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

THE COMMISSIONER: Good morning.

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

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

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

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

MR FITZPATRICK: I do, Commissioner.

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

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

MR MUSTON: Not opposed.

THE COMMISSIONER: Not opposed.

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

MR FITZPATRICK: Yes.

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

MR FITZPATRICK: Yes.

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

of the evidence heard.

MR FITZPATRICK: Yes, that's our application.

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

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

MR MUSTON: No.

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13 June, that the evidence - that is, the transcript and any documents tendered in relation to this evidence - not be published.

Is there anything further I need to do?

MR FITZPATRICK: No.

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

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

MR MUSTON: Thank you.

IN CLOSED COURT

<BENJAMIN EDWARDS, sworn: [10.04am]

<EXAMINATION BY MR MUSTON:

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

Q. You are the chief operating officer of St John of God?
A. Correct.

Q. That's a position you've held since January 2023?
A. Correct.

Q. And prior to that, or prior to taking on that role, you held a range of different roles associated with the delivery of healthcare services by the St John of God organisation in Western Australia, as I understand it?
A. Yes, that's correct.

Q. You have prepared a statement to assist the Commission with its work dated 4 June 2024.
A. Yes.

Q. Have you had an opportunity to read that statement or review that statement before giving your evidence today?
A. I have.

Q. Are you satisfied that the contents of that statement are true and correct?
A. I am.

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

Q. Mr Edwards, since 2015, you tell us that St John of God has operated the Hawkesbury District Health Service pursuant to a series of arrangements with the Nepean Blue Mountains LHD. That's correct?
A. Yes, that's correct, yes.

Q. Just because it is a bit of a mouthful, I might refer to it as "Hawkesbury hospital" going forward, if that's okay?
A. Yes, that's a lot easier.

Q. But prior to 2015, Hawkesbury hospital had been constructed and was operated under a public-private partnership between Catholic Healthcare New South Wales and ACT, and the LHD; is that correct?
A. That's correct, and then we stepped in and effectively took over from the other Catholic provider at that time.

Q. Could you describe the services which, at least at the

moment, or over the last, say, 12 to 18 months, have been delivered through Hawkesbury hospital? Just talk us through what it offers as a facility?
A. So it is a fairly general medium-sized public hospital. It has an emergency department which is quite significant, and provides a typical range of medical and surgical services, maternity services and some community services as well.

Q. You've described it as a "public hospital". Are there private patients treated through that hospital or is it exclusively public?
A. Yes, okay, so within the hospital, there is an area which is nominally dedicated for the treatment of private patients as well, which are typically surgical patients who are listed for procedures as opposed to being acute patients who turn up through the emergency department, and that's always been in part of the arrangement, yes.

Q. Is there a standard range of procedures which historically have been offered to those patients through that part of the facility?
A. Yes. So it typically tends to be planned procedures, so that would include things like endoscopies and surgery within specialties like ear nose and throat, ophthalmology, orthopaedics, soft tissue surgery, but probably at that medium level of complexity, so it's not a very large hospital with significant, you know, ICU infrastructure which means we would undertake more complex operations so middle-tier planned procedures.

Q. Would it be right that equivalent middle-tier planned procedures are also offered to public patients on public lists through the hospital?
A. Absolutely. Yes, there is an option - so the majority of the hospital serves public patients and there is a small proportion of private patients which are treated there as well.

Q. Do you have a sense of how the services offered through Hawkesbury hospital fit into the broader mix within the context of services which are delivered more widely by the Nepean Blue Mountains LHD to its community?
A. I couldn't give you a definitive answer on that. I am aware that there are a series of larger hospitals within the LHD, within fairly close distance, and other hospitals that are being constructed, and they form part of

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

Q. You may have just answered this question, but in the time that you have been in your role, have you been involved in any planning processes where consideration has been given to how the services offered at Hawkesbury hospital might fit within that broader matrix of services offered within the LHD?
A. No.

Q. Are you aware of whether anyone else from St John of God has been involved in any such planning process?
A. I couldn't say definitively no, but I am not aware if they have.

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

Q. Would it enable you to identify areas of overlap?
A. Yes, and also to understand the kind of - the optimum location for services across different hospitals.

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

Q. And then other areas of overlap which might be identified might actually point in the direction of a change in the sense that it may well be that a particular service being delivered at both could far better be delivered only at one or other of the facilities?
A. Yes, effectively a consolidation, yes.

Q. That sort of system-wide approach to service planning would also enable St John of God and the LHD collaboratively to identify any gaps in the delivery of service to the community that they collectively serve, wouldn't it?
A. If it was undertaken in the correct manner, yes, I would expect so.

Q. When you say, "the correct manner", what do you think would be a - I'll use your word. What would be the correct way to go about that task to produce the best outcomes from a planning and delivery perspective?
A. Well, if I think about what we would do in areas where - like in Western Australia, in Perth, where we have several hospitals, we start that process by looking at the population that we serve, how it's changing over time, what the demand of that service, of those patients, are for services, where the location of the hospitals are, the current infrastructure of those hospitals, and that informs decisions around, effectively, in simple terms, which services should be provided at which locations. That's a bit of an oversimplification, but a process in that sort of sequence.

Q. Sorry, I should say, I'm about to ask you another question, but to the extent that you might be seeing the back or side of my head, it's because I'm looking at you on a screen which I suspect is in the opposite direction to the camera that's facing me, so I don't intend any disrespect to you.
A. No, none taken, none taken.

Q. I gather from the answers that you've just given that, at least insofar as you are aware, this collaborative planning process involving the LHD, St John of God and potentially any other deliverers of health services within the LHD is not, insofar as you're aware, happening?
A. It would be hard for me to say that it's not happening at all. I think probably the furthest I could go is to say that our involvement in that process has been very limited. I would assume that that sort of planning process is occurring. I think our involvement in it has been limited.

Q. The involvement of a provider like St John of God in that process is important, is it not?
A. I would think so, yes.

Q. From the perspective of St John of God, it would give an organisation like yours an ability to understand the services that it could best be delivering to the community?
A. Yes, and I also think an ability to plan for what the best future for that hospital is, so yes.

Q. When you talk about that planning, obviously there's

a significant financial element to that. When you talk about the planning for the future, other than the financials, what did you have in mind?
A. So again if I use an example from another geographical location where we have more of a presence, these sorts of discussions would inform things like, you know, the location of services. To the point that you made earlier, often there's a critical mass for some specialist services where you need sufficient volume of patients to make that service safe and so you would make a decision about and consolidate it on to one site or another, and ultimately that typically leads into things like building plans - you know, do we need to expand, do we need to change the nature of a facility, and then that would also feed into staffing, looking - longer-term staffing/recruitment plans as well.

Q. And so that longer view and an ability to adapt the services that might be delivered through a facility like Hawkesbury gives you a greater capacity within an organisation like St John of God to provision or to make adjustments to your services in a way which they are able to be accommodated financially as opposed to, say, something which needs to be done within a very short time frame?
A. Yes, effectively, I think, like any large complex business, long-term planning is critical to future success.

Q. You've touched on this, but that collaborative process and planning of the services that might be usefully delivered through a facility like Hawkesbury could also inform discussions around capital expenditure at the facility relative to other facilities within the LHD, could it not?
A. I would think that it could, yes.

Q. Hawkesbury hospital is an ageing facility. Would that be an apt description?
A. It would.

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

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

what challenges did the ageing nature of the infrastructure of Hawkesbury present, commercially?
A. Yes, so if that question relates specifically to the ageing infrastructure, we were aware from a review that we had undertaken, a broader review, that there were, you know, a significant range of issues with the facility which required investment to get them to a standard that we would be happy with, and that included the building itself but also equipment, and it was not clear to us, because of the way that funding flows through the system, that that funding would be available to us, and so clearly, that caused some concern about the ongoing operational risk of continuing to run the facility.

Q. When you say bringing it up to a level that you would be happy with, what were the particular sources of unhappiness, to use your words, in respect of the infrastructure?
A. Yes, I think - so just like any building that's as old as the one that you've mentioned, that's used heavily, as hospitals tend to be, there's general wear and tear and part of running a hospital business is that you need to invest what we call kind of routine - into routine maintenance every year just to stay on top of, you know, the parts of the building that you see, the corridors, the ceilings, the floors.

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

Q. What were the practical ramifications of the lack of capital investment? Let's start with in terms of the delivery of health care to patients of the hospital. Were there any practical ramifications from that perspective which derived from the absence of significant capital investment?
A. Yes. I think probably the most obvious would be that occasionally, pieces of equipment would not work, and we

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

Q. What about from a workforce perspective, did you find that the lack of significant capital investment had any impact on your ability to attract and retain workforce within the hospital?
A. Look, it's impossible to definitively state that point, however, what we do know from running a large number of hospitals across the country, which are at various stages of their development, is that typically, our - we call our employees caregivers, our caregivers are happier when they're in new, purpose-built buildings, and we can see that through the regular satisfaction surveys that we've undertaken often.

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

Q. Were the challenges associated with the absence of significant capital infrastructure something that was discussed with the LHD?
A. Yes.

Q. And in terms of the timing of those discussions, did those discussions occur in the context of negotiations around the prospective renewal of the agreement to continue running the hospital into the longer term?
A. They were - they happened in two contexts, so they would happen throughout the year as issues popped up, you know, concerns around specific items would be raised as and when, and then, as we were in the process of negotiating

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

Q. So in terms of that first category, raising capital investment issues with the LHD as and when needs arose, was it your experience that the LHD responded by providing capital funding to deal with whatever issue had arisen?
A. I would say it varied. I mean, what I would say was that the LHD were always very pleasant and collaborative to deal with, so the relationship - there was never a relationship problem. It often felt like they were not the decision-makers, so things would typically kind of get referred and then we would find ourselves asking for updates, and the type of response that we would get is that that was being, you know, considered at a level higher and we would have to wait and see. That is not unusual when you're dealing with government, to be frank. So that - yes, but that did - that did occur. So what that meant was we didn't have the same certainty around funding as we would do in our private hospitals, for example.

Q. So in terms of those decisions that had been referred up the chain, did you get a response quickly, typically, to the request for further funding, or was there some delay in receiving an answer to whether or not funding would be provided?
A. Occasionally we would get a quick response, but also, there would be delays or, alternatively, we would be told that there wasn't any available funding.

Q. When you were told that there wasn't any available funding, were you given any explanation as to why?
A. That that was a system-wide issue and that budgets were tight.

Q. At that time, were you given any - did you receive any sense as to whether or not the decision not to fund was in any way referable to a view formed that the funding was not actually required, as opposed to not available?
A. No.

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

A. That's correct, yes.

Q. Is it right to say that that facility is being constructed within the broader catchment currently served by Hawkesbury hospital?
A. Yes, my understanding is that it's fairly close by. I can't remember the exact travel time, but it's a relatively short car journey from Hawkesbury. So it would be within the network, yes.

Q. Is there a perception, or was any view formed within St John of God, as to the potential impact that the opening of Rouse Hill Hospital might have on the services being sought and delivered through Hawkesbury hospital?
A. Look, we could only speculate, which I don't think is helpful, but we did wonder what the impact would be and what the plan was for Hawkesbury with having what appeared to be, you know, a very large, very expensive hospital built so close by. But we were not clear on what the impact would be.

Q. So I gather from some of your earlier answers and the fact that you were left speculating around the impact of the opening of Rouse Hill Hospital, that there was no process whereby anyone from the LHD or the ministry sat down and discussed collaboratively with St John of God just how all of the services to be delivered across the various facilities, including the new one, might fit together?
A. So I was not involved in any discussions like that. It is possible that that could have happened at the more junior level earlier on, so I couldn't definitively say no, but certainly in regard to myself and my predecessor, who had this role before me, we were not involved in those discussions.

