do joint planning.

2

3 Q. Because the range of services that could or perhaps
4 should be provided at Rouse Hill no doubt will be informed,
5 won't it, by what's available within hospitals quite close
6 to Rouse Hill, sitting perhaps within your LHD? Would that
7 be right?

8 A. One would - one would assume so.

9

10 Q. And if they don't coordinate with one another around
11 decision-making of that type, there is a risk that there
12 will be unnecessary overlap in the delivery of services?

13 A. And I think that's where the ministry comes in,
14 because the ministry has oversight of services provided in
15 all of the districts and the sort of populations and the
16 way that the populations sort of feed in, so they have that
17 more central view. So I would imagine, as the clinical
18 services plan is being reviewed by the ministry, that they
19 would be looking at it with that lens.

20

21 Q. But you don't know that to be the case?

22 A. I can't speak on this.

23

24 Q. The advantages of the devolved nature of our health
25 system are such that those who sit within, say, the Nepean
26 Blue Mountains LHD have a good sense of the particular
27 needs and habits of people living within that LHD, in terms
28 of the way in which they access their health care?

29 A. Sorry, that in the district, we have an understanding
30 of our population?

31

32 Q. Yes.

33 A. Yes.

34

35 Q. Perhaps a better understanding than the ministry has,
36 based on whatever data is available to it?

37 A. We obviously talk to our community, so we --

38

39 Q. That's a good start.

40 A. Yes. So for our health services plan, we've
41 undertaken community engagement across the LHD, and we'll
42 continue to do that. Because that obviously provides
43 a greater level of understanding of the data. The health
44 data itself can only just provide you the raw numbers, you
45 know, we need to talk to people about what they actually
46 need and want.

47

1 Q. So to the extent that you've been informed by those
2 discussions, do you think it would be useful for that
3 information to feed in to the planning process about what
4 services might be delivered at, for example, Rouse Hill
5 Hospital?

6 A. As I said, I think the more that we share information,
7 it only advantages the communities we work for.

8

9 Q. As matters stand, though, there has not been
10 consultation with the LHD insofar as you are aware, in
11 relation to that issue?

12 A. But I can't say that there hasn't been consultation
13 with the communities.

14

15 Q. But insofar as you are aware, there's been no
16 consultation with your LHD in relation to that matter?

17 A. As far as I'm aware.

18

19 Q. Coming back to the key issues that you alluded to in
20 the terms sheet, paragraph 16 of your statement refers to
21 the multiple iterations of the terms sheet that existed
22 between 27 October 2022 and 1 September 2023. Each of
23 those iterations was the product, presumably, of continued
24 negotiation between the parties?

25 A. Yes.

26

27 Q. But in respect of each of them, there was no
28 particular meeting of the minds on all issues up until the
29 last one, when, finally, those negotiations produced
30 a terms sheet which was acceptable to both?

31 A. Yes.

32

33 Q. Can I just work through the key issues that you've
34 identified in paragraph 17, briefly with you. In relation
35 to (a), I'm assuming that is at the - it's fairly
36 self-evident: at the end of the term of any new agreement,
37 some arrangement would need to be made as to how staff were
38 going to be handed over?

39 A. Yes.

40

41 Q. That included consideration of things like accrued
42 entitlements and the like, presumably?

43 A. Yes.

44

45 Q. Because the staff within Hawkesbury hospital, were it
46 to be operated by St John of God, would not have been
47 employed by the secretary but, rather, by St John of God?

1 A. Yes.

2

3 Q. So there's the need, at the end of the arrangement,
4 for some acceptable transition arrangement which would work
5 for those employees and for the ministry or for the LHD, in
6 terms of being able to secure the continuing service of
7 that staff, but equally from St John of God, not being
8 stuck with a large burden of accrued entitlements - that
9 was an important matter to resolve?

10 A. Yes. It was around the understanding of how those
11 staff would sort of transition leave, et cetera.

12

13 Q. Was there any real dispute about how that should work
14 as part of the negotiation process?

15 A. Sorry, was there any?

16

17 Q. Was there any real dispute between the parties about
18 how that should work through this negotiation process?

19 A. Some of the detail, yes.

20

21 Q. What were the disputed issues?

22 A. So one of the items was around the transfer of sick
23 leave and long service leave, and the proportion that
24 St John of God would be willing to pay in terms - in
25 respect to those particular types of leave.

26

27 Q. So for a staff member who might have worked at St John
28 of God - at Hawkesbury hospital under the stewardship of
29 St John of God for several years, then becomes an employee
30 of the ministry, and there was a debate being negotiated
31 about the extent to which any accrued entitlements up to
32 the point of transfer would be shared between the ministry
33 and St John of God?

34 A. Yes.

35

36 Q. What about the next issue, the duration of the new
37 services agreement? What was the issue there, recognising
38 that we go on to talk about termination within its term,
39 but the actual term itself, what was contested about that,
40 if anything?

41 A. So when we started the negotiations with St John of
42 God, we were seeking a 20-year agreement, and it became
43 apparent fairly soon that St John of God really were not
44 keen to enter into an agreement of that duration, and so we
45 ended our negotiations really with an agreement to have
46 a five-year agreement.

47

1 Q. Did you perceive it to be desirable from the point of
2 view of the LHD to have an agreement which ran for as long
3 a term as possible, pursuant to which St John of God would
4 be operating Hawkesbury hospital?

5 A. Yes.

6

7 Q. Why?

8 A. Why? The amount of work, to be honest, in sort of
9 negotiating a new agreement. If you were having to do that
10 every couple of years, it's very resource intensive.

11

12 Q. Moving to the next issue, (c) --

13 A. And, sorry, on that point as well, it also gives
14 certainty for the staff. You know, it's very difficult,
15 I think, for the staff, knowing that, you know, the
16 contract is coming to an end and what's going to happen to
17 them. So it is about sort of providing - and reassurance
18 for the community as well.

19

20 Q. Moving down to --

21

22 THE COMMISSIONER: We've heard that point a lot.

23

24 MR MUSTON: Yes.

25

26 Q. In relation to that point, were the agreement to come
27 to an end, the community would assume, would it not, that
28 if St John of God wasn't running the hospital at
29 Hawkesbury, someone, probably the LHD, would be?

30 A. But it still causes concern, I think, in the
31 community.

32

33 THE COMMISSIONER: Q. I think the point Mr Muston just
34 made - it's not like a funding for a particular project
35 which has been going for a few years but might be ended, in
36 which case the staff know they're going to lose their
37 positions or jobs, as distinct from the fact that, here,
38 it's a funding agreement with an entity, but the
39 infrastructure of the hospital remains, so presumably it's
40 going to be used one way or the other and needed to serve
41 the community, or the health needs of the community.

42 A. Absolutely, and our view has been - you know, to where
43 we are now, has been very much around providing that
44 reassurance to the staff and the community, that, you know,
45 1 July is going to look like 1 June, that we want to sort
46 of maintain and, you know, continue those services. But
47 people don't like change and people are scared of change.

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MR MUSTON: Q. Tracking down to item (c), grounds for termination of the new services agreement, what was the real point of contest there?

A. So this is the clause that St John of God actually wanted us to include, that they could terminate the agreement due to financial instability.

Q. So when you say, "financial instability" --

THE COMMISSIONER: Q. You said "instability". Do you mean unsustainability.

A. Unsustainability, sorry, yes, yes. Sorry.

MR MUSTON: Q. So if it became a loss-making venture --

A. Yes.

Q. -- St John of God wanted the opportunity to be able to step away from it without enduring five years' worth, or potentially four years' worth, of continuing losses?

A. Yes.

Q. What was the LHD's view in relation to that as a broad proposition?

A. Well, we were able to sort of negotiate the clause so that we felt that we were meeting St John of God's request to have that sort of as part of a principle that would underpin in the agreement, and we were able to agree with St John of God that there would be sort of - we hadn't agreed the detail of it, but there would be certain components that they had to demonstrate their financial unsustainability at that point.

Q. As part of the negotiations around this, was it drawn to your attention that St John of God felt the amount of funding that was being provided by the LHD for the services delivered through Hawkesbury hospital fell short of the costs of delivering those services?

A. I - during the negotiations, I don't think that was, you know, expressed in those terms, but there was a sense of the - St John of God were keen to ensure that they weren't - they weren't financially disadvantaged through sort of different points, you know, in the clauses, that each of the points - you know, there are a number in there where they wanted it sort of called out quite clearly that St John of God wouldn't be held financially sort of liable if it was the state not investing.

1
2 THE COMMISSIONER: Q. This is no criticism of you. I'm
3 not quite following what seems to be the disconnect between
4 Mr Edwards, who said it was a negative issue for St John of
5 God that the proposed contact would require there to be
6 multiple years of financial losses before the contract
7 could be terminated, which is what he says in 41.3 of his
8 statement, versus 17(c) here, that St John of God were
9 requesting a mechanism to terminate the agreement in the
10 case of financial unsustainability. Given I haven't seen
11 any of this negotiation or the clauses, was your memory
12 that St John of God were seeking - in relation to the
13 mechanism to terminate in the case of financial
14 unsustainability, do you recall precisely what that
15 involved?

16 A. So their rationale for wanting it?

17
18 Q. Well, you're saying they requested a mechanism.
19 A. Yes.

20
21 Q. Do you recall what the mechanism was?

22 A. Well, initially they wanted after - if their financial
23 situation in one year, you know, if they were in deficit,
24 they wanted to be able to give us notice the following
25 year.

26
27 Q. I see.

28 A. We were able to negotiate that it would be every two
29 years, and they would have to give us 18 months' notice,
30 because we argued that, you know, to Ben's point earlier,
31 you need to see a trend; you can't just have sort of six
32 bad months. And so we were both fairly comfortable with
33 that.

34
35 I think one of the issues that we had, and, you know,
36 if you look through the term sheets, the St John of God -
37 we were always very clear that we wanted at least 18
38 months, if not two years, to be able to take back the
39 facility at the point of the moving out, because we - you
40 know, there's an extraordinary amount of work that needs to
41 happen.

42
43 Q. Yes.

44 A. Unfortunately, we find ourselves with - well, found
45 ourselves with six months to take the facility back, which
46 was not ideal.

47

1 THE COMMISSIONER: Thank you. I understand that a bit
2 better now, yes.

3
4 MR MUSTON: Q. To the extent that the facility was
5 profitable or unprofitable, the evidence that has been
6 given by Mr Edwards was to the effect that that was
7 a function of two things: one, the cost of delivering the
8 services, which, in the current climate, was escalating;
9 does that generally accord with your observations within
10 your LHD?

11 A. Yes.

12
13 Q. And the second thing is the extent to which the
14 funding delivered by the ministry to provide the services
15 contemplated by any service level agreement actually
16 matched the costs or kept up with that escalation in the
17 costs. Do you agree they're the two important functions?

18 A. (Witness nods).

19
20 Q. The third is obviously --

21
22 THE COMMISSIONER: Q. I think you nodded again?

23 A. Yes, sorry, yes, yes.

24
25 MR MUSTON: Q. A third consideration is efficiencies or
26 inefficiencies which obviously play into the way in which
27 those two things engage?

28 A. Yes.

29
30 Q. But from the perspective of St John of God, the desire
31 to have an escape clause in the event of unprofitability is
32 driven largely by the fact that it was potentially wholly
33 within the power of the LHD to decide whether or not it
34 would be profitable or unprofitable, having regard to the
35 amount of funding that was provided - was that something
36 that was appreciated at the LHD level?