Q. Are there any particular operational challenges insofar as you were speculating and making decisions based on that speculation - any particular operational challenges that you felt the opening of Rouse Hill Hospital might present?
A. Not really, because I think it was because it was so unclear, and it was in the early stages, around what that hospital or what its service profile would be and what it would look like, it was almost - it would be unhelpful to hypothesise about what the impact would be. So our view was, you know, we had a contract to run Hawkesbury, which was really clear, and that our role was to continue

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

Q. Do you have a copy of your statement handy?
A. Yes.

Q. Could I ask you to turn to paragraph 26 of your statement?
A. Yes.

Q. In fact, in paragraph 23 and 24 you give us, at a highlight level, some of the strategic and local factors which informed the decision to hand back St John of God hospital. I just want to work through some of those considerations. Starting with what you tell us at paragraphs 26 and 27, in a way, are they not really largely the same thing as the considerations which you've identified, at least at a headline level in 24.1?
A. Yes, I guess they are. They are probably a clearer articulation of how the macro conditions that I articulated in 23.1 were impacting us at Hawkesbury.

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

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

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

in the fact that the funding being provided for the delivery of that health care hasn't kept up?
A. Correct.

Q. You offered a moment ago to expand a little bit on why you think, in the post-COVID era, there's been an inflection in terms of the cost of delivering health care. What are the real key drivers, as you see them?
A. Yes, look, I think the pandemic probably provides a useful focal point to state there has been a change since - I suspect there have been other factors as well. So if I think about it largely from a cost perspective, the cost of most things has gone up, and that's not, you know - that's not restricted just to health care. So the cost of most of the things that we purchase has gone up, as global supply chains have become strained, and you'll understand with the context there, that's affected us.

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

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

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

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

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

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

Q. Was there any collaborative approach, insofar as you're aware, taken between St John of God and the LHD to try and avoid a situation in which they were in direct competition with one another for the delivery of health care within the public system to the same community of people?
A. Yes, look, not that I'm aware of, but that doesn't mean it didn't happen, and I probably would just say we operate in many states and I did not see that collaboration happening anywhere. It was pretty much a case of every organisation for themselves because everyone was under such pressure. At that point, most organisations were launching - you know, once the restrictions had been lifted, we were - everyone was going heavily into international recruitment, domestic recruitment, training more people, and that did tend to happen at an organisational level. So I'm not aware of any collaboration, but there wasn't a lot of collaboration really happening in many places across the country.

Q. In terms of your broader experience of delivering

health care across the country, do you think collaboration of that type might actually be a useful step?
A. Yes, absolutely, and I think it's been a learning that has emerged from this. So more recently, if I think about Western Australia, where most of our business is, we now partner with the government to actually travel to other countries to recruit new people together and to work with universities, you know, to set up training courses that we can then get people the appropriate qualifications and bring them into Australia.

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

Q. In the short time that the Western Australian experiment has been afoot, have you found that it has produced outcomes for you in terms of solving some of the workforce challenges that you've been presented with?
A. Yes, look, too early to say. I would say very positive start, but it's in that kind of relationship-building/establishment stage, and I think it would take, you know, six to nine months before it's clear whether it is working or not.

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

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

Q. It had a view at that time that there was at least the prospect of a wider roll-out of arrangements of that type within New South Wales which had not previously been the case; is that right?
A. Sorry, correct. Yes.

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

health care in New South Wales, at least as matters currently stand, is low?
A. Yes. I mean, so you'll obviously be aware there was a parliamentary inquiry in 2019 around Northern Beaches and the report that was published, I think in 2020, was very clear that the direction going forward was that the New South Wales Government would be unlikely, very unlikely, to enter into any further PPPs. So that was a strong signal to us that the kind of strategy which we had been considering would no longer be feasible.

Q. When you say not "feasible", is that because one hospital out here in New South Wales as a stand-alone operation is not a particularly commercially desirable state of affairs, whereas one little foothold which potentially was the loss leader, as it were, for a wider series of operations, might have been?
A. Yes, so just to be clear, we do have two other hospitals in New South Wales, they're both privates and they're both psychiatric hospitals, so a little bit different. We had those hospitals before this one. But to your point, yes, it's commercially very challenging to run one hospital in an isolated state. You really want critical mass so you can share, you know, the sort of support services that feed in to hospitals and the larger you become the more economically sensible it becomes. So to just have a single isolated hospital certainly does create commercial challenges, yes.

Q. We then come to paragraphs 34 to 38. You tell us in a little bit more detail about some of the cost escalations - these are the issues that we've already touched in your oral evidence. Can I ask this in relation to that, though: insofar as you're aware, were these increasing cost pressures shared with the LHD?
A. Yes - so if I've interpreted your question correctly, yes, my understanding is that there were doctor shortages across the whole area and that most hospitals were struggling to recruit the same sorts of staff, yes.

Q. That's a useful answer but my question probably wasn't sufficiently clear. Insofar as Hawkesbury hospital was experiencing these particular cost escalations, and the consequences of that from the point of view of its profitability, was that fact shared with the LHD?
A. Yes, sorry, now I understand. Yes, it absolutely was.

Q. How was it communicated, in what form?
A. So we would have monthly performance meetings where we would discuss, you know, a range of performance factors around the hospital, and I attended those as often as I could and I was very overt and open about sharing the deteriorating financial position of the hospital and would explain why. So that was probably the main reason. There may well be correspondence in emails as well, possibly, but certainly there were meetings where we explained it was becoming rapidly very clear that the hospital's financial performance was deteriorating significantly.

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

Q. The outcome of which, I gather from what is set out in that paragraph, is there is little efficiency left to squeeze out of the hospital. Was that shared with the LHD?
A. The report wasn't, but when we started to have the conversations about not extending the contract, we explained to them that we believed that there was not a lot of cost efficiencies in there. One of the first things you would always look at in this situation is, you know, is the facility running efficiently or are there steps that could be taken to make it run more efficiently? So, yes, that was explained to them. The report that we drafted wasn't, but that point was.

Q. You tell us in paragraph 39 --

THE COMMISSIONER: Q. Was there a reason the review wasn't shared, that you know?
A. Yes, so I guess the review was always intended to be an internal document to inform our decision-making. Given the timing, we were - I guess there was an element of convenience here. So it wasn't like we were in the middle of a contract with another five years to run. Because of the delays of negotiation, we were effectively at a point where it was simple from a contractual perspective to walk away, so it seemed like a sensible time to undertake a review and we undertook that review ourselves with a view to advising ourselves about the best course of action. It was never intended that that review would be shared with them. That wasn't its purpose. But what we did do was relevant elements that came from it were shared.

MR MUSTON: Q. You tell us in paragraph 39, in the second sentence there, that St John of God was informed that it was unlikely that further funding would be available. Who informed St John of God of that fact?
A. So this would refer to those performance meetings that I mentioned earlier, where - so typically, I would attend those along with the local chief executive of the hospital and the local finance director, and we would meet with the management team, the relevant management team from the LHD, and we would have those sorts of discussions. And look, again, very politely, very collaboratively, they would explain to us that that was effectively the position across the whole system, so that, you know, it wasn't like there was pots of money that they could just dip into and give to us. That was the available funding. So, yes, that was the kind of nature of those conversations.

Q. As part of those conversations, was it ever suggested to you that there were inefficiencies which Hawkesbury hospital could overcome in order to deal with the deficit that it was facing?
A. Yeah, I think occasionally there were comments made, so there might be a comment around something like, "Oh, your length of stay looks a bit longer at the moment", which is a KPI for us, like, how long people stay in hospital, or, you know, the number of procedures. So we would go away and look at that, and typically, the length of stay point was because of the case mix of patients that were coming into the hospital was changing, and that's another really significant factor.

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

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

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

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

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

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

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

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

Q. Yes.

A. No.

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

A. Yes.

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

gone away and looked at it and come back and reported your findings, which were that nothing more can be found there in terms of efficiencies. My question is: at the end of that process, was there any increase in the level of funding that was being proffered by the LHD?
A. No. No.

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

Q. And in response to that, did you get any sense or did anyone tell you that they didn't believe or agree with that?
A. That's a good question that I need to consider carefully. Look, I think - I would say they were sympathetic, and the impression that I got was that there had been a general - there would need to be a general tightening of budgets across all of the Department of Health, and so what we were experiencing was happening elsewhere, and therefore, it was no different for us than anywhere else. So I didn't get the impression that they didn't believe us; it was more of a case of, "Well, just the money isn't there."

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

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

obligations owed by its directors are concerned?
A. Sorry, can you just rephrase that question?

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

Q. So to the extent that there might be a deficit, and perhaps a significant deficit, in the funding going forward, which creates a hole in a budget, that has consequences in the hands of the directors of an organisation like St John of God which might not be shared by others working more broadly within the ministry who are under the same budgetary pressures; would that be right?
A. Yeah, I think private and public health are completely - are different in that respect. So overspends that occur in public hospitals are resolved one way or another through additional funding top-ups. We don't have that ability. Although we are a not for profit, we run as a business, so if we start to run at a deficit in a hospital, that's a big problem for us because there aren't other funding pots that we can go to to get that money. So it's a very different operating environment and I think that is one of the key challenges of running PPPs.

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

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

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

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

Q. Do you see that document, Mr Edwards, and recognise it as the Hawkesbury District Health Service pricing proposal for FY2023/24, dated April 2023?
A. Yeah, I can see it. I'm not hugely familiar with that document but I can see it.

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

not in a position to answer any of these questions - that's a document, at least on its face, that would appear to have been prepared by St John of God and submitted to the LHD?
A. I'm trying to have a look at it now.

Q. If you need us to scroll through it in any way just sing out. The operator can roll through to any page that would assist you.
A. So based on what I'm seeing in front of me, it appears that --

THE COMMISSIONER: Q. Perhaps go to the next page. You will see 1.1 "SJGHC propose"?
A. Yeah, okay, so - yes, so, having read that, it does look like a document that we've put together to propose pricing for those two financial years, yes.

MR MUSTON: Q. So that, at least as you understand it, is the document or a document through which St John of God was seeking funding for the 2023/2024 financial year?
A. Correct, and I think there were several documents and correspondence exchanges relating to that matter, yes.

Q. Just in terms of the document itself, and accepting that it might be loosely alluded to in that paragraph commencing "The pandemic" on page 2 that's up on the screen, the document doesn't explicitly spell out any of the matters that you've identified in paragraphs 34 to 38 of your statement - the particular cost pressures. And again, if you need us to scroll through --
A. No, it's fine. So I guess it would - my comment would be that it refers to them at a high level.

Q. It seems, just scrolling through, for example, to page 3, under the heading "1.2.1 Acute Services", it identifies an amount of - or last year's volume of service, NWAU, that was to be delivered, proposes a sum for 2023, annualised and normalised, and then explains why it says there should be, for that year, at the end of that little piece, 9,804 NWAU attributed to acute services as part of the funding allocation. Do you see that?
A. Yes, I guess what I can see in here is comments referring to COVID, impacts on the hospitals; I can see comments that refer to:

> *... the volume allowed this year is not sufficient to meet demand within the*

catchment, even when not taking into consideration addressing of the backlog of patients ...

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

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

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

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

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

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

THE COMMISSIONER: Or to meet the demand.

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

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

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

recognised through the level of activity which is identified - that is to say, if demand increases, then you would seek more activity?
A. Correct, and I think that - I'm just having a look. I think that's spelled out fairly clearly in here.

Q. Yes, it is.
A. Based on - yeah, so that point is made, yeah.

Q. Do we gather from that that it was anticipated that there would likely be an increase in activity and, therefore, more units of activity should be included as part of the budget --
A. Yeah.

Q. -- in the service agreement that was to flow from this proposal, in a range of different areas?
A. Yeah.

Q. And then the next --
A. The bit that refers to the funding rate is in 1.1, which spells out some kind of stipulations around what should be included within the price and refers to historical pay rises and super, et cetera, so those were points that, from a rates perspective, were going to be negotiated as well.

Q. Would it be right to say that this document came on the back of a lengthy series of performance discussions that had been had between St John of God and the LHD where, as I think you've told us, these particular price pressures had been canvassed in some detail?
A. My understanding of this document is that it was something that was prepared, you know, annually as part of the pricing discussions, and so I think, in the background, the performance discussions that we've talked about would have been occurring. But I wouldn't suggest that this paper would have been a result of that. This would be part of a standard process of going through a negotiation.

Q. Sorry, I might not have expressed myself clearly. So this was a standard document which was produced each year, the purpose of which was to identify, in essence, the amount of activity which St John of God anticipated that it would be purchasing, or would be purchased from it by the LHD during the upcoming financial period?
A. Correct.