37 A. Sorry, I'm not sure what you're asking.

38
39 Q. That is to say, from St John of God's perspective, as
40 they were asking for an escape clause in the event that the
41 facility became unsustainable or unprofitable, their view
42 was it could become unsustainable or unprofitable if the
43 funding provided was insufficient to meet the cost of
44 delivering the services?

45 A. Yes.

46
47 Q. That was something which was wholly within the control

1 of the LHD?

2 A. Yes and no.

3

4 Q. When you say "no", in what sense?

5 A. The LHD is allocated a certain budget for all its
6 facilities and the LHD then has a responsibility to be able
7 to divide that budget to each facility to meet the needs of
8 their local communities. So it's not the case that the
9 district is sort of sitting with all these additional
10 buckets of money that they can just sort of pull into. The
11 budget they're given is expended across each of those
12 facilities.

13

14 Q. There's an important difference, though, isn't there,
15 between each of the LHD facilities on the one hand and
16 a facility like Hawkesbury run by a private entity on the
17 other, in the sense that whilst the LHD facilities might be
18 able to endure a deficit, a private entity with directors
19 who owe duties under the Corporations Act can't?

20 A. That's true. But a private partnership also has the
21 ability to be able to attract its own funding through
22 private activity.

23

24 Q. But you don't suggest, do you, that it should be any
25 part of the public health system that public services
26 delivered to public patients should be funded by --

27 A. No.

28

29 Q. -- a PPP participant through its either benefaction or
30 privately derived revenue through other sources?

31 A. No.

32

33 THE COMMISSIONER: Sorry, not a question for Ms Clements,
34 but just a clarification for me. In the oral evidence and
35 in the statements there are quite a few references to these
36 term sheets. Have I missed them in the tender bundle or
37 they're not there? I don't even know how relevant they
38 are, but they've been referred to. Are they in the tender
39 bundle?

40

41 MR MUSTON: Not at the moment. I think I received them at
42 9.40 this morning, which explains why I'm not keen on going
43 through them in much detail. I don't say that critically
44 of anyone. Somewhere between me and where they were
45 ultimately delivered or produced there may have been some
46 delay, but the date --

47

1 THE COMMISSIONER: I see. I was just wondering whether
2 I was misreading something that's actually a terms sheet.

3
4 MR MUSTON: I anticipate we will tender the last one in
5 due course. I don't think it's productive, having regard
6 to my very cursory read through the last one, for us to
7 tender the other eight which show the various iterations.

8
9 THE COMMISSIONER: It's not important for the evidence
10 you're calling at the moment?

11
12 MR MUSTON: No.

13
14 THE COMMISSIONER: Thanks.

15
16 MR MUSTON: To the extent that it's relevant, it can be
17 taken up in some submissions at a later date.

18
19 THE COMMISSIONER: Yes, understood, thank you. Sorry to
20 interrupt.

21
22 MR MUSTON: Q. Could I ask you, then, to go down to
23 item (e), where we come to that old chestnut of the capital
24 contribution. What was the contest between St John of God
25 on the one hand and the LHD on the other in respect of the
26 capital contribution?

27 A. This was - this particular item was really around
28 their ability to be able to meet KPIs, and they didn't want
29 to be - and the abatement regime if they didn't meet KPIs,
30 and they didn't want to be held to an abatement if their
31 view was that they weren't able to meet the KPI because of
32 the lack of investment or the need for sort of capital
33 investment in the facility.

34
35 Q. So breaking that down into a few components, the
36 abatement you talk about is a reduction in the proffered
37 funding in the event that KPIs are not met?

38 A. Yes.

39
40 Q. That is to say, in any given year you might be offered
41 X in funding, but if you failed to meet KPIs it was
42 suggested that X would be reduced by some quantifiable
43 amount?

44 A. That's right.

45
46 Q. The concern was, to the extent that the inability to
47 meet the KPIs was attributable to a failure to invest in

1 infrastructure at Hawkesbury hospital, St John of God
2 didn't want to suffer both the failure to invest in
3 infrastructure and the consequent reduction in its funding?
4 A. That's right.
5
6 Q. Was that seriously in contest as between the LHD and
7 St John of God?
8 A. No. We agreed that if the KPI - the ability to meet
9 the KPI was directly related to capital investment, then,
10 yeah, we wouldn't hold them to meeting - having to meet
11 that KPI.
12
13 Q. And item (f) deals with the same issue, albeit not in
14 respect of capital but, rather, the inadequacy of any
15 funding delivered?
16 A. Yes.
17
18 Q. So did that contemplate a situation, for example,
19 where the KPIs required a particular amount or level of
20 service to be delivered, but if it wasn't adequately
21 funded, and therefore that service was not delivered,
22 St John of God didn't want to have their funding reduced?
23 A. Yes.
24
25 Q. Was that seriously in contest between the LHD and
26 St John of God?
27 A. No, I think we were - we debated it, but in the terms
28 sheet, we agreed that if it was directly related to the
29 inability to be able to fund a capital upgrade, then we
30 wouldn't hold them to it.
31
32 THE COMMISSIONER: Can I just ask, do you have half an
33 hour to go or a short time to go?
34
35 MR MUSTON: Actually I do have a little while to go.
36
37 THE COMMISSIONER: Is it better to adjourn?
38
39 MR MUSTON: Yes.
40
41 THE COMMISSIONER: I'm sorry about that but we'll have
42 to --
43
44 MR MUSTON: No, I'm sorry; the late adjournment threw me
45 off a bit.
46
47 THE COMMISSIONER: We will take the adjournment and we

1 will come back at 5 past 2. We will adjourn until then.

2
3 **LUNCHEON ADJOURNMENT**

4
5 THE COMMISSIONER: When you are ready.

6
7 MR MUSTON: You will be pleased to hear, and the witness
8 will be pleased to hear, that over the lunchtime I have
9 managed to consolidate, and so I can now be quite quick.

10
11 Q. In paragraph 18 you express a view that St John of
12 God's interest in reducing the length of the new service
13 agreement and strengthening its ability to terminate the
14 new service agreement indicated some uncertainty about its
15 interest in continuing the PPP with Nepean Blue Mountains
16 LHD.

17 A. Yes.

18
19 Q. I think we've covered off the issue or touched on the
20 issue around the length of the service agreement, and in
21 respect of the ability to terminate the service agreement,
22 do you accept that what we've come to is, at best, St John
23 of God was expressing a desire to be able to terminate the
24 agreement in the event that it became uncommercial?

25 A. Yes.

26
27 Q. In those circumstances, really, all that indicated to
28 you, wasn't it, was that St John of God might have had some
29 uncertainty about its interest in continuing a PPP
30 arrangement which was commercially disadvantageous to it?

31 A. Yes. Yes. So certainly there was some hesitancy, and
32 I mean, they were very clear that they didn't want to enter
33 into a 20-year agreement with us, but as I say in my
34 statement, I felt that given the length of time that we had
35 taken to agree the terms sheet - and we did agree the terms
36 sheet - that we would get an agreement with them to
37 continue operating the service, but I didn't have
38 confidence that it would be a long-term agreement.

39
40 Q. So on 1 September 2023, St John of God advised that it
41 agreed to the then iteration of the terms sheet?

42 A. (Witness nods).

43
44 Q. I think on 18 October, Lee Gregory, on behalf of the
45 LHD, indicated that the LHD was content with the terms
46 sheet.

47 A. Yes.

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Q. On 5 December, you tell us that St John of God wrote to you, or wrote to the deputy secretary, I should say, indicating an intention to return the Hawkesbury hospital to the LHD?

A. Yes.

Q. Insofar as you are aware of it, what was your sense of what happened between 18 October and 5 December, to bring about that change in position?

A. Yes, so St John of God were signalling that they were experiencing losses for the first quarter of the new financial year. We had had - the LHD had had a meeting with the St John of God team to that effect, and we, at that point, did offer to sort of work with them to look for efficiencies and to see if any of - any of the work that we were doing in the district sort of may be able to assist. We were aware that the board were meeting to - and, you know, this was obviously a point of interest to the board and that the board were sort of regularly, when they met, discussing Hawkesbury specifically.

Q. Were you told that St John of God had conducted a fairly rigorous efficiency review at Hawkesbury hospital?

A. I wasn't necessarily, I don't think, aware of that. That would have been through the performance meetings that that was discussed.

Q. You were not involved in those meetings?

A. I attended them sometimes if my diary allowed, and that was more really around to provide any updates around the negotiations or anything relating to service planning.

Q. Did you have any reason to believe that what was described as a significant loss being experienced by St John of God was attributable to any particular inefficiencies within their operations?

A. No. Not that - I had - I can't comment, really.

Q. You just simply didn't know one way or the other?

A. Mmm.

MR MUSTON: I think I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Thank you.

1 Mr Chiu, do you have any questions?

2

3 MR CHIU: Just one question.

4

5 <EXAMINATION BY MR CHIU:

6

7 MR CHIU: Q. Are you involved in the process of the
8 handover of St John of God back to the district?

9 A. Yes, I am.

10

11 Q. As part of your involvement, have you had reason to
12 look into the question of whether it was operating
13 efficiently under St John of God?

14 A. In taking it back, we are sort of becoming aware of
15 some areas that sort of - we may do things slightly
16 differently with them, and I think there are sort of, you
17 know, definitely sort of opportunities to leverage off sort
18 of HealthShare and other contracts to look at some of the
19 employment arrangements of staff as well.

20

21 Q. Can you be a bit more specific about which areas
22 you're talking about?

23 A. Yes. So some of the arrangements for the employment
24 of some of their senior medical staff, we're - sort of
25 we're looking into.

26

27 Q. When you say you're "looking into", are you looking
28 into it in relation to efficiency?

29 A. Just bringing it into line with state awards.

30

31 Q. When you say, "bringing it into line" with state
32 awards, are they not aligned with state awards?

33 A. No, there are some instances where they're not.

34

35 Q. And by that, do you mean some staff are being paid
36 significantly more than state awards?

37 A. That's my understanding.

38

39 MR CHIU: No further questions.

40

41 THE COMMISSIONER: Thanks.

42

43 I take it you have no questions?

44

45 MR FITZPATRICK: No.

46

47 THE COMMISSIONER: Thank you very much for your time.

1 We're very grateful. You are excused.

2

3 <THE WITNESS WITHDREW

4

5 MR MUSTON: The next witness is Lee Gregory.

6

7 <LEE GREGORY, sworn: [2.18pm]

8

9 <EXAMINATION BY MR MUSTON:

10

11 MR MUSTON: Q. Could you please state your full name for
12 the record again, please, Mr Gregory?

13 A. Yes, Lee Gregory.

14

15 Q. You're the acting chief executive of the Nepean Blue
16 Mountains LHD?

17 A. Yeah; that's correct.

18

19 Q. Which I think you've told us previously is a role that
20 you've held since September 2023?

21 A. Yes, that's correct.

22

23 Q. You have prepared two statements to assist the
24 Commission to date. The first is dated 9 April 2024, which
25 we've already heard some oral evidence from you in respect
26 of?

27 A. Yes.

28

29 Q. And most recently, a statement dated 6 June 2024?

30 A. Yes.

31

32 Q. Have you had an opportunity to read the 6 June 2024
33 statement before giving your evidence today?

34 A. Yes, I have, yes.

35

36 Q. Are you satisfied that the content of that statement
37 is true and correct?

38 A. Yes.

39

40 MR MUSTON: In due course, Commissioner, that will form
41 part of the bulk tender.

42

43 THE COMMISSIONER: Yes.

44

45 MR MUSTON: Q. We can probably be quite brief,
46 Mr Gregory. You came to be involved in the Nepean Blue
47 Mountains LHD's interactions with St John of God relatively

1 late in the piece, it would be fair to say?

2 A. Yes, that's correct, yes.

3

4 Q. I think you tell us in paragraph 14 that your
5 involvement commenced when you commenced in your current
6 role in September 2023.

7 A. Yes.

8

9 Q. At that point, it was your understanding that a period
10 of negotiation had occurred - quite a lengthy period of
11 negotiation had occurred between the LHD and St John of
12 God?

13 A. Yes, that's correct, yes.

14

15 Q. Resulting in the agreement or at least acceptance by
16 St John of God of some terms - of a terms sheet which had
17 been exchanged and negotiated between the parties?

18 A. Yes, yes.

19

20 Q. I think presumably when you commenced, you were told
21 that on 1 September 2023, St John of God had communicated
22 in writing their acceptance of those terms?

23 A. Sorry, just say that again?

24

25 Q. Upon commencement of your role as acting CE, you
26 presumably were told, perhaps not immediately, that on
27 1 September 2023, St John of God had communicated in
28 writing its acceptance of the --

29 A. Yes. Sorry, yes, that was part of my - part of the
30 brief I got, yes.

31

32 Q. -- terms sheet. You, on 18 October 2023, sent an
33 email to the chief executive of St John of God advising of
34 the LHD's acceptance of those terms?

35 A. Yes.

36

37 Q. Could I ask, between your commencement in September
38 2023 and when you sent that 18 October 2023 email, what did
39 you do to satisfy yourself that it was an appropriate email
40 to send?

41 A. Yes, I mean, it's just mainly through the briefing
42 I got, reading of the terms sheet and just the briefing
43 from the staff on the whole issue around St John of God and
44 where we were at, and I was pretty comfortable in where we
45 had got to with the terms sheet and the content of it, so,
46 yes.

47

1 Q. Did you take any step to satisfy yourself that the
2 terms sheet reflected an agreement or terms of an agreement
3 which would be satisfactory to the ministry?

4 A. No, not directly, I just took the advice of the team.
5 I didn't directly contact the ministry, if you like, to
6 say, you know, "Are you happy with this", I just took the
7 advice of the team. But that's not unusual, yes.

8
9 Q. In terms of the advice of the team, did the advice of
10 the team that you were provided with include any indication
11 of the interactions, if any, that had happened between the
12 LHD and the ministry as to the suitability from its
13 perspective of the terms sheet?

14 A. I'm just trying to - yes, I think so, I think so. I'm
15 just trying to recollect. But I think generally in the
16 briefing, I would have generally got a briefing that talked
17 me through how we'd got to where we'd got, interactions
18 with the ministry and sort of, if you like, a summary of
19 the view of the ministry, where it was at, you know, so --

20
21 Q. It was, on any view, a significant contract in the
22 context of the LHD's operations?

23 A. Sorry, was it a significant contract?

24
25 Q. On any view, it was a significant contract in the
26 context of the LHD's operations?

27 A. Yes, it was, yes. Absolutely, yes.

28
29 Q. Do you think you would have expressed your acceptance
30 to the terms sheet on 18 October 2023 unless you had
31 satisfied yourself that it was reflective of an agreement,
32 or the terms of an agreement, which were acceptable to the
33 ministry?

34 A. I - so the way I understood it was the ministry was
35 comfortable with the terms sheet. We were - though there
36 were still things to be worked through, I think
37 particularly with reference to the sinking fund, if I
38 remember rightly, but that everyone was in sort of broad
39 agreement where things were at.

40
41 Q. So between sending your email on 18 October 2023 and
42 5 December 2023, as you tell us in paragraph 17, something
43 happened which changed the dynamic of the negotiations?

44 A. Mmm.

45
46 Q. Such that St John of God communicated its intention to
47 return Hawkesbury hospital to the LHD?

1 A. Yes.

2

3 Q. Did you, in your short time in the LHD, have a sense
4 of what that change might have been?

5 A. My recollection was that I think the only thing that
6 changed between - prior to 5 December and 18 October,
7 whatever, was probably just that they had come to the -
8 increasingly come to the thought of not continuing the
9 contract, and then they had the board meeting which made
10 the final decision, in the middle of November, I think, or
11 5 November, or something like that. But the key thing was
12 that decision at board meeting, I think, around whatever
13 that date was in November.

14

15 Q. Is that something that was communicated to you by
16 St John of God - that is, "We're having a board meeting, in
17 the course of which we're going to give serious
18 consideration to whether or not we actually want to go
19 ahead with this after all"?

20 A. Yes, that's my recollection, yes, because I think
21 I recall being on a meeting with Bryan Pyne and
22 Deb Willcox, and we had - I think we - yes, certainly
23 that's my recollection.

24

25 Q. How many meetings did you attend in relation to the
26 negotiations up to 5 December with St John of God?

27 A. Oh, it would only have been maybe one or two, no
28 more than that. Sorry, so maybe one or two meetings with
29 Deb Willcox and Bryan Pyne, and then I think I attended one
30 performance meeting, and there was lots of informal, if you
31 like, conversation around the whole issue of Hawkesbury,
32 so, yes.

33

34 THE COMMISSIONER: No criticism of either of you, but the
35 date - we're getting 5 November and 5 December. It is
36 5 December?

37

38 MR MUSTON: 5 December. Sorry, did I say November?

39

40 THE WITNESS: No, I said 5 November. I said 5 November.
41 Yes, so that's probably my - that's my mistake.

42

43 THE COMMISSIONER: That's fine.

44

45 MR MUSTON: Q. I was about to ask you a question about
46 timing. From a timing perspective, the meetings that you
47 refer to as having occurred between yourself, Bryan Pyne,

1 is it --

2 A. Yes.

3

4 Q. -- and Deb Willcox, when did they occur relative to
5 your email of 18 October and the 5 December letter from
6 St John of God?

7 A. I think - yes, my recollection is I think they
8 occurred around November, I think Bryan had written to Deb.
9 I may be getting this wrong, but, yes, roughly the memory
10 is Bryan had written to Deb and we had - there was at least
11 one phone hook-up with me, Bryan and Deb on the issue.

12

13 Q. In the course of that meeting, I think you've told us
14 but correct me if I've misunderstood you --

15 A. Yes.

16

17 Q. -- that that was a point at which it was suggested
18 that there was going to be a board meeting at St John of
19 God to decide what to do in relation to --

20 A. Yes, that was - yes.

21

22 Q. Do you remember them telling you during the course of
23 that meeting what had prompted that careful consideration
24 by the board of St John of God that lead to the change of
25 position?

26 A. Just the things that had been - they'd been
27 articulating for a long period of time, the issue around
28 the increasing deterioration in the financial viability of
29 the hospital, the infrastructure, you know, the capital
30 funding issue, the clinical service planning, all those
31 things that they'd been talking - it was no different, you
32 know, the same themes.

33

34 Q. So in relation to that, these are issues they'd been
35 raising for some time, and presumably they'd been raising
36 those issues, at least as you understood it, before you
37 arrived on the scene?

38 A. Yeah, but I think the financial one in particular had
39 sort of gathered a head of steam through '23/24 financial
40 year, yeah.

41

42 Q. So just commencing with those expressions of these
43 views and concerns prior to your arrival, were you told
44 anything upon arrival at the LHD about these concerns
45 around the financial viability of Hawkesbury hospital and
46 the extent to which they had been expressed by St John of
47 God?

1 A. Yes, so part of the briefing I got that they took me
2 through, and I think - yes, certainly I got a briefing
3 around the issues around, you know, the capital equipment
4 issues and the financial viability issues that they had
5 been raising, and I think I'd probably make two
6 distinctions. Prior to the - I think generally the sense
7 that I got was prior to '23/24, and that sort of escalation
8 in costs within the health system, they were - it was -
9 a lot of it was around activity overruns, you know, so they
10 were seeking funding for additional activity that they'd
11 done and overrunning their targets. And then we got into
12 '23/24 and the whole - you know, effects of COVID on the
13 whole of the health system and there were all the
14 increasing costs that we've seen across staffing and the
15 inflation in the broader economy, that started to play in
16 as well.

17

18 Q. So the briefing that you received in relation to that,
19 who was that briefing delivered by? Was it obviously staff
20 members within the LHD?

21 A. Yes, so - yes, so Vanessa, Vanessa Clements, and then
22 Luke Bellman, the director of finance for the district.

23

24 Q. Was that briefing a written document, the briefing?

25 A. No, it was largely verbal, yes - verbal for me, yes.

26

27 Q. At the point of your arrival on the scene, you also
28 became involved in discussions around the funding which was
29 proposed for the Hawkesbury hospital for the '23/24 period;
30 is that right?

31 A. Yes, not really, not to a great extent, only in the
32 sense that by the time I'd got there, had the briefing, it
33 was pretty well on the way to them - you know, the
34 indications around wanting to not continue the contract,
35 so - yeah, we - I mean, we had discussions around it,
36 around, you know, through the performance agreement and
37 outside, but it sort of pretty quickly got into that sort
38 of phase of their not wanting to continue.

39

40 Q. So do I infer from that answer that you were having
41 some performance discussions, performance review
42 discussions, with St John of God in relation to Hawkesbury
43 hospital in parallel with these wider discussions?

44 A. Yes, what I was referring to was the monthly
45 performance meetings that we have with St John of God, and
46 I attended at least one, I think maybe one in - definitely
47 one in October, I can't remember whether I attended

1 the November one, and then after that, you know, there was
2 the decision - so I attended one in October, definitely;
3 can't remember, recall, whether I attended November's; and
4 then after that, it was early December, the date they had
5 made the decision to not continue the service.
6

7 Q. In the October discussion, performance discussion that
8 you had, did St John of God express its view that the
9 funding that was being provided to it by the LHD was
10 inadequate to meet the costs of delivering the services --

11 A. Yes, can I just go --

12
13 Q. -- required under the service agreement?

14 A. Yes, if I can just go back a step, there was actually
15 a meet and greet with me prior to that, performance meeting
16 in early October, and at that meeting Ben was on the line
17 from Perth and then he started to talk then around some of
18 the deterioration in the financial position of the
19 hospital, so yes.
20

21 Q. So meet and greet meeting, he expressed a view to you
22 that the amount of funding that was being provided to
23 St John of God to run Hawkesbury hospital fell short of the
24 costs of delivering the services required to be delivered
25 through that hospital; is that right?

26 A. He expressed it in the form of they were starting to
27 experience cost pressures and therefore deteriorating
28 financial viability of the hospital, as opposed to the way
29 you've characterised it and funding not being enough. It
30 was sort of the other way around but same thing.
31

32 Q. The same thing?

33 A. Yes, yes.
34

35 Q. However he expressed it, you understood him to be
36 saying, "It is costing us more to deliver" --

37 A. Yes.
38

39 Q. --- "the services than we are receiving by way of
40 funding from the LHD"?

41 Yes.
42

43 Q. Did you go back to anyone within the LHD and explore
44 with them whether there was any history around that that
45 might be relevant to your ongoing discussions with St John
46 of God around that issue?

47 A. No, I didn't, no.

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Q. Did you have any reason to doubt that what he was telling you was right?

A. No, no. I mean, we had seen the cost pressures across the system so there was no reason to doubt what they were saying at all. We have had, and continue to have, a good relationship with St John of God, as well, so - yes.

MR MUSTON: Could I ask the witness to be shown the document behind tab G.014, which is [SJ0.0001.0005.0046].

Q. It should pop up on the screen. Look at either the one in front of you or the one immediately to your right --

A. Yes, thank you, yes.

Q. -- whichever works best for your eyes and glasses.

A. Yes.

Q. It would be a close run thing for me. I don't suggest that you were on the scene at the LHD when this document was provided, but is that a document that you had cause to consider when you did arrive at the LHD and you were considering funding issues relative or referable to St John of God?