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?

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

MR MUSTON: Q. But as at '23/24, there was - perhaps coming to the tail end of it, there had been a period of working through a significant backlog of a type of surgery as a consequence of the shut-down during COVID; is that right?
A. Yes, correct. It's not unusual for, in the public sector, hospitals to be asked to undertake additional levels of activity, usually surgical, kind of backlog work, to catch up, and that would certainly happen to us at certain points during the year, and we could either - we either were or weren't able to help depending on how busy we are at that time.

Q. Can I get you to go back to a document which I think in your folder is G.013. It's [SJO.0001.0005.0044]. It's a letter dated 2 August 2023.
A. Is that a letter to Strephon?

Q. It is, 2 August 2023. Do you have that letter in front of you?
A. Yes.

Q. So just looking at the first --

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

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

Q. Do you know whether it is, Mr Edwards?
A. Whether - sorry, whether it is what?

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

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

the deferral of the budget, whilst perhaps a political necessity, what was the impact, or what impact does that have on a private organisation like St John of God?
A. That's a significant problem for us, because it creates a big vacuum in our ability to plan. So if we don't know what budget we have, it makes it really challenging to understand what needs to be done to ensure that the hospital can operate sustainably. It creates a level of uncertainty, and that was a big factor, in terms of that lack of clarity.

Q. Is that a political reality that you experience in other jurisdictions that St John of God operates, or has it been done differently or better in other jurisdictions from the perspective of an organisation like yours?
A. We haven't experienced significant delays like that.

Q. So could I come down to the bullet points, just at the bottom of the first page there. The letter is to formally advise Hawkesbury District Health Service of the following: the first is the interim allocation, which is basically the same as the 2023 allocation. Do we take it from that, that to the extent that the document that we've just been looking at - that is, the April 2023 pricing proposal - was seeking an increase in activity, that at least as at 2 August no increase had been forthcoming?
A. Correct. So we effectively had said, based on our understanding of the demand that was coming through the facility, that we needed to - that we would need to increase our activity, and our interpretation of this was saying that there was no funding to support that.

Q. Dealing with the next bullet point, could you explain to us what you understood that to mean?
A. So I believe this is a conversation around clearing backlogs on waiting lists, so people who have been waiting for operations and what would need to be done to - and the amount of activity that would need to be undertaken to clear that backlog.

Q. And then in the third bullet point, "Non-ABF components" are set at FY2023 amounts. What were the non-ABF components that sat within the budget allocation each year, in general terms?
A. Yes, so that would be things like the capital funding that we discussed earlier would come out of - would not be ABF; the top-ups we've talked about, so if we were required

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

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

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

Q. But what it appears was being said there is that that had not taken into account some wage increases which were --
A. Yeah. I would say roughly - roughly - our costs were increasing above 5 per cent at that time, across the board, so --

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

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

Q. Let's creep our way towards that, step-wise. The next document I want to take you to is G.012, which is, for the operator, [SJO.0001.0005.0041]. Do you have that document in front of you? It is a letter from the LHD to Strephon Billinghurst dated 25 October 2023?
A. Sorry, I'm just trying to find it.

Q. I think in your folder it's probably G.012?
A. Yeah, my tabs are numbered.

Q. It should be number 12. Tab number 12, I'm told.
A. Twelve? Okay, cool. Yeah, got it.

Q. And just to make sure we've bot got the same thing in front of us, it's a letter dated 25 October 2023?
A. Yeah, yeah.

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

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

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

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

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

MR MUSTON: Well, I can ask the witness.

Q. Do you think anyone within St John of God found that information particularly useful in the context of its operations - that is to say, everything up to at least the subheading on page 2, "NSW Health State Price"?
A. I think probably the politest way to answer that question is that we were interested in the information that related to us.

Q. Just if I could take you back to page 1, in the final paragraph, there's a reference to the "challenging financial landscape". Did you understand that to be a reference to the escalation factors that you have identified as driving up the cost of delivering health care within the wider context of Australia, or did you understand the challenging financial landscape to be more a reference to the amount of money that the LHD had been provided for the delivery of services?
A. My - if you're talking about the paragraph that begins "In a challenging financial landscape" --

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

> *... will require strong financial controls including affordable FTE levels and achieving Efficiency Improvement Plans.*

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

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

Q. Just dealing with the efficiency review - and I think you've probably answered this but to make sure temporally we are right - at some point by or before 25 October 2023, are you satisfied that you had communicated to the LHD that such efficiencies as could be won within Hawkesbury hospital had been found and secured?
A. So we had fed that to them verbally in the meetings that we'd had, that we'd undertaken a review and that we did not feel that there were further efficiency savings that could be made, and I think said, "If you want to come and have a look yourself and see what you can find, that's fine, but we've undertaken a fairly rigorous review and we cannot find any further savings."

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

Q. In terms of the invitation that you've just alluded to to "come and have a look yourself", was that ever taken up by anyone within the LHD?
A. Yes, look, so I think, yes, there definitely was interactions. I would have to say the LHD were proficient at looking at data and asking questions about why things were happening, the length of stay example was one that I used earlier, and so it was clear that they were monitoring what we were doing and having a look, as opposed to standing back.

Q. In terms of at least your interactions with the LHD, at any point prior to 25 October 2023, had anyone from the LHD actually told you, as a result of this process we've just canvassed, that there were further efficiencies which you could find within Hawkesbury hospital?
A. I think it was insinuated at times through comments like, kind of, the length of stay piece, and I can't remember the details but I believe - I believe that there were conversations around, you know, "Are there other changes that could be made here to save further money?" Which we would periodically look at, because, you know, often in a hospital you will find other things - that there are other things that you can do. So, yes, those sorts of comments were made to us.

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

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

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

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

MR MUSTON: Yes, 0005.0046.

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

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

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

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

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

Q. I will ask you, sir, 10,285 is the total acute; correct?
A. I'm struggling to - I can see the document on the screen. I'm struggling to find the one that you're comparing it with.

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

A. Oh, yeah, okay.

Q. And then, looking at the other document, it's got "Acute", 9,527. Do you see that?
A. Yes. So my - I'm assuming from there that, yes, we asked for a number, and we received a number that was lower.

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

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

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

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

Q. -- of whether that was or wasn't the case?
A. Look, not the - not in detail --

THE COMMISSIONER: Q. Just make the assumption that it is.
A. Yeah, not in detail, but what I remember is that, I guess it was a negotiation and we put forward what we believed we required and then when we got the budget through overall it was less than we were hoping for and expecting, in most areas, as you have said, not all. I think ED may be an exception.

MR MUSTON: Q. At the conclusion of that negotiation - that is to say, when or shortly after the 25 October letter behind tab 12 was received - did anyone from the LHD explain to you why the amount of activity which you had projected would come through the Hawkesbury hospital was not going to be funded?
A. So my recollection is that the main response we got to those sorts of questions just was that there was not enough money overall in the health system and that every LHD and every hospital would be receiving less, and therefore, the experience that we were encountering was just in line - was a reflection of the broader picture that was going on.

THE COMMISSIONER: Q. Do I assume from your answer, at least to your knowledge, no-one from the LHD said, "Look, the activity amounts in your pricing proposal are just plain wrong and here's the reason or reasons for that"; rather, it was there just wasn't enough money?
A. I do not recall there being any discrepancies around volume, like, disagreements around volume. What I remember from the discussions was that they were focused around availability of funding.

Q. And I think you've probably answered the next question within that answer, but you're not aware of a document that was provided by the LHD or any other aspect of NSW Health that says, "Thanks for your pricing proposal, but here are the written reasons why it's wrong", for whatever particular reason?
A. I'm not aware of one. It's possible that one could exist that I haven't seen but I'm not aware of one.

THE COMMISSIONER: Thanks.

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

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

MR MUSTON: I'll probably be 10 minutes.

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

MR MUSTON: Q. [SJO.0001.0006.0046].

A. Yeah.

Q. Just to make sure we're looking at the same document, it is a letter from Strephon Billinghurst from St John of God to Lee Gregory dated 28 November 2023. Do we have the same document in front of us?
A. Yeah, I've got it, yes.

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

Q. In respect of that, do you recall receiving any response to that proposition from Mr Gregory or anyone else from the LHD?
A. I don't recall receiving anything. There may have been something, but not that I can recall seeing.

Q. Turning over to the second page, to the paragraph immediately above the subheading "HDHS Activity", the letter expresses a conclusion as to the financial forecast and the loss which was anticipated. Again, do you recall receiving any response to that letter or was any doubt expressed by anybody from the LHD, Mr Gregory or otherwise, at least to you, about the correctness of your prediction that there would be a $4.8 million loss?
A. No. I think my recollection is that they trusted our calculations and that was never challenged.

Q. In relation to capital, could I just ask you to go down to the bottom paragraph on the second page there, commencing, "Whilst we appreciate"? Could you tell us briefly what your understanding of the independent audit that had been on the agenda for over 18 months comprised, if you know?
A. Yeah, look, so I wasn't directly involved, so I could only speak at a high level here. My understanding is that there had been an ongoing dialogue about a series of effectively infrastructure upgrades, you know, and equipment upgrades, like I was referring to earlier, and at some stage it was proposed that an audit would be undertaken by the LHD to undertake an audit to inform that. However that work took a very long period of time, and I think you will see there that 18 months was referenced,

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

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

Q. Just in relation to the audit, are you aware of what stage it had reached? I mean, at least from the perspective of St John of God, are you aware of an occasion when an auditor went and walked around?
A. Yeah, yeah, so my - I believe the work certainly was undertaken and there were people out on site having a look round, et cetera, and --

Q. Who was doing that work, do you know?
A. I couldn't name them. I think it was relevant kind of experts, either from the LHD or perhaps contracted by the LHD and I think --

THE COMMISSIONER: Q. But if it was by the LHD, it's not an independent audit, at least as I would understand it. Was it an external firm or people within the LHD?
A. I can't be definitive. I thought it - I thought it was overseen by people within the LHD, but I cannot be absolutely certain of that. It's something you would want to check with them.

MR MUSTON: Q. So at around this time, you were at the pointy end of the negotiations around the potential extension of the contract between St John of God and the LHD in respect of the continued operation of Hawkesbury hospital; is that right?
A. So this was November. I think, to be honest, by this point we were close to making a decision. So in - I mean, those negotiations had been going on for years. They were very protracted and slow with, you know, terms sheets bouncing between solicitors, et cetera, so they had been going on for a long time. I can't remember the exact dates here, but towards the back end of that year, we had formed

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

Q. Can I just step through the chronology with you briefly?
A. Yeah.

Q. You have your two years' worth of discussions and contract extensions relating to the prospective continued operation of the facility by St John of God. As we understand it, on 1 September 2023, St John of God indicated that it would accept a terms sheet that had been produced at the conclusion of those two years worth of negotiations as a way forward. Is that something that you recall?
A. I - sorry, so we did accept a terms sheet. I can't remember the exact date.

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

THE COMMISSIONER: 1 September 2023?

MR MUSTON: 2023.

Q. On 18 October 2023, the LHD communicated to St John of God that it also accepted the then iteration of the terms sheet. So it would seem that by 18 October, at least a potential bargain, subject to documentation, had been reached as between St John of God and the LHD. I don't intend to suggest it was binding in any way, but what I would like to explore with you is what changed between 1 September and then 5 December, when the letter you allude to in your statement was sent confirming that St John of God would not continue in its operation of Hawkesbury?
A. Yeah, so I think the simplest way I can answer that is that once financial year '24 began, which was July, we started to see that rapidly deteriorating result, and, you know, often you'll have a month or two that's difficult, but it is a blip and you come back, so kind of July, August, fine. By the time we get to September it is a trend and a profound and significant trend.

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

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

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

Q. And, secondly, and importantly, a failure in the funding mechanism to keep up with those increases, such that the amount of funding that was being offered, including through the 25 October letter that we were looking at a moment ago, simply was insufficient to meet the costs of delivering those services; is that right?
A. Correct. Yes, it's - I think it is as simple as that. So in health service provision, the two big factors are how much does it cost you to provide your services and how much are you being funded, and if those two, you know, dynamics are in line, then things work; if they start to slip out of line, you have a problem, and that's effectively what occurred during that period and it just happened very rapidly.