A. Yes, no, I didn't look at this document, yes.

Q. Did not look at that document at all?

A. No.

THE COMMISSIONER: Q. Meaning not in any time that was relevant other than slightly before giving evidence?

A. Sorry, say that again, Commissioner?

Q. You didn't look at this document in the time before St John of God said, "We're not going ahead, we're not going any further", on 5 December?

A. No.

MR MUSTON: Q. Track back to the document behind tab G.013, [SJ0.0001.0005.0044]. That's a letter dated 2 August 2023, so again, before your time at the LHD, from Strephon - to Strephon Billinghamurst. It's been signed by Ms Clements in her capacity as acting chief executive. Is that a document that you had any reason to look at when you arrived at the LHD and in the context of your discussions or negotiations with St John of God around the funding of Hawkesbury hospital?

- 1 A. No, I don't recall - no, I didn't look at this one.
2
- 3 Q. You, through your involvement in the system prior to
4 your arrival at Nepean Blue Mountains LHD, would be
5 familiar with the concept of a deferral of the LHD's budget
6 referable to political changes?
7 A. Sorry, say that again. The deferral of the LHD's
8 budget due to --
9
- 10 Q. Just look at the first paragraph of that letter.
11 A. Oh, this was the interim - yes, because of the state
12 budget, and it was delayed, yes.
13
- 14 Q. The state budget was delayed?
15 A. Familiar with that, yes.
16
- 17 Q. So the message conveyed through this letter, I gather,
18 based on my reading of it, was to the effect that, "We
19 don't have an answer to your funding request or your
20 funding proposal of April 2023 yet, because there's been
21 a delay in the completion of the budget"?
22 A. Yes.
23
- 24 Q. Could we then track back to the document behind
25 tab G.012, [SJ0.0001.0005.0041]. This one might be more
26 familiar to you. That's a letter from, it would appear,
27 you to Mr Billingham dated 25 October 2023?
28 A. Yes.
29
- 30 Q. You were the author of that letter, I assume?
31 A. Well, not directly the author but, yes, the signatory,
32 obviously.
33
- 34 Q. What involvement did you have in the preparation of
35 that letter, which was issued under your name?
36 A. Yes, so it would have been prepared by the finance
37 department and generally it's sort of a generic letter that
38 goes out to all the facilities, and I'd have reviewed it
39 prior to signature.
40
- 41 Q. You say a letter that went out to all of the
42 facilities. The only facility that was not part of the
43 ministry, at least at that time, within your LHD was
44 St John of God, wasn't it?
45 A. Yeah; that's correct, yes.
46
- 47 Q. So this letter fell into a subtly different category

1 to those that might have been sent to hospitals that were
2 wholly within the LHD's control and operation?

3 A. Yes.

4

5 Q. Just running down to the bottom of page 1, you refer
6 there to a "challenging financial landscape". Is that
7 language you included in the letter or is that language
8 that was included by someone else?

9 A. Oh, I mean, it's language included by someone else but
10 I've clearly signed off the letter, so --

11

12 Q. What did you understand that to mean when the letter
13 refers to a "challenging financial landscape"? Challenging
14 in what respect?

15 A. I think it was just reflecting what was an
16 increasingly challenging financial landscape for the whole
17 of the health system, you know, post COVID, with the
18 workforce shortages --

19

20 THE COMMISSIONER: Q. Increasing costs?

21 A. Yes, and all the increasing costs that we see in the
22 economy and in our workforce, so I think it's just
23 reflective of that.

24

25 MR MUSTON: Q. You see at the very last line there,
26 there's a reference to "efficiency improvement plans"?

27 A. Yes.

28

29 Q. Did you, in writing this letter, have any reason to
30 believe that there were inefficiencies to be weeded out of
31 the operations at Hawkesbury hospital, insofar as they had
32 been conducted by St John of God?

33 A. Yeah, no, we didn't - I didn't have anything directly.
34 Again, it's like a generic, broad context paragraph,
35 I think. We didn't have any - I didn't have anything that
36 said to me that St John of God weren't operating the
37 hospital at a - you know, a reasonable level of efficiency
38 but, you know, there's always more you can do in any
39 hospital in terms of efficiency.

40

41 Q. By this stage, were you - well, let me take it a few
42 steps at a time. If we turn over to page 2, you see
43 there's a communication there about the state price and the
44 state efficient price under the heading, "NSW Health State
45 Price"?

46 A. Mmm.

47

1 Q. Do you recall having discussions with anyone from
2 St John of God about the extent to which either of those
3 figures recognised the costs of delivering services in the
4 challenging financial landscape that was prevailing?

5 A. Yeah, I didn't have a - well, we didn't have a - we
6 had conversations, like I talked about before, where they
7 started to talk around their - you know, the increased
8 costs and the deteriorating financial position, but we
9 didn't have a direct - I don't recall a direct conversation
10 with them that said, "Well, the state price is X. There's
11 our costs at Y", that direct link that you're referring
12 to --

13

14 Q. When you say there wasn't a direct conversation to
15 that effect, are you really alluding to what they really
16 said to you was, "Here is the funding we receive under this
17 model; here are the services that we're delivering
18 consistent with what's required of us under the service
19 agreement. There's a gap"?

20 A. Yes, pretty much, yes.

21

22 Q. Can I just ask, in relation to the next little bit
23 down, if you see the subheading "HDHS Budget", and there is
24 a box underneath it?

25 A. Yes.

26

27 Q. The first question: you see in the top, each of the
28 columns is given a title, the second column is "NWAU23"?

29 A. Yes.

30

31 Q. So as I read this correspondence, and in particular
32 what appears at the very bottom of the box, this is
33 a reference to the NWAU which has been allocated to the
34 hospital for the '23/24 period; is that right?

35 A. Yes.

36

37 Q. So for the avoidance of any doubt, the "NWAU23" is not
38 a reference to some past year's figure; it's a reference to
39 the NWAU that had been provided by the LHD as what it was
40 intending to purchase from St John of God?

41 A. Yes, that's correct, yes.

42

43 Q. We've been through the figures already, and I won't
44 take you through them unless it will assist you, but the
45 figures which are provided in that column, other than those
46 that relate to ED, are lower, significantly so in some
47 cases, than what had been proposed by St John of God as the

1 activity which it anticipated it would conduct through the
2 hospital. Is there any reason for that, insofar as you are
3 aware?

4 A. Yes, one of the reasons I think will be the acute
5 activity doesn't contain the additional elective surgery
6 I think we were purchasing from St John of God in that
7 year, and the pricing proposal that was up before does. So
8 I think that's - it's not quite like apples - a like for
9 like comparison, I think.

10
11 Q. Let's just sanity-check that. If we go to the
12 document [SJ0.0001.0005.0046], and perhaps if we could sit
13 that side by side with the box on the - you're one step
14 ahead of me. If we go to "Acute Services", which is on
15 page 0004 of the Hawkesbury District Health Service
16 document, when you refer to the wait list figures, that's
17 a reference to the 10,285 for acute activity figure which
18 appears at the very bottom of the screen, or moments ago
19 appeared at the very bottom of the screen on the right-hand
20 side?

21 A. Yes, yes.

22
23 Q. So that's the total NWAU value for acute care, taking
24 into account, amongst other things, the acute waiting list.
25 If we track up to the "Acute" baseline, just a little bit
26 higher, do you see there, in the second - the
27 paragraph immediately above "Acute - Waiting List",
28 commencing "Accordingly, St John of God Health Care
29 propose" - do you see that paragraph?

30 A. Yes.

31
32 Q. So what seems to be being proposed there is before you
33 add the acute wait list, there is an NWAU value of 9,777,
34 adjusted by a day, on account of it being a leap year, to
35 the 9,804, for the pre-acute wait list acute care. Is that
36 as you understand that document?

37 A. Yes.

38
39 Q. If we then track back to the table on the other side
40 there, the acute care is 9,527?

41 A. Yes.

42
43 Q. So would I be right in assuming that if we assume, as
44 you've said in your evidence, that the acute care shouldn't
45 be contrasted with the total acute care including the wait
46 list, because that's an apples and pears, as I understand
47 you to tell us, but even if you compare the acute figure

1 with the equivalent figure taking out the acute wait list
2 number, it's still significantly lower than that which was
3 being sought by St John of God in respect of acute care,
4 isn't it?

5 A. Yes.

6
7 Q. Is there any reason for that, insofar as you're aware?

8 A. Yes, I think I can only - well, it's probably just
9 a symptom of the fact of us trying to balance our funding
10 constraints across the district. So if we think we've got,
11 you know, four or five hospitals, all our other services,
12 and we have, you know, a fixed budget and NWAU, we're
13 trying to allocate them out as best we can across the
14 district. So it just reflects, I think, at least in part,
15 the funding constraints we've got with the district.

16
17 Sorry, the other thing I would say is I can't recall,
18 but there may well have been - I just can't recall but the
19 other bit may possibly would be that there might have been
20 a difference in view of the projected activity that's going
21 to go through the hospital. That would be the other
22 reason, or potentially would be the other reason. I just
23 don't know whether that was the case here.

24
25 THE COMMISSIONER: Q. I was going to ask you, are you
26 hypothesising there rather than knowing?

27 A. Well, that's what I'm saying, I don't know if that was
28 the case. It's either one of two reasons. It's - well,
29 it'd be two. One, it's us trying to balance our funding
30 constraints and, you know, the amount of NWAU we have
31 there.

32
33 Q. But balancing funding constraints, though,
34 I understand what balancing funding constraints is, but
35 that's not necessarily related to volume of activity, is
36 it? That's just balancing?

37 A. Yes, it is in the sense that we get a volume of
38 activity purchased - the ministry provides us with a level
39 of funding based on a volume of activity.

40
41 MR MUSTON: Q. The ministry funds you by reference to
42 a large bucket of activity --

43 A. Yes.

44
45 Q. -- if I could describe it in that way?

46 A. Yes.

47

1 Q. No doubt split between acute, ED, et cetera?

2 A. Yes, that's correct, yes.

3

4 Q. And you or, well, the LHD then embarks upon a process
5 of distributing that bucket across the various hospitals
6 within its footprint?

7 A. Yes, that's correct.

8

9 Q. I think this probably is the same answer as the one
10 you just gave to the Commissioner a moment ago, but insofar
11 as there's a difference between what has been anticipated
12 or proposed as the anticipated activity within Hawkesbury
13 hospital on the one hand, and what was the activity which
14 was allocated to it in this document, you had no reason to
15 believe, or were not told by anyone, that the activity
16 projections which St John of God had put forward were
17 wrong?

18 A. No, I don't recall being told - no, nobody told me
19 their projections were wrong. I can't recall that, no.

20

21 Q. So the net consequence of the funding allocation which
22 was being conveyed through this letter was, as you
23 understood it, wasn't it, that St John of God was going to
24 be receiving less funding than it was going to be incurring
25 in costs to deliver services through the '23/24 period?

26 A. Yes, that's my understanding, yes, and that's what
27 they --

28

29 Q. You understood that St John of God was a little bit
30 different to other facilities within the LHD insofar as it
31 was operated by a private enterprise?

32 A. Yes.

33

34 Q. Or a not for profit?

35 A. Yes.

36

37 Q. In what way was it appropriate, in your view, to pay
38 that private enterprise less than it was going to incur in
39 delivering the services that you were requiring of them
40 throughout the '23/24 period?

41 A. Sorry, let me go back a step. So when I say
42 I understood this would be less than the cost of the - it
43 was costing St John of God to run the hospital, that was as
44 a consequence of the conversations that we got into with
45 St John of God post issuing of this letter and those - all
46 those - the response to our budget letter, et cetera.

47

1 Q. I think this letter is 25 October. So as I understood
2 your earlier evidence, your meet and greet with them was at
3 the beginning of October; is that right?

4 A. Yes.

5

6 Q. So they had had that discussion with you during the
7 meet and greet, yes?

8 A. Yes, that's correct, yes.

9

10 Q. And then are you able to recall when, in the calendar
11 month, roughly, these performance meetings used to be held?
12 Were they mid month, early month, end of the month?

13 A. Usually I think around the third week of the month,
14 possibly.

15

16 Q. So assuming that sort of held roughly true in October,
17 you would have had both of those meetings with St John of
18 God before the 25 October 2023 letter went out, would you
19 not?

20 A. Yes.

21

22 Q. So I come back to, I think, my earlier question: in
23 what ways did you perceive, as the chief executive sending
24 that letter, was it appropriate to be offering a private
25 enterprise like St John of God less money for the delivery
26 of the services required of it under the services agreement
27 than it would cost for them to provide those services?

28 A. Yes, so probably two things: one, I understood that
29 they had a financial problem. The level of it was to be
30 established - you know, they started to indicate to us it
31 was a deteriorating financial problem, different from, you
32 know, previous years which was based on the level of
33 activity to be purchased. I understood also that was
34 obviously going to be a negotiated process. We were in the
35 negotiation for the terms sheet and the new agreement. So
36 it was in that sort of broader context we were issuing that
37 budget letter.

38

39 Q. But in terms of the financial problem that you allude
40 to, I think you've told us that you had no reason to think
41 that that financial problem was referable to inefficiencies
42 in the manner of the operation of the hospital by St John
43 of God?

44 A. I didn't have any evidence to say that that was the
45 case, no.

46

47 Q. You had no reason to believe or no evidence available

1 to you that suggested that the financial problems which had
2 emerged were referable to anything other than a widening
3 gap between the cost of delivering the services required
4 under the service agreements and the funding that was being
5 provided for the delivery of those services, did you?

6 A. Sorry, just repeat that question for me.

7
8 Q. You had no reason to believe that the financial
9 problem experienced by St John of God was referable to
10 anything other than a widening gap between the cost of
11 delivering services in the challenging financial
12 environment and the amount of funding that was being
13 delivered through the services agreement in order for it to
14 do so?

15 A. Yeah, I'd probably characterise it as more at that
16 time, in my mind, it needed to be established more clearly.
17 I get - you know, like, I get and acknowledged and
18 understood the issue around rising costs in the health
19 system, but in my mind at that time we had more work to do
20 to understand it.

21
22 Q. Unless and until such time as you understood there was
23 something wrong with what you were being told - I think you
24 told us a while ago you had no reason to think that what
25 they were telling you wasn't correct - I ask you again, in
26 what way did you regard it as appropriate in the context of
27 dealings with a private entity to be proffering them less
28 money to deliver services than it was going to cost them to
29 deliver those services, the services that were required of
30 them under the service agreement?

31 A. Yes, I think - well, again, I come back to, one, we're
32 trying to balance the whole of district budget and, two, we
33 were in a broader context of a negotiation with them for
34 a new service agreement, so yes, that's why --

35
36 Q. But a balancing of the whole of the district's budget
37 is one thing when you're dealing with those parts of the
38 district which are part of the ministry?

39 A. Mmm.

40
41 Q. You would agree with that, wouldn't you?

42 A. Yes.

43
44 Q. That is to say, to the extent that the ministry is
45 going to potentially suffer a loss in one of its various
46 hospitals, it's swings and roundabouts, you take your
47 budget, you deliver it into those various pockets in

1 whatever way you want to, but ultimately it is the ministry
2 who is going to suffer the loss; is that right?

3 A. Well, yes, yes.

4

5 Q. Perhaps via the LHD?

6 A. Yes.

7

8 Q. The LHD will suffer a loss, but ultimately, it is the
9 ministry that suffers that loss in the event that the cost
10 of delivering services exceeds whatever it is the ministry
11 has delivered to the LHD to do so?

12 A. Yes, yes.

13

14 Q. But the LHD and the ministry are wholly quarantined,
15 aren't they, from any losses sustained within a private
16 enterprise like St John of God?

17 A. Well, yeah, it's different. What you're saying, it's
18 different for St John of God. Yes, I get what you are
19 saying, yeah.

20

21 THE COMMISSIONER: Q. Just so I understand your answer
22 on Mr Muston's question about appropriateness, it's, "Yes,
23 we didn't have any evidence to doubt what St John of God
24 were telling us about costs and the deficit they were
25 facing", but you thought there was more work to be done to
26 understand that gap; is that --

27 A. Yes, that's correct. And I think the other comment
28 I'd make is historically, the way this has gone - and I've
29 seen in other sort of similar arrangements, is - there
30 tends to be a negotiation and additional funding or top-ups
31 provided on an ad hoc basis.

32

33 MR MUSTON: Q. That's the way it works within the
34 ministry, isn't it? Where insufficient funding is provided
35 to deliver a service, you do your best to provide the
36 service with that money, and that, no doubt, drives
37 efficiency - is that right?

38 A. That's one way of putting it, I would suggest.

39

40 Q. But your expectation is within the ministry, at the
41 end of the day, if it really was not enough, it would be
42 topped up?

43 A. No, not necessarily, no. Not necessarily.

44

45 Q. What are the consequences for a ministry owned and
46 operated entity if there's no top-up?

47 A. Well, it's - simple consequence - there's no - there's

1 not the same consequence as there is for a private sector
2 entity.

3
4 Q. But a private entity who is left with a funding gap is
5 faced, amongst other things, with the prospect of a claim
6 of insolvent trading?

7 A. But that's - well, potentially, yes, but St John of
8 God Hawkesbury is part of a bigger group of St John of God,
9 but yes, potentially. I accept the characterisation, the
10 point you're making around the difference between a private
11 and public sector entity, obviously.

12
13 THE COMMISSIONER: Q. They still may not want to run any
14 part of their business that runs a loss?

15 A. Yes, no, I'm not disputing that. I agree, yes.

16
17 MR MUSTON: Q. And it would be no answer to that to say,
18 "Well, usually the way these things happen is you get
19 a top-up if it really gets bad at the end"?

20 A. Well, I think historically, there's been - whenever
21 you send - on an annual basis, whatever budget letter they
22 get it's usually resulting in a negotiation, that has
23 happened and resulted in additional funding to them, and
24 I think that was some of the points Ben was making around
25 the uncertainty of funding, you know, when they've got
26 over - when they've overran the level of activity, the
27 district's tried to find and fund additional activity, not
28 every year, but in previous years it has happened, is my
29 understanding.

30
31 Q. When you say "historically", other than the short
32 involvement you tell us about at Northern Beaches in
33 paragraph 20 and following, what has your involvement been
34 in dealing with PPPs throughout your time working within
35 health?

36 A. So this one, Northern Beaches, and a bit on the Royal
37 North Shore PPP as well.

38
39 THE COMMISSIONER: Just as an aside, not for you,
40 Mr Gregory, you mentioned Northern Beaches, and there is
41 part of this statement that deals with that. You probably
42 may have had a discussion with Mr Chiu, I don't know, but
43 that's not part of these hearings.

44
45 MR MUSTON: I'm not going to be asking any questions about
46 Northern Beaches. The statement will be tendered.
47 Commissioner, you will have seen the content of the

1 statement dealing with Northern Beaches.

2

3 THE COMMISSIONER: As is, but if something emerges
4 regarding Northern Beaches, it will be dealt with at
5 another time.

6

7 MR MUSTON: And perhaps in another place. We have to give
8 careful consideration as to how we deal with that.

9

10 THE COMMISSIONER: Yes, certainly.

11

12 MR MUSTON: I think that exhausts the questions I had of
13 this witness, Commissioner.

14

15 THE COMMISSIONER: Mr Chiu, do you have any questions?

16

17 MR CHIU: Yes, Commissioner.

18

19 **<EXAMINATION BY MR CHIU:**

20

21 MR CHIU: Q. Mr Gregory, you were asked some questions
22 earlier, about - to explain the appropriateness, as
23 I understand it, of letting St John of God hospital,
24 Hawkesbury, fall into deficit, and you were explaining some
25 of the consequences of increasing the funding to remove
26 that deficit?

27

A. Mmm.

28

29 Q. What sort of consequences might there be for the rest
30 of your district of increasing the funding for that
31 hospital --

32

A. Yes.

33

34 Q. -- so that the deficit would be removed?

35

A. Yes, so it would mean simply we would have to remove
36 funding from another facility or service across the
37 district to accommodate any increased funding for St John
38 of God.

39

40 THE COMMISSIONER: Q. Is that assuming that the LHD
41 doesn't get extra funding from the ministry to compensate
42 for that?

43

A. Yes, but, I mean, regardless of - we wouldn't get
44 specific funding for St John of God from the ministry.
45 We'd just get a macro level of - a macro level of funding
46 increase, and we may or may not - and that's not even - it
47 doesn't happen, you know, in some years you may get very

1 little growth funding.

2

3 But probably the point you're making is in
4 distributing the district's income, if you up for St John
5 of God, you're going to have to less for someone else.

6

7 Q. If the LHD's budget stays the same, you've got to get
8 that money from somewhere else?

9

A. Yes.

10

11 Q. Is that the short answer?

12

A. Yes, yes.

13

14 MR CHIU: Q. Why couldn't you just go back to ministry
15 and say, "Well, this is to ensure St John of God stays
16 operating Hawkesbury hospital. That's why we're in
17 deficit. You're just going to have to fund it". Why can't
18 you just have that conversation with the ministry?

19

A. Yes, the way the funding negotiations work with the
20 ministry is we go through an annual negotiation around the
21 level of activity the ministry will purchase from the
22 district. Within that, we may be able to put up with one,
23 two, three, four priorities, but given, you know, the
24 constraints on the whole of the health system, the
25 likelihood (a) of your priorities being specifically funded
26 is very low, and (b) the level of growth funding that the
27 district's received in recent years has been low as well.
28 Yes.

29

30 Q. What are the consequences if you're in deficit for
31 year after year?

32

A. Yes, so if you're in deficit year after year, it
33 becomes - so, like, for instance, Nepean Blue Mountains is
34 on - the ministry has a performance monitoring framework,
35 nought to 4, I think. Nought, yes, everything's okay; 4 is
36 the ministry step in. Nepean Blue Mountains is on level 3
37 and that's in part because of its financial difficulties.

38

39 MR CHIU: No further questions, thanks.

40

41 THE COMMISSIONER: I will say this in case it - maybe it
42 won't help. The question about appropriateness that
43 Mr Muston asked, I didn't take it as an implied criticism,
44 certainly not of Mr Gregory, or even directly related only
45 to the LHD, but to be a broader question of appropriateness
46 generally; is that what - you're nodding your head, so --
47

1 MR MUSTON: I think something arises from that last
2 passage, if I could.

3
4 THE COMMISSIONER: Yes, go ahead.

5
6 **<EXAMINATION BY MR MUSTON:**

7
8 MR MUSTON: Q. So the issue is, you say, in order to
9 share the acquired activity across the system, a decision
10 needs to be made about how it's going to be distributed
11 amongst the various facilities, including Hawkesbury
12 hospital, operated by St John of God. A consequence of
13 that - that sharing of the activity - is St John of God is
14 placed in a position where it suffers, or will suffer,
15 a deficit; is that right - as you understood it?

16 A. Yeah, I think that will - yeah. I would only qualify
17 that by saying in my mind at the time, we needed more - to
18 do more work to understand it, but yes.