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

renew was the commercial and financial performance of the hospital, it really boils down to what you perceived to be the inadequacy of the funding that was provided, or being offered, by the LHD for the delivery of the services contemplated by the service agreement? And, presumably, future service agreements?
A. Yeah. I mean, look, if we'd undertaken the efficiency review and had found that the hospital was incredibly inefficient and there was lots of, you know, surplus costs, then we would have undertaken a cost reduction exercise to resolve that, but we didn't; we found out that it was running extremely efficiently, which left us with no other conclusion to draw than the issue was funding, and we saw no prospects, based on the discussions that we had been having, that that was likely to get any better in the short to medium term. And there were clauses within the new contract which we would have had to have signed which would have placed us at a significant risk if that had continued, just in terms of how many years of poor results we would have had to have experienced before we could exit the contract, which was a new clause.

Q. Could I ask you to jump forward to paragraph 53 of your statement.
A. Yeah.

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

Q. In what way, or what material way, did you think Hawkesbury hospital was not fully integrated into the public hospital system when it was being operated by St John of God?
A. Yeah, so I think there's probably two kind of macro factors that I would pick out as being significant. I think the first is just that when you have a PPP arrangement, it brings in a different level of complexity, so rather than it being, you know, government - state government working right from the top all the way through, you are dealing with another party with a different

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

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

MR MUSTON: Thank you, Mr Edwards.

I have no further questions for this witness, Commissioner.

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

MR CHIU: Just a couple of questions, yes.

<EXAMINATION BY MR CHIU:

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

Q. You've got that document in front of you?
A. Yes.

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

Q. Was it the case that the independent audit was, in fact, conducted by a contractor independent of the local health district? Is that your recollection?
A. Yes, so I honestly couldn't say, and I wouldn't want to misspeak as to that. I'm not - I'm not sure who undertook it.

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

Q. Do you recall that when the report came out, a copy was provided to St John of God for review?
A. I do believe that we saw a copy of the report, yes.

Q. And do you recall when that was?
A. I don't, I'm sorry.

Q. Was it the case, and tell me if you don't recall, that by the time the report came to St John of God, you had already made the decision not to extend the contract?
A. It was all around - I think a lot - I can't give you a definitive answer and it's not because I'm dodging; it's more just because so many things were happening at the same time, it felt like everything was coming together at the same time. So, you know, we were negotiating the terms sheet. There were - in addition to that, below that there was negotiations around the funding. There was pieces like this audit, there was our review - all seemed to be happening at a similar time, so I couldn't - I could not be clear on the exact timing of that versus our decision, so, sorry.

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

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

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

THE COMMISSIONER: Yes.

MR CHIU: Q. Just one final issue, Mr Edwards. When the decision was made not to renew - this was, as I understand from your earlier evidence, a little bit of time after the final terms sheet in September 2023 - did St John of God undertake an analysis as to how much more funding at that time it would require in order to renew the contract?
A. Yes, so I think we had a view on how much funding and volume would need to increase and some of that is contained within the correspondence. I think the fact that that was rather a moot point was that whenever we had discussed any sort of either volume or rate increase, the messaging back had been very politely a version of, "That is not going to happen. There is no more money. There's no more money in the system, there's no more money for other LHDs, there's no more money for other hospitals and there's no more money for the Hawkesbury." So I don't think we spent too much time getting into the detail of that because it had been made clear to us that there wasn't additional funding.

Q. I understand you didn't spend too much time on it, but when you did land on a figure, is that produced in any document anywhere?
A. I would have to check. I couldn't say off the top of my head.

MR CHIU: No more questions, Commissioner.

THE COMMISSIONER: Thank you.

Mr Fitzpatrick, do you have any questions?

MR FITZPATRICK: No questions.

THE COMMISSIONER: Thank you. Mr Edwards, thank you very much for your time. We're very grateful. You are excused.

THE WITNESS: Thank you. Have a good day.

THE COMMISSIONER: Thanks, you too.

<THE WITNESS WITHDREW

THE COMMISSIONER: We will adjourn until 10 past 12. Is that suitable?

MR MUSTON: Yes.

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

SHORT ADJOURNMENT

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

<VANESSA JANE CLEMENTS, affirmed: [12.16pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. Vanessa Jane Clements.

Q. And you're the director - planning redevelopment and project management office for the Nepean Blue Mountains LHD?
A. Yes.

Q. That's a mouthful?
A. Yes.

Q. You've held that role since January 2022?
A. That's correct.

Q. And have you had any previous roles within the public health system?
A. In the public health system, yes.

Q. What is your public health background prior to coming into your current role?
A. So I moved to Australia in 2006. Prior to that, I worked in the NHS. By trade I'm a midwife. My first few roles in New South Wales were in sort of maternity services, I worked at Sutherland Hospital and then the area health service and St George Hospital. I then worked for the perinatal services network and then have worked for a number of years in the Ministry of Health before coming to the district in 2022.

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

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

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

Q. You have prepared a statement to assist the Inquiry with its work dated 6 June 2024?
A. Yes.

Q. Have you had an opportunity to read or review that statement before giving your evidence today?
A. Yes, I have.

Q. Are you satisfied that its content is true and correct to the best of your knowledge?
A. Yes.

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

THE COMMISSIONER: Sure.

MR MUSTON: Q. Just a moment ago you told us a little bit about the infrastructure funding which had been received by the LHD, or has been received by the LHD in recent times. Has any infrastructure funding been received, or was any infrastructure funding sought or received, in respect of Hawkesbury hospital during the period that you've been in the role?
A. So last year, in 2023, so the district has an annual -

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

Q. When last year?
A. That would be by the end of the financial year last year.

Q. So some time before 30 June 2023?
A. So - yeah. So we would have started working on that probably in January '23.

Q. When, roughly, to the best that you can recall, was the good news received from ministry in relation to the funding of the upgrade?
A. We weren't allocated funding. So we identified it as an area - as a priority area for the LHD.

Q. So you sought some funding for the emergency department at Hawkesbury hospital, but at least as the process rolled through in the 2023/2024 year, you were not allocated any funding for that?
A. No. And we're submitting it again this year.

Q. In your time, has any other funding, infrastructure funding, been sought with respect to prospective upgrades at Hawkesbury hospital?
A. There are ongoing - as Ben, who was - previously had mentioned, there were various items at various stages of the years, I understand, that were identified as priorities for Hawkesbury. My understanding is since 2019, we invested about $2.1 million in upgrades at Hawkesbury, so that included a big capital investment to upgrade the chillers for their airconditioning.

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

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

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

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

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

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

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

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

Q. Did you have any role to play in relation to the annual service agreement negotiation and issue process?
A. No.

Q. Who was responsible for that within the LHD?
A. The director of finance.

Q. Do you know whether it was the director of finance or someone else who had final responsibility for determining the amount of funding that would be provided to St John of God under that arrangement annually?
A. I'm not directly involved in those conversations.

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

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

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

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

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

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

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

Q. Could I ask you to have a look at that document not yet on the screen, which is [SJO.0001.0005.0044]. That's a letter from the LHD to Strephon Billinghurst. Did you have dealings with Strephon Billinghurst in your role?
A. Yes.

Q. If we could just scroll down to the second page of that document, at the very foot, the bottom of the page, the signature block there, it appears, maybe during a short interregnum at Nepean Blue Mountains hospital, you signed that document?
A. Yes. So the chief executive was on annual leave so I was acting as chief executive.

Q. So in connection with this document, other than signing it in your capacity as the acting chief executive, did you have any involvement in its composition?
A. When you're acting as the chief executive, you rely on your colleagues' expertise in their areas.

Q. So to the --

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

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

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

Q. Can I ask, who attended those meetings usually?
A. So our legal counsel from the LHD side, St John of God's legal counsel, the chief executive at the time, on

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

Q. In terms of legal counsel, were they internal in-house lawyers or external lawyers that had been retained, starting with the LHD?
A. Yes, so the LHD, we had Freehills assisting us, so external to the LHD. St John of God at that time had an in-house lawyer.

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

Q. -- to inform the approach that they were suggesting that you should take in relation to the negotiations with St John of God?
A. Yes. So as we started working through the terms sheet, there were areas that we needed to seek ministry guidance as to if the ministry were happy with us sort of taking certain - or agreeing to certain terms.

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

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

Q. At the point at which the LHD was going to be potentially saying, "Yes, we agree with this terms sheet, let's go ahead", did you understand that the ministry would need to be consulted to confirm whether or not it was acceptable to the ministry?
A. We were - we regularly had check-ins with the ministry to ensure that the ministry would be comfortable with the items in the terms sheet, but if we had got to the point that we did have a draft agreement, we would have sought ministry approval before the signing of that agreement.

Q. If the ministry hadn't approved to the terms in the draft, the LHD would never have proceeded to sign it, I presume?
A. I think we would have tried to negotiate a mutually acceptable clause.

Q. When you say you would have sought to negotiate, you would have sought to change the agreement with St John of God in a way that made it acceptable to the ministry?
A. I mean, the - sorry, I am --

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

Q. -- about an agreement as between the LHD and St John of God?
A. Yes.

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

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

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

A. Yes.

Q. That is to say, before the LHD entered into the agreement?
A. Yes.

Q. If the ministry had not been forthcoming with that approval, the LHD would not have gone it alone and signed the agreement, would it?
A. We didn't get to that point.

Q. I understand that --
A. Yes.

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

Q. "In theory"? When you say "in theory", is that because you never reached that point?
A. We never reached that point and I think through the series of negotiations we were having with St John of God on the terms sheet, we were able to negotiate a position that both the ministry, St John of God and ourselves were comfortable with.

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

Q. Is there any reason why the ministry wasn't negotiating directly with St John of God in relation to this facility?
A. My understanding is that the Hawkesbury hospital, as it's now known, is actually part of Nepean Blue Mountains LHD. So it's part of our LHD in the same way that all of

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

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

Q. In paragraph 15 - do you see the final sentence there - you refer to the fact that in February 2023, St John of God were invited to participate in discussions with the deputy secretary, the health system strategy and planning, which you attended. Do you recall St John of God or any representatives of St John of God attending meetings with ministry representatives as part of the process?
A. Yes. So the chief executive and Ben would have attended that meeting and the chief executive regularly would reach out to the deputy secretary to have conversations.

Q. What was discussed in the meeting that you allude to in the last sentence of paragraph 15, to the extent you can recall it?
A. Yeah, so to my recollection, it was talking around some of the key areas of negotiation. So sort of they wanted to talk about service planning, they wanted to talk around the transition of their staff, if - you know, at a point that the contract came to an end, and probably the capital component, that generally seemed to be an area that they were concerned about.

Q. You referred a moment ago to the fact that the chief executive was in regular discussions with the deputy secretary. The chief executive at that time was who?
A. So by this time, it was Bryan Pyne.

Q. And the relevant deputy secretary who Mr Pyne was in discussions with?
A. Deb Willcox.

Q. How did you become aware of those regular discussions

between Mr Pyne and Ms Willcox?
A. I wouldn't say they were regular. I mean, I wouldn't like to say they - but I know that there were occasions where there would be - we would have a meeting and then he would perhaps phone Deb afterwards to have a discussion with her.

Q. When you say that, did he say to you at the end of the meeting, "I'm going to call Deb Willcox and have a chat with her about this"?
A. No.

Q. Or did you get some feedback from --
A. No.

Q. -- Ms Willcox saying, "Well, I've just had a conversation with him and this is what he told me"?
A. We would be asked to provide advice.

Q. On what sort of issues?
A. The same issues.

Q. When you say "the same issues", what were the key issues that advice was being sought from you in relation to?
A. Oh, the capital component, the sort of transition of staff, the KPI abatements - the issues in the terms sheet that really we'd spent most of our time sort of negotiating around.

Q. So you've identified in paragraph 17 what you describe as some of the key issues. Are they the topics that were the subject of regular discussions between you and St John of God?
A. Yes.

Q. On the one hand?
A. Yes.

Q. And were they the same topics that were regularly the subject of discussions between Ms Willcox and/or her department and you, through which this advice was sought?
A. These are certainly areas that we briefed the ministry on.

Q. I might come back to those areas, if that's okay. You refer in paragraph 15, at the very end of that sentence, to

an invitation to undertake some joint clinical service planning.
A. Mmm.

Q. What did you envisage, or what was envisaged, as best you understand it, by that concept, "joint clinical services planning"?
A. So for me it was really about including St John of God and Hawkesbury district hospital in the service planning that the district was doing. So we - in I think 2021, before I started, the district had already started working on a district-wide health services plan. That was paused at the time, you know, because of COVID and what have you, so when I commenced in the district, we recommenced that piece of work and were keen to make sure that we included Hawkesbury in that piece of work.

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

Q. Just pausing there, what were the other priority reasons?
A. Accreditation of the LHD. We had some work to do for accreditation. So we recommenced the project at the beginning of this year, by which time, obviously, St John of God had made their decision. So the interim general manager is now on that steering committee. And that, the health services plan, really is about setting the strategic direction for the district, in terms of planning, including Hawkesbury.

Q. Recognising that it pre-dates your time in your current role, but based on what you understand or have been told, is it your sense that St John of God had previously been involved in any planning process around the way in which services would be delivered to the community within the LHD?
A. I really can't comment.

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

Rouse Hill Hospital on the operations of Hawkesbury something that was discussed?
A. No. So we actually had our first meeting around - about Rouse Hill with the planning team at Rouse Hill last week.

Q. Accepting that it's going to be an LHD issue not a St John of God issue going forward, has consideration now been given to where Hawkesbury hospital might fit in to the mix of services delivered to the LHD once Rouse Hill Hospital is up and operational?
A. So our understanding from the planners in Western Sydney is that they're just in the final stages of completing their clinical services plan themselves. That hasn't been - I think they - I think - sorry. I think that's in with the ministry now but they haven't got their final clinical services plan. How it will impact on the LHD and Hawkesbury district hospital is yet to be seen. We haven't seen the detail of their clinical services plan.

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

Q. Does Rouse Hill Hospital sit within the footprint of Nepean Blue Mountains LHD or is it in Western Sydney?
A. It's in Western Sydney.

Q. Nevertheless, it will no doubt serve people sitting within the catchment of the Nepean Blue Mountains LHD to the extent that they might be on that side of it?
A. Certainly our expectation is that some of our patients may choose to go to Rouse Hill.

Q. To the extent that the new hospital at Rouse Hill might attract some patients who live within your LHD, or services used or utilised by people living within your LHD might more efficiently or effectively be delivered through the new hospital at Rouse Hill, do you have a view about whether or not it would be desirable if - for your LHD to be involved in the planning process around what clinical services should or shouldn't be delivered through that facility?
A. The range of services that will be delivered at Rouse Hill hasn't yet been decided, as far as I'm aware. My personal opinion is there's always advantage in planners

coming together to do joint planning.

Q. Because the range of services that could or perhaps should be provided at Rouse Hill no doubt will be informed, won't it, by what's available within hospitals quite close to Rouse Hill, sitting perhaps within your LHD? Would that be right?
A. One would - one would assume so.

Q. And if they don't coordinate with one another around decision-making of that type, there is a risk that there will be unnecessary overlap in the delivery of services?
A. And I think that's where the ministry comes in, because the ministry has oversight of services provided in all of the districts and the sort of populations and the way that the populations sort of feed in, so they have that more central view. So I would imagine, as the clinical services plan is being reviewed by the ministry, that they would be looking at it with that lens.

Q. But you don't know that to be the case?
A. I can't speak on this.

Q. The advantages of the devolved nature of our health system are such that those who sit within, say, the Nepean Blue Mountains LHD have a good sense of the particular needs and habits of people living within that LHD, in terms of the way in which they access their health care?
A. Sorry, that in the district, we have an understanding of our population?

Q. Yes.
A. Yes.

Q. Perhaps a better understanding than the ministry has, based on whatever data is available to it?
A. We obviously talk to our community, so we --

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

Q. So to the extent that you've been informed by those discussions, do you think it would be useful for that information to feed in to the planning process about what services might be delivered at, for example, Rouse Hill Hospital?
A. As I said, I think the more that we share information, it only advantages the communities we work for.

Q. As matters stand, though, there has not been consultation with the LHD insofar as you are aware, in relation to that issue?
A. But I can't say that there hasn't been consultation with the communities.

Q. But insofar as you are aware, there's been no consultation with your LHD in relation to that matter?
A. As far as I'm aware.

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

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

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

Q. That included consideration of things like accrued entitlements and the like, presumably?
A. Yes.

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

A. Yes.

Q. So there's the need, at the end of the arrangement, for some acceptable transition arrangement which would work for those employees and for the ministry or for the LHD, in terms of being able to secure the continuing service of that staff, but equally from St John of God, not being stuck with a large burden of accrued entitlements - that was an important matter to resolve?
A. Yes. It was around the understanding of how those staff would sort of transition leave, et cetera.

Q. Was there any real dispute about how that should work as part of the negotiation process?
A. Sorry, was there any?

Q. Was there any real dispute between the parties about how that should work through this negotiation process?
A. Some of the detail, yes.

Q. What were the disputed issues?
A. So one of the items was around the transfer of sick leave and long service leave, and the proportion that St John of God would be willing to pay in terms - in respect to those particular types of leave.

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

Q. What about the next issue, the duration of the new services agreement? What was the issue there, recognising that we go on to talk about termination within its term, but the actual term itself, what was contested about that, if anything?
A. So when we started the negotiations with St John of God, we were seeking a 20-year agreement, and it became apparent fairly soon that St John of God really were not keen to enter into an agreement of that duration, and so we ended our negotiations really with an agreement to have a five-year agreement.

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

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

Q. Moving to the next issue, (c) --
A. And, sorry, on that point as well, it also gives certainty for the staff. You know, it's very difficult, I think, for the staff, knowing that, you know, the contract is coming to an end and what's going to happen to them. So it is about sort of providing - and reassurance for the community as well.

Q. Moving down to --

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

MR MUSTON: Yes.

Q. In relation to that point, were the agreement to come to an end, the community would assume, would it not, that if St John of God wasn't running the hospital at Hawkesbury, someone, probably the LHD, would be?
A. But it still causes concern, I think, in the community.

THE COMMISSIONER: Q. I think the point Mr Muston just made - it's not like a funding for a particular project which has been going for a few years but might be ended, in which case the staff know they're going to lose their positions or jobs, as distinct from the fact that, here, it's a funding agreement with an entity, but the infrastructure of the hospital remains, so presumably it's going to be used one way or the other and needed to serve the community, or the health needs of the community.
A. Absolutely, and our view has been - you know, to where we are now, has been very much around providing that reassurance to the staff and the community, that, you know, 1 July is going to look like 1 June, that we want to sort of maintain and, you know, continue those services. But people don't like change and people are scared of change.

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.

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

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

Q. Do you recall what the mechanism was?
A. Well, initially they wanted after - if their financial situation in one year, you know, if they were in deficit, they wanted to be able to give us notice the following year.

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

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

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

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

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

Q. And the second thing is the extent to which the funding delivered by the ministry to provide the services contemplated by any service level agreement actually matched the costs or kept up with that escalation in the costs. Do you agree they're the two important functions?
A. (Witness nods).

Q. The third is obviously --

THE COMMISSIONER: Q. I think you nodded again?
A. Yes, sorry, yes, yes.

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

Q. But from the perspective of St John of God, the desire to have an escape clause in the event of unprofitability is driven largely by the fact that it was potentially wholly within the power of the LHD to decide whether or not it would be profitable or unprofitable, having regard to the amount of funding that was provided - was that something that was appreciated at the LHD level?
A. Sorry, I'm not sure what you're asking.

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

Q. That was something which was wholly within the control

of the LHD?
A. Yes and no.

Q. When you say "no", in what sense?
A. The LHD is allocated a certain budget for all its facilities and the LHD then has a responsibility to be able to divide that budget to each facility to meet the needs of their local communities. So it's not the case that the district is sort of sitting with all these additional buckets of money that they can just sort of pull into. The budget they're given is expended across each of those facilities.

Q. There's an important difference, though, isn't there, between each of the LHD facilities on the one hand and a facility like Hawkesbury run by a private entity on the other, in the sense that whilst the LHD facilities might be able to endure a deficit, a private entity with directors who owe duties under the Corporations Act can't?
A. That's true. But a private partnership also has the ability to be able to attract its own funding through private activity.

Q. But you don't suggest, do you, that it should be any part of the public health system that public services delivered to public patients should be funded by --
A. No.

Q. -- a PPP participant through its either benefaction or privately derived revenue through other sources?
A. No.

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

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

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

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

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

MR MUSTON: No.

THE COMMISSIONER: Thanks.

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

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

MR MUSTON: Q. Could I ask you, then, to go down to item (e), where we come to that old chestnut of the capital contribution. What was the contest between St John of God on the one hand and the LHD on the other in respect of the capital contribution?
A. This was - this particular item was really around their ability to be able to meet KPIs, and they didn't want to be - and the abatement regime if they didn't meet KPIs, and they didn't want to be held to an abatement if their view was that they weren't able to meet the KPI because of the lack of investment or the need for sort of capital investment in the facility.

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

Q. That is to say, in any given year you might be offered X in funding, but if you failed to meet KPIs it was suggested that X would be reduced by some quantifiable amount?
A. That's right.

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

infrastructure at Hawkesbury hospital, St John of God didn't want to suffer both the failure to invest in infrastructure and the consequent reduction in its funding?
A. That's right.

Q. Was that seriously in contest as between the LHD and St John of God?
A. No. We agreed that if the KPI - the ability to meet the KPI was directly related to capital investment, then, yeah, we wouldn't hold them to meeting - having to meet that KPI.

Q. And item (f) deals with the same issue, albeit not in respect of capital but, rather, the inadequacy of any funding delivered?
A. Yes.

Q. So did that contemplate a situation, for example, where the KPIs required a particular amount or level of service to be delivered, but if it wasn't adequately funded, and therefore that service was not delivered, St John of God didn't want to have their funding reduced?
A. Yes.

Q. Was that seriously in contest between the LHD and St John of God?
A. No, I think we were - we debated it, but in the terms sheet, we agreed that if it was directly related to the inability to be able to fund a capital upgrade, then we wouldn't hold them to it.

THE COMMISSIONER: Can I just ask, do you have half an hour to go or a short time to go?

MR MUSTON: Actually I do have a little while to go.

THE COMMISSIONER: Is it better to adjourn?

MR MUSTON: Yes.

THE COMMISSIONER: I'm sorry about that but we'll have to --

MR MUSTON: No, I'm sorry; the late adjournment threw me off a bit.

THE COMMISSIONER: We will take the adjournment and we

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

LUNCHEON ADJOURNMENT

THE COMMISSIONER: When you are ready.

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

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

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

Q. In those circumstances, really, all that indicated to you, wasn't it, was that St John of God might have had some uncertainty about its interest in continuing a PPP arrangement which was commercially disadvantageous to it?
A. Yes. Yes. So certainly there was some hesitancy, and I mean, they were very clear that they didn't want to enter into a 20-year agreement with us, but as I say in my statement, I felt that given the length of time that we had taken to agree the terms sheet - and we did agree the terms sheet - that we would get an agreement with them to continue operating the service, but I didn't have confidence that it would be a long-term agreement.

Q. So on 1 September 2023, St John of God advised that it agreed to the then iteration of the terms sheet?
A. (Witness nods).

Q. I think on 18 October, Lee Gregory, on behalf of the LHD, indicated that the LHD was content with the terms sheet.
A. Yes.

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.

Mr Chiu, do you have any questions?

MR CHIU: Just one question.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Are you involved in the process of the handover of St John of God back to the district?
A. Yes, I am.

Q. As part of your involvement, have you had reason to look into the question of whether it was operating efficiently under St John of God?
A. In taking it back, we are sort of becoming aware of some areas that sort of - we may do things slightly differently with them, and I think there are sort of, you know, definitely sort of opportunities to leverage off sort of HealthShare and other contracts to look at some of the employment arrangements of staff as well.