19
20 Q. The reason that that distribution happens is so as to
21 ensure that the LHD does not itself fall into a deficit,
22 insofar as its budgetary arrangements with the ministry are
23 concerned, as best is possible?

24 A. No, the district's been in deficit probably for
25 a number of years before I came there, so it's operating
26 already in a really difficult financial environment.

27
28 Q. Let me reframe it. It doesn't want to be in a bigger
29 deficit than the one that it's currently in?

30 A. Yes.

31
32 Q. In fact, no doubt your ambition as the chief executive
33 of the LHD is to make that deficit smaller?

34 A. Yes, that's correct, yes.

35
36 Q. And a way that that was being achieved was through
37 this distribution of activity across the various facilities
38 in a way that you say fairly shared, as it were, the pain
39 amongst each of those facilities, including Hawkesbury
40 hospital?

41 A. Yes, no, I don't think we - we don't distribute
42 activity out on the basis of what it will do to our
43 financial deficit; it's just distributed out as best and as
44 fairly as we can, given the constraints that we've got. We
45 don't look at it and go, "Well, that's going to impact our
46 deficit", you know, it's really around trying to manage the
47 deficit overall, what's affordable for the district.

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Q. But to the extent that the deficit - that St John of God was suffering a deficit as a result of that process, as I think they told you in a subsequent item of correspondence in November, a \$4.8 million deficit, that was to the benefit of the LHD, wasn't it?

A. So the \$4 million deficit, my recollection is, only came out later. At the time of - around this time, it was starting to - they had done their first quarter forecasts and it was nowhere near - my recollection, it wasn't \$4 million that was being projected. That came later on and, if I'm not wrong, post the decision to transfer back to the district, as the financial year went on.

Q. But any deficit that was going to be suffered by St John of God would be to the benefit of the LHD insofar as it would reduce the benefit that sat within the LHD's budget; is that right?

A. Yes, that's correct, if you're saying that - as opposed to us providing them with additional funding and therefore expense to the district, that would be correct. Because it would --

Q. Did anyone go back to the ministry at the time of these discussions and say, "St John of God tell us, and we've no reason to doubt, that they will suffer a significant deficit if they're not given more funding. Therefore, you should give us, the LHD, at least sufficient funding to make sure that St John of God is not left in that position"?

A. No, we didn't.

MR MUSTON: No further questions.

THE COMMISSIONER: Can I just ask a question, just on the documents that are still on the screen. I'd forgotten to ask it before.

Q. On the left-hand document, can we go to nearer the top of the page. Just pausing there, do you see the - can you just help me with this, where it's got the heading, which helpfully, isn't in bold, "NSW Health State Price", do you see that?

A. Yes.

Q. Do you see the words, "NSW State Price ... is \$5,323 ... whilst the NSW State Efficient Price is \$5,207

1 and has been informed by the Cost per NWAU data"
2 et cetera. What should I take the meaning of the words
3 "informed by" to mean? Is that "based on" or something
4 else?

5 A. So where the state price is derived from is there is
6 a costing study undertaken by the ministry of all the
7 hospitals in the state, so we all submit our data, our
8 activity and costing data, and from that the ministry would
9 then derive the state price.

10
11 Q. So does "informed by" mean based on that data, or just
12 having some form of regard to it?

13 A. I couldn't tell you how - exactly how they calculate
14 it.

15
16 Q. All right, thanks.

17 A. But it's derived from the costing study.

18
19 THE COMMISSIONER: Did anything come out of that?

20
21 MR CHIU: No.

22
23 THE COMMISSIONER: Thanks. I take it you have got
24 nothing?

25
26 MR FITZPATRICK: No.

27
28 THE COMMISSIONER: Thank you very much for your time,
29 Mr Gregory, again, we're very grateful. You're excused.

30
31 THE WITNESS: Thanks, Commissioner.

32
33 <THE WITNESS WITHDREW

34
35 MR MUSTON: The next witness, Commissioner, is Christopher
36 Blake, the chief executive officer of St Vincent's Health
37 Australia. We're just having a discussion on the Bar table
38 about whether this morning's order extends to St Vincent's.

39
40 I might canvass that quickly with Mr Jones who is
41 going to appearing for St Vincent's.

42
43 THE COMMISSIONER: I didn't quite hear that, sorry.

44
45 MR MUSTON: We're just canvassing on our side of the Bar
46 table about whether this morning's order about live
47 streaming and transcript extends to St Vincent's.

1
2 THE COMMISSIONER: Is Mr Jones here? Do you want to have
3 a talk with him? Do you want me to adjourn for five
4 minutes?
5
6 MR MUSTON: Perhaps for five minutes. I'm not going to be
7 an hour with Mr Blake, so that will --
8
9 THE COMMISSIONER: I will adjourn until you tell me to
10 come back.
11
12 MR MUSTON: Thank you.
13
14 **SHORT ADJOURNMENT**
15
16 MR MUSTON: Mr Jones, I think, will announce his
17 appearance.
18
19 MR JONES: With your leave, I appear for St Vincent's
20 Sydney.
21
22 THE COMMISSIONER: Thank you, Mr Jones. Leave is granted.
23
24 MR MUSTON: In relation to the issue that I touched on
25 shortly before the adjournment, the order that was made
26 this morning in respect of the live stream not being up and
27 the transcript being made the subject of a suppression
28 order pending any application between now and 5 o'clock,
29 that does not apply to this witness's evidence. So that
30 can be business as usual.
31
32 THE COMMISSIONER: All right. And I'm going to be told
33 something about the order I made, because I'm starting to
34 get confused as to why I made the order, to be honest.
35
36 MR MUSTON: The order that you made on the application of
37 St John of God, and indirectly health, was because those
38 two entities are engaged in that negotiation around the
39 hand-back and they just want an opportunity to look at --
40
41 THE COMMISSIONER: It was out of an abundance of caution
42 that's no doubt entirely appropriate.
43
44 MR MUSTON: Perhaps between now and 5 o'clock tomorrow --
45
46 THE COMMISSIONER: It doesn't apply now.
47

1 MR MUSTON: If no further application is made between now
2 and 5 o'clock tomorrow, then it's all just --

3

4 THE COMMISSIONER: Understood.

5

6 **IN OPEN COURT**

7

8 MR MUSTON: I call Christopher John Blake.

9

10 <CHRISTOPHER JOHN BLAKE, sworn: [3.09pm]

11

12 <EXAMINATION BY MR MUSTON:

13

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

16 A. Christopher John Blake.

17

18 Q. You are the group chief executive officer of
19 St Vincent's Health Australia?

20 A. I am.

21

22 Q. It is a role you have held since October 2022?

23 A. Yes.

24

25 Q. You've prepared a statement dated 6 June 2024 to
26 assist the Commission with its work?

27 A. Yes.

28

29 Q. Have you had an opportunity to read that statement
30 before giving your evidence today?

31 A. Yes, I have.

32

33 Q. And you're satisfied that the content of it is true
34 and correct to the best of your knowledge?

35 A. I am.

36

37 MR MUSTON: Thank you. Commissioner, that will form part
38 of the bulk tender in due course.

39

40 THE COMMISSIONER: Sure.

41

42 MR MUSTON: Q. Do you have a copy of your statement with
43 you?

44 A. I do.

45

46 Q. I will let you get your drink of water first.

47 A. Thank you.

1
2 Q. Could I take you to paragraph 5 of your statement,
3 where you tell us about the previous roles you've held.
4 Prior to your commencement in your current role, do you
5 have a background or experience in the health sector?
6 A. I've always had a connection to health, yes,
7 principally through my roles on boards of research
8 institutions closely associated with hospitals, but my
9 prior background has mostly been working through
10 organisations going through dramatic change, so - as my day
11 job.

12
13 Q. So the other than day job activities have given you
14 a reasonable sense of the wide and complex ecosystem that
15 is the public health system?

16 A. Indeed, you could say it's the confluence of dramatic
17 change happening and the experience in health care.

18
19 Q. In your capacity as group CEO of St Vincent's Health
20 Australia, do you have a familiarity with the way in which
21 St Vincent's Hospital Sydney is funded to provide the
22 services that it provides to public patients as part of the
23 public health system?

24 A. Yes, I do generally. The negotiations of those
25 funding arrangements are made by the CEO of the St
26 Vincent's Hospital Sydney, who reports to me, but I have
27 a general understanding of the funding, yes.

28
29 Q. In terms of the oversight and decision-making around
30 how St Vincent's Sydney might proceed in the event it were
31 to reach any sort of impasse in respect of those funding
32 arrangements, how does that work within the broad corporate
33 structure of St Vincent's Health Australia?

34 A. So the funding arrangements themselves are made
35 directly with the ministry. It's one of the few AHOs that
36 are directly funded through an agreement with the ministry
37 and we - Anna, who is the CEO, Anna McFadgen, who is the
38 CEO, is very closely integrated into the normal
39 arrangements of funding, as are all of the public hospital
40 CEOs.

41
42 In the event of an impasse, as you say, obviously that
43 would be brought up through those funding negotiations and
44 indeed through our governance structure and our chairman of
45 the board, who is also involved in that, as is the chairman
46 of the board of any LHD.

47

1 Q. Because St Vincent's Sydney is a wholly owned
2 subsidiary of St Vincent's Health Australia?

3 A. It is, yes.
4

5 Q. It has an independent - does it have a board which is
6 independent of St Vincent's Health Australia?

7 A. No, it has a board - the subsidiary hospital, the
8 public hospital in Sydney, reports to the board of
9 St Vincent's Health Australia. It's one of the two public
10 hospitals, actually. We have one in Victoria as well.
11

12 Q. So from the point of view of the internal governance
13 of St Vincent's Health Australia, large decisions like
14 annual funding agreements for a large public hospital, to
15 what extent is St Vincent's Health Australia involved in
16 any ultimate sign-off in respect of those decisions?

17 A. Well, the funding agreement has to be approved by the
18 board through the normal governance arrangements, but it's
19 negotiated directly. So the final agreement is signed off
20 by the board and signed by the chair and the CEO of the
21 public hospital.
22

23 Q. In terms of the process that leads to the negotiation
24 of that service level agreement, are you able to describe,
25 at least insofar as you have visibility of it, how that
26 process works from St Vincent's perspective?

27 A. Well, it's an annual agreement, as I understand are
28 all of the LHD agreements, and that there is an annual
29 negotiation for the services to be provided for the
30 following year, and then our CEO participates, in exactly
31 the same way as all of the other CEOs of the LHDs and an
32 agreement is struck for the volume of services against the
33 funding that's required for each year.
34

35 Q. The actual agreement that ultimately results from that
36 process is, I think as you point out, an agreement which is
37 built largely around the volume of activity --

38 A. Yes.
39

40 Q. -- which is to be purchased. The service agreements
41 don't seem to say in any detailed way what the actual
42 services which are to be provided from year to year will
43 involve?

44 A. Well, there is a level of detail that's negotiated.
45 That would be a question that would be better put to the
46 CEO of the hospital, she has - because she's involved in
47 the detail of those services, both the volume and the

1 particular services including the specialist services that
2 are provided.

3
4 Q. St Vincent's Health Australia also, I think you've
5 told us, operates a large public hospital in Victoria?

6 A. Yes, it does.

7
8 Q. Are you able to express any views, from the
9 perspective of someone who has got a high level visibility
10 of both processes, as to where the Victorian system differs
11 from that which exists in Australia [sic] and perhaps where
12 it is better or worse, from a funding perspective?

13 A. Well, I guess they're - both systems suffer from
14 exactly the same system pressures, which no doubt have been
15 discussed throughout the Inquiry. In terms of funding, the
16 arrangements are similar in some ways but different in
17 terms of the term. So in Victoria, for example, our term
18 is a longer-term arrangement, still with annual priorities
19 that are set within the term, but a much longer term than
20 exists in New South Wales.

21
22 THE COMMISSIONER: Q. "Longer term" meaning exactly?

23 A. It's a 20-year term in Victoria.

24
25 MR MUSTON: Q. So from the perspective of an albeit not
26 for profit commercial organisation like St Vincent's
27 Australia, are there advantages to that longer term in
28 terms of the way you operate?

29 A. Yes, there are clear advantages.

30
31 Q. What are they?

32 A. The principal advantage is level of confidence for
33 planning in the long run. In Victoria there is also, as
34 part of that agreement, an annual capital funding
35 allocation as well. So the combination of those two things
36 provides much more confidence for the board, which, as an
37 independent board, has all of the normal corporate
38 governance obligations of a board that is - you know,
39 particularly goes to things like solvency. So it requires
40 that level of confidence, or at least in Victoria it gives
41 an additional level of confidence, because it's
42 a multi-year agreement.

43
44 Q. That capital funding is not a feature of the annual
45 service agreements that St Vincent's Sydney enters into?

46 A. My understanding in Sydney is that the LHDs make
47 a pitch for capital, particularly for major capital works,

1 and to the extent that St Vincent's is part of the LHD
2 network, they can make that pitch. It is not an annual
3 allocation.
4

5 Q. From the perspective of running a hospital or the
6 commercialities around running a hospital as
7 a not-for-profit entity, what are the benefits, if any, of
8 that commitment, annual commitment, to a capital - a
9 contribution towards capital funding?

10 A. Well, I think there's two. One is, obviously, the
11 ability to plan in the long run. Health care in particular
12 at the moment is changing rapidly and requires longer
13 cycles of change, particularly as the assets that are
14 required in delivering health care change. So you're able
15 to plan in a longer term. And of course, the second is
16 you're able to plan for the retooling, in the shorter term,
17 of the assets, and have an asset maintenance schedule that,
18 if there is an allocation in an annual and longer-term
19 plan, you're able to actually plan the retooling,
20 refurbishment and investment in those assets along the way.
21

22 Q. The absence of that sort of arrangement in New South
23 Wales, is it something which is necessarily done on more of
24 an ad hoc basis at St Vincent's Sydney?

25 A. I would say "ad hoc" is probably a good description.
26 Without that support, obviously you - the system tends to
27 a more break/fix cycle, what they're really doing is
28 investing in those things that are end of life because they
29 have to, at the end of the life, to continue the services,
30 which obviously means that it adds a little bit of risk to
31 the continuation of the delivery of the services that
32 depend on those underlying assets - not just the buildings,
33 of course, but the buildings being the primary asset.
34

35 Q. Other than the capital issue that we've been
36 discussing, are there any other particular challenges
37 associated with the New South Wales funding model which you
38 perceive make it difficult to deliver services through
39 St Vincent's as part of the public hospital system of
40 New South Wales?

41 A. I think they're the primary differences, but they are
42 big differences. I mean, they are - the inability to plan
43 in the longer run is obviously a very critical difference,
44 and it does impact the ability to plan, particularly when
45 the system is changing as rapidly as it is. So whilst
46 there's not that many differences, the differences that
47 exist are big and impactful.

1
2 Q. At least as at 25 March of this year, St Vincent's
3 Hospital Sydney board had indicated to the health secretary
4 that it was not in a position to execute its '23/24 service
5 agreement?

6 A. Well, there was a letter that was sent by the chair
7 requesting the right to negotiate a longer-term agreement
8 for the same reason that we've just discussed, for the
9 ability to plan with some level of confidence, and of
10 course, as I said, the board of St Vincent's has
11 a different level of obligation from a corporate governance
12 perspective because it doesn't have the backstop of the
13 state government.

14
15 Q. So when you refer to the different level of
16 responsibility, you have in mind things like an obligation
17 not to engage in insolvent trading?

18 A. Yes, well, the St Vincent's board would not be able to
19 continue delivering the services if the forward prospect
20 was a continual deficiency.

21
22 Q. Unlike, say, an entity within the ministry that might
23 hope and assume, but perhaps not be certain about a top-up
24 at some point in the future, it's not a luxury that a board
25 of a private corporation --

26 A. Yes, the obligations and liabilities of the board
27 members are different from that respect, yes.

28
29 Q. So other than a desire to negotiate or discuss
30 a longer-term agreement, was there any other particular
31 reason why, insofar as you're aware, the chair of the board
32 of St Vincent's Sydney indicated an inability on the part
33 of that organisation to execute the service level - the
34 service agreement?

35 A. No. It mainly goes to the certainty for planning.
36 I mean, the fact is that St Vincent's is - St Vincent's has
37 the longest standing community partnership with the state
38 government for the delivery of public health care in
39 New South Wales' history, so it's a known entity, it's an
40 organisation that wants to continue that work, for,
41 hopefully, another hundred years, and so we're looking for
42 the basis on which we could begin planning for the future
43 of health care and our role in it, with the level of
44 confidence for our longer-term arrangement.

45
46 Q. I gather from some of the material that we've seen
47 that one particular issue which emerged during discussions

1 between St Vincent's Sydney and the ministry was a deficit
2 in or a gulf between the costs of delivering the services
3 required under the service agreement and the funding that
4 was being provided for that purpose. Is that an issue that
5 you're aware of?

6 A. Yes. As would be well understood generally,
7 particularly coming out of COVID, the additional costs in
8 the system were inflating at a rate which is higher than
9 the funding, so that obviously can't continue for multiple
10 years, given the kind of organisation that St Vincent's is.
11

12 Q. And did that feature in the decision by the board not
13 to execute the services agreement, at least as at 25 March
14 2024 - that is, a view that the amount of funding being
15 delivered under that agreement would be insufficient to
16 meet the costs of delivering those services?

17 A. Well, I think there's two aspects of it. One is the
18 certainty of the funding, and the certainty of the funding
19 for things that require us as an organisation to commit
20 across multiple years. So that's number 1.
21

22 Then the second is that in-year certainty that we're
23 able to plan out at least for the next 12 months, that we
24 wouldn't be in a position at the end of the year, or that
25 we would have sufficient levers to ensure that we could
26 match the cost structure of the delivery of health services
27 at Darlinghurst with the income that's --
28

29 Q. Dealing with those two, perhaps in reverse order,
30 within the year itself, do I infer from that answer that
31 there was a concern that the amount of money that was to be
32 delivered through the funding arrangement that year would
33 be insufficient to meet the costs of delivering the
34 services required to be delivered under the agreement in
35 that year?

36 A. Yes, that would definitely be the concern.
37

38 Q. And in terms of the first issue, was there a further
39 concern that the ability to deliver services in the longer
40 term required some commitment on the part of St Vincent's
41 Sydney in terms of capital and building up workforce and
42 the like, which, in the event that that funding was not
43 continuing, would create or compound the existing
44 inter-year problem?

45 A. Indeed, yes. I mean, you have two big costs in health
46 care. The vast majority of the in-year costs is obviously
47 salary and wages, which, in and of themselves, have been

1 inflating and, you know, appropriately so. And then
2 there's the assets, the buildings, which really are the
3 longest-standing commitment to the delivery of care,
4 because once you've got an asset, you have - not just that
5 you need to pay for it up-front, you actually have to
6 maintain it over time and, of course, it's the maintenance
7 of our assets that we are increasingly concerned about,
8 given that we haven't invested in some assets that are
9 coming to end of life.

10
11 Q. Again, if I'm reading more into the correspondence
12 than I should, it does appear that as at 25 March 2024,
13 something of an impasse had arisen as between St Vincent's
14 Sydney and the ministry about the amount of funding that
15 was to be provided under the service level agreement?

16 A. Well, I wouldn't call it an impasse. What I would say
17 is that we have been clear with each other that we need to
18 sit down and work through the process of what a longer-term
19 agreement would look like, and I'm sure that Anna McFadgen,
20 the CEO, could give you more details of the actual process
21 for that.

22
23 Q. The 2023/24 service agreement, was it ultimately
24 executed?

25 A. The existing in-year one was, with the requirement or
26 the request that we sit down to plan out the longer-term
27 arrangements.

28
29 Q. In terms of the planning of those longer-term
30 arrangements, without needing to get into the details of
31 what the negotiations might involve, to the extent that
32 St Vincent's Hospital Sydney is not able to reach
33 a long-term position that it is comfortable will provide it
34 with the financial security that it needs, what are the
35 realistic options for it, insofar as its ongoing dealings
36 with the ministry are concerned?

37 A. Well, clearly the obligations of the board would be
38 that it cannot sign off on the hospital's continuing
39 operation without the support, and we've had that support
40 for 165 years, so our goal would be to continue that
41 support. And it's been a happy arrangement that we've been
42 able to negotiate for a very long time, so that's what we
43 are assuming will be the outcome of the negotiations that
44 we work through with the ministry.

45
46 Q. Hoping that it will, what I'm exploring with you is,
47 as at least in your role with St Vincent's Health

1 Australia, what do you perceive to be the options for
2 St Vincent's Sydney in the event that no such happy
3 agreement can be reached?

4 A. Well, we would need to work through that, and we are.
5 Clearly, the first and foremost implication is that we
6 couldn't continue to operate if we didn't have sufficient
7 funding, because the board would not be able to commit to
8 the continued operations of a hospital that wasn't able to
9 continue to pay its expenses.

10

11 Q. Could I ask you to turn to paragraph 38 of your
12 statement. This may be a question better directed at the
13 CE of the hospital, in which case, feel free to tell me,
14 but those paragraphs form part of a series of paragraphs in
15 which you discuss various outreach and other services which
16 are being delivered by St Vincent's Health Australia,
17 outside of the footprint of St Vincent's Darlinghurst.

18

19

20 Q. In respect of paragraphs 38 to 40, the DREAM program,
21 can I ask, what discussions, if any, insofar as you're
22 aware, happened at a ministry level when decisions were
23 being made about where that program was to be rolled out?

24

25

26

27

28 Q. Again, you may not know the answer. Do you know what
29 the genesis of the DREAM program was?

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Q. No doubt endocrinologists and others involved in the
formulation of that DREAM program on the Darlinghurst
campus came to the view that the areas in the Murrumbidgee,
in and around Tumut, were an area which had a particular
need for outreach services of the type that are being

1 provided?

2 A. Yes, indeed, and it's been a very successful program,
3 not just for the outreach that is provided to a regional
4 area, but I understand a large proportion of the people who
5 have accessed that are First Nations people as well. So it
6 covers a number of under-served populations, and I know our
7 clinicians are very enthusiastic about providing that kind
8 of support. Again, given the kind of organisation that
9 St Vincent's has been traditionally, we really do look for
10 those opportunities, including where it requires innovative
11 funding like philanthropy in that case.

12
13 Q. Are you aware of any formal planning process involving
14 St Vincent's Australia or Sydney and the ministry where
15 consideration is given to just how services offered or
16 potentially offered by St Vincent's through those sorts of
17 programs might be best deployed across the wider population
18 in New South Wales, to best achieve the greatest success or
19 benefits?

20 A. Indeed, we obviously advocate at multiple levels, not
21 just for services that are funded within the state support
22 through the ministry, but also federally. So there are
23 services like that one. There's another service, for
24 example, that we are presenting as a proposal to the
25 department in - the federal department of health in
26 relation to an innovative combination of both public,
27 private and aged care services. So we advocate at multiple
28 levels.

29
30 In relation to the diabetes service, that would
31 absolutely have been presented as an option and as
32 a service that's provided in that case through, you know,
33 the avenues that the CEO has and that the clinicians have
34 through the services that they connect with in the network.