Q. Can you be a bit more specific about which areas you're talking about?
A. Yes. So some of the arrangements for the employment of some of their senior medical staff, we're - sort of we're looking into.

Q. When you say you're "looking into", are you looking into it in relation to efficiency?
A. Just bringing it into line with state awards.

Q. When you say, "bringing it into line" with state awards, are they not aligned with state awards?
A. No, there are some instances where they're not.

Q. And by that, do you mean some staff are being paid significantly more than state awards?
A. That's my understanding.

MR CHIU: No further questions.

THE COMMISSIONER: Thanks.

I take it you have no questions?

MR FITZPATRICK: No.

THE COMMISSIONER: Thank you very much for your time.

We're very grateful. You are excused.

<THE WITNESS WITHDREW

MR MUSTON: The next witness is Lee Gregory.

<LEE GREGORY, sworn: [2.18pm]

<EXAMINATION BY MR MUSTON:

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

Q. You're the acting chief executive of the Nepean Blue Mountains LHD?
A. Yeah; that's correct.

Q. Which I think you've told us previously is a role that you've held since September 2023?
A. Yes, that's correct.

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

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

Q. Have you had an opportunity to read the 6 June 2024 statement before giving your evidence today?
A. Yes, I have, yes.

Q. Are you satisfied that the content of that statement is true and correct?
A. Yes.

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

THE COMMISSIONER: Yes.

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

late in the piece, it would be fair to say?
A. Yes, that's correct, yes.

Q. I think you tell us in paragraph 14 that your involvement commenced when you commenced in your current role in September 2023.
A. Yes.

Q. At that point, it was your understanding that a period of negotiation had occurred - quite a lengthy period of negotiation had occurred between the LHD and St John of God?
A. Yes, that's correct, yes.

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

Q. I think presumably when you commenced, you were told that on 1 September 2023, St John of God had communicated in writing their acceptance of those terms?
A. Sorry, just say that again?

Q. Upon commencement of your role as acting CE, you presumably were told, perhaps not immediately, that on 1 September 2023, St John of God had communicated in writing its acceptance of the --
A. Yes. Sorry, yes, that was part of my - part of the brief I got, yes.

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

Q. Could I ask, between your commencement in September 2023 and when you sent that 18 October 2023 email, what did you do to satisfy yourself that it was an appropriate email to send?
A. Yes, I mean, it's just mainly through the briefing I got, reading of the terms sheet and just the briefing from the staff on the whole issue around St John of God and where we were at, and I was pretty comfortable in where we had got to with the terms sheet and the content of it, so, yes.

Q. Did you take any step to satisfy yourself that the terms sheet reflected an agreement or terms of an agreement which would be satisfactory to the ministry?
A. No, not directly, I just took the advice of the team. I didn't directly contact the ministry, if you like, to say, you know, "Are you happy with this", I just took the advice of the team. But that's not unusual, yes.

Q. In terms of the advice of the team, did the advice of the team that you were provided with include any indication of the interactions, if any, that had happened between the LHD and the ministry as to the suitability from its perspective of the terms sheet?
A. I'm just trying to - yes, I think so, I think so. I'm just trying to recollect. But I think generally in the briefing, I would have generally got a briefing that talked me through how we'd got to where we'd got, interactions with the ministry and sort of, if you like, a summary of the view of the ministry, where it was at, you know, so --

Q. It was, on any view, a significant contract in the context of the LHD's operations?
A. Sorry, was it a significant contract?

Q. On any view, it was a significant contract in the context of the LHD's operations?
A. Yes, it was, yes. Absolutely, yes.

Q. Do you think you would have expressed your acceptance to the terms sheet on 18 October 2023 unless you had satisfied yourself that it was reflective of an agreement, or the terms of an agreement, which were acceptable to the ministry?
A. I - so the way I understood it was the ministry was comfortable with the terms sheet. We were - though there were still things to be worked through, I think particularly with reference to the sinking fund, if I remember rightly, but that everyone was in sort of broad agreement where things were at.

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

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

A. Yes.

Q. Did you, in your short time in the LHD, have a sense of what that change might have been?
A. My recollection was that I think the only thing that changed between - prior to 5 December and 18 October, whatever, was probably just that they had come to the - increasingly come to the thought of not continuing the contract, and then they had the board meeting which made the final decision, in the middle of November, I think, or 5 November, or something like that. But the key thing was that decision at board meeting, I think, around whatever that date was in November.

Q. Is that something that was communicated to you by St John of God - that is, "We're having a board meeting, in the course of which we're going to give serious consideration to whether or not we actually want to go ahead with this after all"?
A. Yes, that's my recollection, yes, because I think I recall being on a meeting with Bryan Pyne and Deb Willcox, and we had - I think we - yes, certainly that's my recollection.

Q. How many meetings did you attend in relation to the negotiations up to 5 December with St John of God?
A. Oh, it would only have been maybe one or two, no more than that. Sorry, so maybe one or two meetings with Deb Willcox and Bryan Pyne, and then I think I attended one performance meeting, and there was lots of informal, if you like, conversation around the whole issue of Hawkesbury, so, yes.

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

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

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

THE COMMISSIONER: That's fine.

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

is it --
A. Yes.

Q. -- and Deb Willcox, when did they occur relative to your email of 18 October and the 5 December letter from St John of God?
A. I think - yes, my recollection is I think they occurred around November, I think Bryan had written to Deb. I may be getting this wrong, but, yes, roughly the memory is Bryan had written to Deb and we had - there was at least one phone hook-up with me, Bryan and Deb on the issue.

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

Q. -- that that was a point at which it was suggested that there was going to be a board meeting at St John of God to decide what to do in relation to --
A. Yes, that was - yes.

Q. Do you remember them telling you during the course of that meeting what had prompted that careful consideration by the board of St John of God that lead to the change of position?
A. Just the things that had been - they'd been articulating for a long period of time, the issue around the increasing deterioration in the financial viability of the hospital, the infrastructure, you know, the capital funding issue, the clinical service planning, all those things that they'd been talking - it was no different, you know, the same themes.

Q. So in relation to that, these are issues they'd been raising for some time, and presumably they'd been raising those issues, at least as you understood it, before you arrived on the scene?
A. Yeah, but I think the financial one in particular had sort of gathered a head of steam through '23/24 financial year, yeah.

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

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

Q. So the briefing that you received in relation to that, who was that briefing delivered by? Was it obviously staff members within the LHD?
A. Yes, so - yes, so Vanessa, Vanessa Clements, and then Luke Bellman, the director of finance for the district.

Q. Was that briefing a written document, the briefing?
A. No, it was largely verbal, yes - verbal for me, yes.

Q. At the point of your arrival on the scene, you also became involved in discussions around the funding which was proposed for the Hawkesbury hospital for the '23/24 period; is that right?
A. Yes, not really, not to a great extent, only in the sense that by the time I'd got there, had the briefing, it was pretty well on the way to them - you know, the indications around wanting to not continue the contract, so - yeah, we - I mean, we had discussions around it, around, you know, through the performance agreement and outside, but it sort of pretty quickly got into that sort of phase of their not wanting to continue.

Q. So do I infer from that answer that you were having some performance discussions, performance review discussions, with St John of God in relation to Hawkesbury hospital in parallel with these wider discussions?
A. Yes, what I was referring to was the monthly performance meetings that we have with St John of God, and I attended at least one, I think maybe one in - definitely one in October, I can't remember whether I attended

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

Q. In the October discussion, performance discussion that you had, did St John of God express its view that the funding that was being provided to it by the LHD was inadequate to meet the costs of delivering the services --
A. Yes, can I just go --

Q. -- required under the service agreement?
A. Yes, if I can just go back a step, there was actually a meet and greet with me prior to that, performance meeting in early October, and at that meeting Ben was on the line from Perth and then he started to talk then around some of the deterioration in the financial position of the hospital, so yes.

Q. So meet and greet meeting, he expressed a view to you that the amount of funding that was being provided to St John of God to run Hawkesbury hospital fell short of the costs of delivering the services required to be delivered through that hospital; is that right?
A. He expressed it in the form of they were starting to experience cost pressures and therefore deteriorating financial viability of the hospital, as opposed to the way you've characterised it and funding not being enough. It was sort of the other way around but same thing.

Q. The same thing?
A. Yes, yes.

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

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

Q. Did you go back to anyone within the LHD and explore with them whether there was any history around that that might be relevant to your ongoing discussions with St John of God around that issue?
A. No, I didn't, no.

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 [SJO.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, [SJO.0001.0005.0044]. That's a letter dated 2 August 2023, so again, before your time at the LHD, from Strephon - to Strephon Billinghurst. 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?

A. No, I don't recall - no, I didn't look at this one.

Q. You, through your involvement in the system prior to your arrival at Nepean Blue Mountains LHD, would be familiar with the concept of a deferral of the LHD's budget referable to political changes?
A. Sorry, say that again. The deferral of the LHD's budget due to --

Q. Just look at the first paragraph of that letter.
A. Oh, this was the interim - yes, because of the state budget, and it was delayed, yes.

Q. The state budget was delayed?
A. Familiar with that, yes.

Q. So the message conveyed through this letter, I gather, based on my reading of it, was to the effect that, "We don't have an answer to your funding request or your funding proposal of April 2023 yet, because there's been a delay in the completion of the budget"?
A. Yes.

Q. Could we then track back to the document behind tab G.012, [SJO.0001.0005.0041]. This one might be more familiar to you. That's a letter from, it would appear, you to Mr Billinghurst dated 25 October 2023?
A. Yes.

Q. You were the author of that letter, I assume?
A. Well, not directly the author but, yes, the signatory, obviously.

Q. What involvement did you have in the preparation of that letter, which was issued under your name?
A. Yes, so it would have been prepared by the finance department and generally it's sort of a generic letter that goes out to all the facilities, and I'd have reviewed it prior to signature.

Q. You say a letter that went out to all of the facilities. The only facility that was not part of the ministry, at least at that time, within your LHD was St John of God, wasn't it?
A. Yeah; that's correct, yes.

Q. So this letter fell into a subtly different category

to those that might have been sent to hospitals that were wholly within the LHD's control and operation?
A. Yes.

Q. Just running down to the bottom of page 1, you refer there to a "challenging financial landscape". Is that language you included in the letter or is that language that was included by someone else?
A. Oh, I mean, it's language included by someone else but I've clearly signed off the letter, so --

Q. What did you understand that to mean when the letter refers to a "challenging financial landscape"? Challenging in what respect?
A. I think it was just reflecting what was an increasingly challenging financial landscape for the whole of the health system, you know, post COVID, wit the workforce shortages --

THE COMMISSIONER: Q. Increasing costs?
A. Yes, and all the increasing costs that we see in the economy and in our workforce, so I think it's just reflective of that.

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

Q. Did you, in writing this letter, have any reason to believe that there were inefficiencies to be weeded out of the operations at Hawkesbury hospital, insofar as they had been conducted by St John of God?
A. Yeah, no, we didn't - I didn't have anything directly. Again, it's like a generic, broad context paragraph, I think. We didn't have any - I didn't have anything that said to me that St John of God weren't operating the hospital at a - you know, a reasonable level of efficiency but, you know, there's always more you can do in any hospital in terms of efficiency.

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

Q. Do you recall having discussions with anyone from St John of God about the extent to which either of those figures recognised the costs of delivering services in the challenging financial landscape that was prevailing?
A. Yeah, I didn't have a - well, we didn't have a - we had conversations, like I talked about before, where they started to talk around their - you know, the increased costs and the deteriorating financial position, but we didn't have a direct - I don't recall a direct conversation with them that said, "Well, the state price is X. There's our costs at Y", that direct link that you're referring to --

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

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

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

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

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

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

activity which it anticipated it would conduct through the hospital. Is there any reason for that, insofar as you are aware?
A. Yes, one of the reasons I think will be the acute activity doesn't contain the additional elective surgery I think we were purchasing from St John of God in that year, and the pricing proposal that was up before does. So I think that's - it's not quite like apples - a like for like comparison, I think.

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

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

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

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

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

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

Q. Is there any reason for that, insofar as you're aware?
A. Yes, I think I can only - well, it's probably just a symptom of the fact of us trying to balance our funding constraints across the district. So if we think we've got, you know, four or five hospitals, all our other services, and we have, you know, a fixed budget and NWAU, we're trying to allocate them out as best we can across the district. So it just reflects, I think, at least in part, the funding constraints we've got with the district.

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

THE COMMISSIONER: Q. I was going to ask you, are you hypothesising there rather than knowing?
A. Well, that's what I'm saying, I don't know if that was the case. It's either one of two reasons. It's - well, it'd be two. One, it's us trying to balance our funding constraints and, you know, the amount of NWAU we have there.

Q. But balancing funding constraints, though, I understand what balancing funding constraints is, but that's not necessarily related to volume of activity, is it? That's just balancing?
A. Yes, it is in the sense that we get a volume of activity purchased - the ministry provides us with a level of funding based on a volume of activity.

MR MUSTON: Q. The ministry funds you by reference to a large bucket of activity --
A. Yes.

Q. -- if I could describe it in that way?
A. Yes.

Q. No doubt split between acute, ED, et cetera?
A. Yes, that's correct, yes.

Q. And you or, well, the LHD then embarks upon a process of distributing that bucket across the various hospitals within its footprint?
A. Yes, that's correct.

Q. I think this probably is the same answer as the one you just gave to the Commissioner a moment ago, but insofar as there's a difference between what has been anticipated or proposed as the anticipated activity within Hawkesbury hospital on the one hand, and what was the activity which was allocated to it in this document, you had no reason to believe, or were not told by anyone, that the activity projections which St John of God had put forward were wrong?
A. No, I don't recall being told - no, nobody told me their projections were wrong. I can't recall that, no.

Q. So the net consequence of the funding allocation which was being conveyed through this letter was, as you understood it, wasn't it, that St John of God was going to be receiving less funding than it was going to be incurring in costs to deliver services through the '23/24 period?
A. Yes, that's my understanding, yes, and that's what they --

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

Q. Or a not for profit?
A. Yes.

Q. In what way was it appropriate, in your view, to pay that private enterprise less than it was going to incur in delivering the services that you were requiring of them throughout the '23/24 period?
A. Sorry, let me go back a step. So when I say I understood this would be less than the cost of the - it was costing St John of God to run the hospital, that was as a consequence of the conversations that we got into with St John of God post issuing of this letter and those - all those - the response to our budget letter, et cetera.

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

Q. So they had had that discussion with you during the meet and greet, yes?
A. Yes, that's correct, yes.

Q. And then are you able to recall when, in the calendar month, roughly, these performance meetings used to be held? Were they mid month, early month, end of the month?
A. Usually I think around the third week of the month, possibly.

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

Q. So I come back to, I think, my earlier question: in what ways did you perceive, as the chief executive sending that letter, was it appropriate to be offering a private enterprise like St John of God less money for the delivery of the services required of it under the services agreement than it would cost for them to provide those services?
A. Yes, so probably two things: one, I understood that they had a financial problem. The level of it was to be established - you know, they started to indicate to us it was a deteriorating financial problem, different from, you know, previous years which was based on the level of activity to be purchased. I understood also that was obviously going to be a negotiated process. We were in the negotiation for the terms sheet and the new agreement. So it was in that sort of broader context we were issuing that budget letter.

Q. But in terms of the financial problem that you allude to, I think you've told us that you had no reason to think that that financial problem was referable to inefficiencies in the manner of the operation of the hospital by St John of God?
A. I didn't have any evidence to say that that was the case, no.

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

to you that suggested that the financial problems which had emerged were referable to anything other than a widening gap between the cost of delivering the services required under the service agreements and the funding that was being provided for the delivery of those services, did you?
A. Sorry, just repeat that question for me.

Q. You had no reason to believe that the financial problem experienced by St John of God was referable to anything other than a widening gap between the cost of delivering services in the challenging financial environment and the amount of funding that was being delivered through the services agreement in order for it to do so?
A. Yeah, I'd probably characterise it as more at that time, in my mind, it needed to be established more clearly. I get - you know, like, I get and acknowledged and understood the issue around rising costs in the health system, but in my mind at that time we had more work to do to understand it.

Q. Unless and until such time as you understood there was something wrong with what you were being told - I think you told us a while ago you had no reason to think that what they were telling you wasn't correct - I ask you again, in what way did you regard it as appropriate in the context of dealings with a private entity to be proffering them less money to deliver services than it was going to cost them to deliver those services, the services that were required of them under the service agreement?
A. Yes, I think - well, again, I come back to, one, we're trying to balance the whole of district budget and, two, we were in a broader context of a negotiation with them for a new service agreement, so yes, that's why --

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

Q. You would agree with that, wouldn't you?
A. Yes.

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

whatever way you want to, but ultimately it is the ministry who is going to suffer the loss; is that right?
A. Well, yes, yes.

Q. Perhaps via the LHD?
A. Yes.

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

Q. But the LHD and the ministry are wholly quarantined, aren't they, from any losses sustained within a private enterprise like St John of God?
A. Well, yeah, it's different. What you're saying, it's different for St John of God. Yes, I get what you are saying, yeah.

THE COMMISSIONER: Q. Just so I understand your answer on Mr Muston's question about appropriateness, it's, "Yes, we didn't have any evidence to doubt what St John of God were telling us about costs and the deficit they were facing", but you thought there was more work to be done to understand that gap; is that --
A. Yes, that's correct. And I think the other comment I'd make is historically, the way this has gone - and I've seen in other sort of similar arrangements, is - there tends to be a negotiation and additional funding or top-ups provided on an ad hoc basis.

MR MUSTON: Q. That's the way it works within the ministry, isn't it? Where insufficient funding is provided to deliver a service, you do your best to provide the service with that money, and that, no doubt, drives efficiency - is that right?
A. That's one way of putting it, I would suggest.

Q. But your expectation is within the ministry, at the end of the day, if it really was not enough, it would be topped up?
A. No, not necessarily, no. Not necessarily.

Q. What are the consequences for a ministry owned and operated entity if there's no top-up?
A. Well, it's - simple consequence - there's no - there's

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

Q. But a private entity who is left with a funding gap is faced, amongst other things, with the prospect of a claim of insolvent trading?
A. But that's - well, potentially, yes, but St John of God Hawkesbury is part of a bigger group of St John of God, but yes, potentially. I accept the characterisation, the point you're making around the difference between a private and public sector entity, obviously.

THE COMMISSIONER: Q. They still may not want to run any part of their business that runs a loss?
A. Yes, no, I'm not disputing that. I agree, yes.

MR MUSTON: Q. And it would be no answer to that to say, "Well, usually the way these things happen is you get a top-up if it really gets bad at the end"?
A. Well, I think historically, there's been - whenever you send - on an annual basis, whatever budget letter they get it's usually resulting in a negotiation, that has happened and resulted in additional funding to them, and I think that was some of the points Ben was making around the uncertainty of funding, you know, when they've got over - when they've overran the level of activity, the district's tried to find and fund additional activity, not every year, but in previous years it has happened, is my understanding.

Q. When you say "historically", other than the short involvement you tell us about at Northern Beaches in paragraph 20 and following, what has your involvement been in dealing with PPPs throughout your time working within health?
A. So this one, Northern Beaches, and a bit on the Royal North Shore PPP as well.

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

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

statement dealing with Northern Beaches.

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

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

THE COMMISSIONER: Yes, certainly.

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

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

MR CHIU: Yes, Commissioner.

<EXAMINATION BY MR CHIU:

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

Q. What sort of consequences might there be for the rest of your district of increasing the funding for that hospital --
A. Yes.

Q. -- so that the deficit would be removed?
A. Yes, so it would mean simply we would have to remove funding from another facility or service across the district to accommodate any increased funding for St John of God.

THE COMMISSIONER: Q. Is that assuming that the LHD doesn't get extra funding from the ministry to compensate for that?
A. Yes, but, I mean, regardless of - we wouldn't get specific funding for St John of God from the ministry. We'd just get a macro level of - a macro level of funding increase, and we may or may not - and that's not even - it doesn't happen, you know, in some years you may get very

little growth funding.

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

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

Q. Is that the short answer?
A. Yes, yes.

MR CHIU: Q. Why couldn't you just go back to ministry and say, "Well, this is to ensure St John of God stays operating Hawkesbury hospital. That's why we're in deficit. You're just going to have to fund it". Why can't you just have that conversation with the ministry?
A. Yes, the way the funding negotiations work with the ministry is we go through an annual negotiation around the level of activity the ministry will purchase from the district. Within that, we may be able to put up with one, two, three, four priorities, but given, you know, the constraints on the whole of the health system, the likelihood (a) of your priorities being specifically funded is very low, and (b) the level of growth funding that the district's received in recent years has been low as well. Yes.

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

MR CHIU: No further questions, thanks.

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

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

THE COMMISSIONER: Yes, go ahead.

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. So the issue is, you say, in order to share the acquired activity across the system, a decision needs to be made about how it's going to be distributed amongst the various facilities, including Hawkesbury hospital, operated by St John of God. A consequence of that - that sharing of the activity - is St John of God is placed in a position where it suffers, or will suffer, a deficit; is that right - as you understood it?
A. Yeah, I think that will - yeah. I would only qualify that by saying in my mind at the time, we needed more - to do more work to understand it, but yes.

Q. The reason that that distribution happens is so as to ensure that the LHD does not itself fall into a deficit, insofar as its budgetary arrangements with the ministry are concerned, as best is possible?
A. No, the district's been in deficit probably for a number of years before I came there, so it's operating already in a really difficult financial environment.

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

Q. In fact, no doubt your ambition as the chief executive of the LHD is to make that deficit smaller?
A. Yes, that's correct, yes.

Q. And a way that that was being achieved was through this distribution of activity across the various facilities in a way that you say fairly shared, as it were, the pain amongst each of those facilities, including Hawkesbury hospital?
A. Yes, no, I don't think we - we don't distribute activity out on the basis of what it will do to our financial deficit; it's just distributed out as best and as fairly as we can, given the constraints that we've got. We don't look at it and go, "Well, that's going to impact our deficit", you know, it's really around trying to manage the deficit overall, what's affordable for the district.

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

and has been informed by the Cost per NWAU data" et cetera. What should I take the meaning of the words "informed by" to mean? Is that "based on" or something else?
A. So where the state price is derived from is there is a costing study undertaken by the ministry of all the hospitals in the state, so we all submit our data, our activity and costing data, and from that the ministry would then derive the state price.

Q. So does "informed by" mean based on that data, or just having some form of regard to it?
A. I couldn't tell you how - exactly how they calculate it.

Q. All right, thanks.
A. But it's derived from the costing study.

THE COMMISSIONER: Did anything come out of that?

MR CHIU: No.

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

MR FITZPATRICK: No.

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

THE WITNESS: Thanks, Commissioner.

<THE WITNESS WITHDREW

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

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

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

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

THE COMMISSIONER: Is Mr Jones here? Do you want to have a talk with him? Do you want me to adjourn for five minutes?

MR MUSTON: Perhaps for five minutes. I'm not going to be an hour with Mr Blake, so that will --

THE COMMISSIONER: I will adjourn until you tell me to come back.

MR MUSTON: Thank you.

SHORT ADJOURNMENT

MR MUSTON: Mr Jones, I think, will announce his appearance.

MR JONES: With your leave, I appear for St Vincent's Sydney.

THE COMMISSIONER: Thank you, Mr Jones. Leave is granted.

MR MUSTON: In relation to the issue that I touched on shortly before the adjournment, the order that was made this morning in respect of the live stream not being up and the transcript being made the subject of a suppression order pending any application between now and 5 o'clock, that does not apply to this witness's evidence. So that can be business as usual.

THE COMMISSIONER: All right. And I'm going to be told something about the order I made, because I'm starting to get confused as to why I made the order, to be honest.

MR MUSTON: The order that you made on the application of St John of God, and indirectly health, was because those two entities are engaged in that negotiation around the hand-back and they just want an opportunity to look at --

THE COMMISSIONER: It was out of an abundance of caution that's no doubt entirely appropriate.

MR MUSTON: Perhaps between now and 5 o'clock tomorrow --

THE COMMISSIONER: It doesn't apply now.