35
36 Q. To the extent, if any, to which it's not happening, do
37 you see that there may be some merit in a strategic
38 approach which brings together providers of services like
39 the DREAM program and others offered by St Vincent's and
40 the public health system with a view to collaborating and
41 coordinating the delivery of those services within the
42 community to best meet its needs?

43 A. Well, indeed, I think at a time when health care is
44 changing as rapidly as it is, and is being innovated
45 through a whole range of drivers, not just the ones that -
46 the obvious ones of demographics and ageing and all those
47 kinds of things, but technology, actually requires

1 a different way of combining the services that are
2 currently funded through multiple different funding
3 mechanisms to navigate through that in a way that
4 reconfigures those services to the community, and I think
5 organisations like St Vincent's, which are one of the few
6 microcosms of the whole system - so if you think about us
7 in public health, in private health, in aged care, the
8 delivery of virtual care and co-located with world class
9 research institutes, organisations like that become
10 relatively more important in the system than less
11 important, because they are potential sandpits for reform,
12 in particular, in those areas where you don't have to
13 create something new to reconfigure the services across all
14 of those settings. That is quite difficult to do in a
15 single mono-line, single-funded part of the health care
16 system, whether that be state, federal, private or aged
17 care. Indeed, all of those are required in the health care
18 system to deliver services, and, of course, that is the
19 system, the system is not one of those parts, and I think
20 sometimes, we fall back on the description of one part as
21 the system, as opposed to all of those components.

22
23 Q. And these are the issues which you address in
24 paragraph 59 of your statement as observations or ways in
25 which the broader health system might potentially be
26 reconfigured to deliver better outcomes?

27 A. Indeed. I mean, one example, of course, that I'm sure
28 the Inquiry has heard multiple times, is that one of the
29 biggest drivers of the costs in the health care system is
30 ageing, and attached to that is ageing with chronic
31 disease, so, of course, the maths of the combination of
32 those two things means that the system is much harder to
33 fund in all parts of the system over time.

34
35 There are two ways to approach that. One is to think
36 about increasing the funding in each part of the system.
37 The second is to reconfigure it, and I think one of the
38 things we're saying is that there are ways of reconfiguring
39 it without building something new, and I think the example
40 I gave in my witness statement, for example, is the
41 potential for reconfiguring the delivery of healthy ageing
42 not just in a public hospital but combining the services in
43 a public hospital with potentially step-down settings in
44 facilities that already exist but are funded simply through
45 federal aged care models but aren't necessarily connected
46 to the other stages - sorry, the other components of health
47 care. An organisation like St Vincent's has the

1 opportunity to reconfigure those because they are all in
2 one ecosystem, and in fact, that could be done quite
3 rapidly and potentially much more rapidly than exists in
4 other parts of the system.

5
6 Q. There are two elements to it, the first is in a
7 physical sense they're all in the one St Vincent's
8 ecosystem?

9 A. That's true.

10
11 Q. The physical?

12 A. Yes.

13
14 Q. The second sense is, in a financial sense,
15 St Vincent's has access to the various streams, disparate
16 streams of funding which feed into each of those parts and
17 is able to effectively pool them and distribute them in the
18 way that it perceives will deliver the best outcome for the
19 community served by that little ecosystem?

20 A. Yes, I would say that the joint assets could be used
21 more efficiently. The funding itself doesn't necessarily
22 get pooled but could be navigated carefully into that
23 reconfigured system. So the public funding that goes to
24 the Sydney public hospital, for example, that is captured
25 only in that public setting, but that doesn't mean that you
26 could not deliver a public step-down care, to get an old
27 person out of the hospital faster into a more appropriate
28 setting, including in the home or a repurposed residential
29 aged care facility, or, indeed, to a remote or a satellite
30 hospital ward, by reconfiguring the assets and being able
31 to navigate the funding into where that care is, because,
32 of course, you're talking about one person.

33
34 There is not an aged care patient and a public
35 hospital patient and an at home patient through virtual
36 care; they're actually one patient. What we're talking
37 about is the potential for organisations like
38 St Vincent's - and there are others, but St Vincent's is
39 certainly the largest and has the two largest public
40 hospitals in the system - organisations like St Vincent's
41 could be a partner in reconfiguring that funding for where
42 that care is delivered, because of course, what you're
43 really trying to do is re-navigate the way the funding
44 lands in the most appropriate place for that care to happen
45 at the lowest cost. But it's not just the lowest cost.
46 Sometimes the most appropriate place actually does drive
47 efficiencies, because if you're an older person receiving

1 care, the reality is the last place you want to end up is
2 in a public hospital, and be stuck there because there is
3 no other place for you to go. It's very - without those
4 other assets, it's very hard to reconfigure the system to
5 provide another place to go.
6

7 Q. How is it that an organisation like St Vincent's can
8 break down some of those funding demarcation lines, though,
9 just dealing with that example? There is, we heard,
10 a tension on the one hand between a patient, who probably
11 should not be in an acute ward in a hospital, being sent
12 out to an aged care facility, and that tension really flows
13 from the fact that it's a different funding source to the
14 state, who has got the capacity to discharge someone, which
15 is responsible, then, for picking up and meeting the care
16 of that patient in the aged care facility.

17 A. That's true. I would say, though, that there is
18 a role of reconfiguring the funding around the place of the
19 care, and at the moment, the system is structured by the
20 funding, not the care.
21

22 Q. How is it that St Vincent's as an organisation has the
23 capacity to be a Petri dish, as it were, for a reconfigured
24 mindset around that funding in the context of a program
25 like the one you've told us about?

26 A. Well, I think it's clear that a system that has all
27 the component parts is a system that has the opportunity to
28 reconfigure the parts and to work with the funders as
29 partners to work out how to reconfigure those parts. An
30 organisation - I mean, every single part of the system is
31 important, including the private health care, because it
32 takes pressure off the public system, but an organisation
33 like St Vincent's has all of those parts and has, as its
34 purpose, the delivery of health care without a profit
35 motive. So basically, the reconfiguration happens to
36 determine the best possible place for the most efficient
37 care and the best care, in that location, without
38 necessarily having to share any of those resources with
39 anyone outside the system.
40

41 Q. Does the absence of a profit, the need for a profit
42 margin, also combine with the fact that if St Vincent's has
43 each of these disparate parts of the ecosystem under its
44 control, and each of the funding streams feeding into them,
45 it matters little to St Vincent's whether costs are shifted
46 from one silo to the other because it ultimately is all its
47 money?

1 A. Well, I wouldn't characterise it as shifting the cost.
2 What I would do is making sure that the reconfiguration of
3 the funding stream can be navigated to the care, without
4 necessarily - so if you're a public patient, the reality is
5 that has to be funded through the public system. But that
6 doesn't mean that you can't come up with an innovative
7 arrangement to ensure that the part of care for that public
8 patient in an integrated setting is paid for out of the
9 public system in a fair way. That is simply just another
10 way of thinking about a service level agreement for the
11 value of care that's provided in a lower cost setting in a
12 different way.

13
14 Those things are possible. They need to be worked
15 through. I think the point that I'm making is that you
16 don't get to design that system easily if you don't have
17 all the parts of the system, and I think if - you often
18 hear that there is a divide between the state and federal
19 funding, through the different components of funding -
20 Medicare, NDIS - through the state funding system, through
21 the private health insurers, and indeed philanthropy,
22 because philanthropy is an important part of funding for
23 some parts of the system, that actually the system itself
24 is only structured around each of those. So you have to be
25 playing in every single part of that value chain of health
26 care to be able to reconfigure it, and the point is that
27 there aren't many organisations that can do that.
28 St Vincent's is one. There are others.

29
30 Q. Can I ask you one last question about the philanthropy
31 that you have just raised. To the extent that an
32 organisation like St Vincent's, which has the benefit of
33 significant philanthropy, might be delivering care within
34 the public system or as part of the public system --

35 A. Yes.

36
37 Q. -- do you have a view on what role, if any,
38 philanthropy should play in the funding of the strictly
39 public component of that care?

40 A. Well, my view as the group CEO is that public services
41 should be funded out of the public system. Philanthropy is
42 extraordinarily valuable when you're looking to innovate,
43 and I think that's where it should be used best, and
44 I think, you know, that is where St Vincent's has
45 historically used philanthropy best. If you look at the
46 pathway out of the public hospital into, for example,
47 research institutes, it's usually been that bit of

1 philanthropy that has enabled something to happen in a
2 mixed setting - public/private research. That is harder to
3 do in a single setting, either because it doesn't fit
4 within the priorities of a purely publicly funded system,
5 or if you are a purely privately funded system without
6 philanthropy, the reality is if you are a for profit, then
7 doing something new and innovative, particularly if you
8 can't do it at scale quickly, is not something that you
9 would necessarily choose to do, because there's no margin
10 in it for the system.

11
12 We don't have that issue. And philanthropy is
13 a critical part of being able to provide that, if you like,
14 innovation funding that enables the connection across all
15 of those, and it's what makes Darlinghurst - also in
16 Victoria for us, Fitzroy - such a unique place to be able
17 to do that, because, of course, you have the collocation on
18 those sites of the public, the private, and, of course, the
19 world class research institutes like Victor Chang, Garvan,
20 all large in their own right but also globally recognised.

21
22 MR MUSTON: Thank you, Mr Blake.

23
24 Commissioner, I have no further questions for this
25 witness.

26
27 THE COMMISSIONER: Thank you. Mr Chiu, do you have any
28 questions?

29
30 MR CHIU: I don't have any questions.

31
32 THE COMMISSIONER: I take it you don't have any questions?

33
34 MR JONES: I don't, Commissioner.

35
36 THE COMMISSIONER: Thank you very much for your time,
37 Mr Blake.

38
39 THE WITNESS: Thank you.

40
41 THE COMMISSIONER: We're very grateful. You are excused.

42
43 <THE WITNESS WITHDREW

44
45 MR MUSTON: Tomorrow we can adjourn until 10. There was
46 at one time --

47

1 THE COMMISSIONER: Can you just give me a rundown of who
2 is giving evidence tomorrow? I've got Ms McFadgen at 2,
3 but on my list there is a range of tentatives.
4

5 MR MUSTON: Yes. I think we've got two clinicians'
6 statements that have come in. I confess, for my part,
7 I haven't had an opportunity to absorb them.
8

9 THE COMMISSIONER: All right, tell me later.
10

11 MR MUSTON: I think it is unlikely we will be requiring
12 any oral evidence from them, but no-one should stand down
13 just yet.
14

15 THE COMMISSIONER: Is there a chance that Ms McFadgen is
16 the only witness tomorrow?
17

18 MR MUSTON: Yes, there is. A good chance.
19

20 THE COMMISSIONER: Do we adjourn until 10 anyway, but is
21 she listed at 2 for a convenience reason?
22

23 MR MUSTON: She is now at 10.
24

25 THE COMMISSIONER: Oh, she is now at 10, okay.
26

27 MR MUSTON: So she was at 2 in the expectation that some
28 of these other statements might more usefully have resulted
29 in oral evidence given before hers. I think it is now
30 10 o'clock, and I think it is likely --
31

32 THE COMMISSIONER: Undoubtedly, the thing I should have
33 just done is adjourn until 10 o'clock tomorrow, so we'll do
34 that.
35

36 MR MUSTON: Trust the process, Commissioner. Trust the
37 process.
38

39 THE COMMISSIONER: Yes. Thank you. We'll adjourn until
40 then, thanks.
41

42 **AT 3.46PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
43 **TO THURSDAY, 13 JUNE 2024 AT 10AM**
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47

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