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

THE COMMISSIONER: Understood.

IN OPEN COURT

MR MUSTON: I call Christopher John Blake.

<CHRISTOPHER JOHN BLAKE, sworn: [3.09pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you please state your full name for the record?
A. Christopher John Blake.

Q. You are the group chief executive officer of St Vincent's Health Australia?
A. I am.

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

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

Q. Have you had an opportunity to read that statement before giving your evidence today?
A. Yes, I have.

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

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

THE COMMISSIONER: Sure.

MR MUSTON: Q. Do you have a copy of your statement with you?
A. I do.

Q. I will let you get your drink of water first.
A. Thank you.

Q. Could I take you to paragraph 5 of your statement, where you tell us about the previous roles you've held. Prior to your commencement in your current role, do you have a background or experience in the health sector?
A. I've always had a connection to health, yes, principally through my roles on boards of research institutions closely associated with hospitals, but my prior background has mostly been working through organisations going through dramatic change, so - as my day job.

Q. So the other than day job activities have given you a reasonable sense of the wide and complex ecosystem that is the public health system?
A. Indeed, you could say it's the confluence of dramatic change happening and the experience in health care.

Q. In your capacity as group CEO of St Vincent's Health Australia, do you have a familiarity with the way in which St Vincent's Hospital Sydney is funded to provide the services that it provides to public patients as part of the public health system?
A. Yes, I do generally. The negotiations of those funding arrangements are made by the CEO of the St Vincent's Hospital Sydney, who reports to me, but I have a general understanding of the funding, yes.

Q. In terms of the oversight and decision-making around how St Vincent's Sydney might proceed in the event it were to reach any sort of impasse in respect of those funding arrangements, how does that work within the broad corporate structure of St Vincent's Health Australia?
A. So the funding arrangements themselves are made directly with the ministry. It's one of the few AHOs that are directly funded through an agreement with the ministry and we - Anna, who is the CEO, Anna McFadgen, who is the CEO, is very closely integrated into the normal arrangements of funding, as are all of the public hospital CEOs.

In the event of an impasse, as you say, obviously that would be brought up through those funding negotiations and indeed through our governance structure and our chairman of the board, who is also involved in that, as is the chairman of the board of any LHD.

Q. Because St Vincent's Sydney is a wholly owned subsidiary of St Vincent's Health Australia?
A. It is, yes.

Q. It has an independent - does it have a board which is independent of St Vincent's Health Australia?
A. No, it has a board - the subsidiary hospital, the public hospital in Sydney, reports to the board of St Vincent's Health Australia. It's one of the two public hospitals, actually. We have one in Victoria as well.

Q. So from the point of view of the internal governance of St Vincent's Health Australia, large decisions like annual funding agreements for a large public hospital, to what extent is St Vincent's Health Australia involved in any ultimate sign-off in respect of those decisions?
A. Well, the funding agreement has to be approved by the board through the normal governance arrangements, but it's negotiated directly. So the final agreement is signed off by the board and signed by the chair and the CEO of the public hospital.

Q. In terms of the process that leads to the negotiation of that service level agreement, are you able to describe, at least insofar as you have visibility of it, how that process works from St Vincent's perspective?
A. Well, it's an annual agreement, as I understand are all of the LHD agreements, and that there is an annual negotiation for the services to be provided for the following year, and then our CEO participates, in exactly the same way as all of the other CEOs of the LHDs and an agreement is struck for the volume of services against the funding that's required for each year.

Q. The actual agreement that ultimately results from that process is, I think as you point out, an agreement which is built largely around the volume of activity --
A. Yes.

Q. -- which is to be purchased. The service agreements don't seem to say in any detailed way what the actual services which are to be provided from year to year will involve?
A. Well, there is a level of detail that's negotiated. That would be a question that would be better put to the CEO of the hospital, she has - because she's involved in the detail of those services, both the volume and the

particular services including the specialist services that are provided.

Q. St Vincent's Health Australia also, I think you've told us, operates a large public hospital in Victoria?
A. Yes, it does.

Q. Are you able to express any views, from the perspective of someone who has got a high level visibility of both processes, as to where the Victorian system differs from that which exists in Australia [sic] and perhaps where it is better or worse, from a funding perspective?
A. Well, I guess they're - both systems suffer from exactly the same system pressures, which no doubt have been discussed throughout the Inquiry. In terms of funding, the arrangements are similar in some ways but different in terms of the term. So in Victoria, for example, our term is a longer-term arrangement, still with annual priorities that are set within the term, but a much longer term than exists in New South Wales.

THE COMMISSIONER: Q. "Longer term" meaning exactly?
A. It's a 20-year term in Victoria.

MR MUSTON: Q. So from the perspective of an albeit not for profit commercial organisation like St Vincent's Australia, are there advantages to that longer term in terms of the way you operate?
A. Yes, there are clear advantages.

Q. What are they?
A. The principal advantage is level of confidence for planning in the long run. In Victoria there is also, as part of that agreement, an annual capital funding allocation as well. So the combination of those two things provides much more confidence for the board, which, as an independent board, has all of the normal corporate governance obligations of a board that is - you know, particularly goes to things like solvency. So it requires that level of confidence, or at least in Victoria it gives an additional level of confidence, because it's a multi-year agreement.

Q. That capital funding is not a feature of the annual service agreements that St Vincent's Sydney enters into?
A. My understanding in Sydney is that the LHDs make a pitch for capital, particularly for major capital works,

and to the extent that St Vincent's is part of the LHD network, they can make that pitch. It is not an annual allocation.

Q. From the perspective of running a hospital or the commercialities around running a hospital as a not-for-profit entity, what are the benefits, if any, of that commitment, annual commitment, to a capital - a contribution towards capital funding?
A. Well, I think there's two. One is, obviously, the ability to plan in the long run. Health care in particular at the moment is changing rapidly and requires longer cycles of change, particularly as the assets that are required in delivering health care change. So you're able to plan in a longer term. And of course, the second is you're able to plan for the retooling, in the shorter term, of the assets, and have an asset maintenance schedule that, if there is an allocation in an annual and longer-term plan, you're able to actually plan the retooling, refurbishment and investment in those assets along the way.

Q. The absence of that sort of arrangement in New South Wales, is it something which is necessarily done on more of an ad hoc basis at St Vincent's Sydney?
A. I would say "ad hoc" is probably a good description. Without that support, obviously you - the system tends to a more break/fix cycle, what they're really doing is investing in those things that are end of life because they have to, at the end of the life, to continue the services, which obviously means that it adds a little bit of risk to the continuation of the delivery of the services that depend on those underlying assets - not just the buildings, of course, but the buildings being the primary asset.

Q. Other than the capital issue that we've been discussing, are there any other particular challenges associated with the New South Wales funding model which you perceive make it difficult to deliver services through St Vincent's as part of the public hospital system of New South Wales?
A. I think they're the primary differences, but they are big differences. I mean, they are - the inability to plan in the longer run is obviously a very critical difference, and it does impact the ability to plan, particularly when the system is changing as rapidly as it is. So whilst there's not that many differences, the differences that exist are big and impactful.

Q. At least as at 25 March of this year, St Vincent's Hospital Sydney board had indicated to the health secretary that it was not in a position to execute its '23/24 service agreement?
A. Well, there was a letter that was sent by the chair requesting the right to negotiate a longer-term agreement for the same reason that we've just discussed, for the ability to plan with some level of confidence, and of course, as I said, the board of St Vincent's has a different level of obligation from a corporate governance perspective because it doesn't have the backstop of the state government.

Q. So when you refer to the different level of responsibility, you have in mind things like an obligation not to engage in insolvent trading?
A. Yes, well, the St Vincent's board would not be able to continue delivering the services if the forward prospect was a continual deficiency.

Q. Unlike, say, an entity within the ministry that might hope and assume, but perhaps not be certain about a top-up at some point in the future, it's not a luxury that a board of a private corporation --
A. Yes, the obligations and liabilities of the board members are different from that respect, yes.

Q. So other than a desire to negotiate or discuss a longer-term agreement, was there any other particular reason why, insofar as you're aware, the chair of the board of St Vincent's Sydney indicated an inability on the part of that organisation to execute the service level - the service agreement?
A. No. It mainly goes to the certainty for planning. I mean, the fact is that St Vincent's is - St Vincent's has the longest standing community partnership with the state government for the delivery of public health care in New South Wales' history, so it's a known entity, it's an organisation that wants to continue that work, for, hopefully, another hundred years, and so we're looking for the basis on which we could begin planning for the future of health care and our role in it, with the level of confidence for our longer-term arrangement.

Q. I gather from some of the material that we've seen that one particular issue which emerged during discussions

between St Vincent's Sydney and the ministry was a deficit in or a gulf between the costs of delivering the services required under the service agreement and the funding that was being provided for that purpose. Is that an issue that you're aware of?
A. Yes. As would be well understood generally, particularly coming out of COVID, the additional costs in the system were inflating at a rate which is higher than the funding, so that obviously can't continue for multiple years, given the kind of organisation that St Vincent's is.

Q. And did that feature in the decision by the board not to execute the services agreement, at least as at 25 March 2024 - that is, a view that the amount of funding being delivered under that agreement would be insufficient to meet the costs of delivering those services?
A. Well, I think there's two aspects of it. One is the certainty of the funding, and the certainty of the funding for things that require us as an organisation to commit across multiple years. So that's number 1.

Then the second is that in-year certainty that we're able to plan out at least for the next 12 months, that we wouldn't be in a position at the end of the year, or that we would have sufficient levers to ensure that we could match the cost structure of the delivery of health services at Darlinghurst with the income that's --

Q. Dealing with those two, perhaps in reverse order, within the year itself, do I infer from that answer that there was a concern that the amount of money that was to be delivered through the funding arrangement that year would be insufficient to meet the costs of delivering the services required to be delivered under the agreement in that year?
A. Yes, that would definitely be the concern.

Q. And in terms of the first issue, was there a further concern that the ability to deliver services in the longer term required some commitment on the part of St Vincent's Sydney in terms of capital and building up workforce and the like, which, in the event that that funding was not continuing, would create or compound the existing inter-year problem?
A. Indeed, yes. I mean, you have two big costs in health care. The vast majority of the in-year costs is obviously salary and wages, which, in and of themselves, have been

inflating and, you know, appropriately so. And then there's the assets, the buildings, which really are the longest-standing commitment to the delivery of care, because once you've got an asset, you have - not just that you need to pay for it up-front, you actually have to maintain it over time and, of course, it's the maintenance of our assets that we are increasingly concerned about, given that we haven't invested in some assets that are coming to end of life.

Q. Again, if I'm reading more into the correspondence than I should, it does appear that as at 25 March 2024, something of an impasse had arisen as between St Vincent's Sydney and the ministry about the amount of funding that was to be provided under the service level agreement?
A. Well, I wouldn't call it an impasse. What I would say is that we have been clear with each other that we need to sit down and work through the process of what a longer-term agreement would look like, and I'm sure that Anna McFadgen, the CEO, could give you more details of the actual process for that.

Q. The 2023/24 service agreement, was it ultimately executed?
A. The existing in-year one was, with the requirement or the request that we sit down to plan out the longer-term arrangements.

Q. In terms of the planning of those longer-term arrangements, without needing to get into the details of what the negotiations might involve, to the extent that St Vincent's Hospital Sydney is not able to reach a long-term position that it is comfortable will provide it with the financial security that it needs, what are the realistic options for it, insofar as its ongoing dealings with the ministry are concerned?
A. Well, clearly the obligations of the board would be that it cannot sign off on the hospital's continuing operation without the support, and we've had that support for 165 years, so our goal would be to continue that support. And it's been a happy arrangement that we've been able to negotiate for a very long time, so that's what we are assuming will be the outcome of the negotiations that we work through with the ministry.

Q. Hoping that it will, what I'm exploring with you is, as at least in your role with St Vincent's Health

Australia, what do you perceive to be the options for St Vincent's Sydney in the event that no such happy agreement can be reached?
A. Well, we would need to work through that, and we are. Clearly, the first and foremost implication is that we couldn't continue to operate if we didn't have sufficient funding, because the board would not be able to commit to the continued operations of a hospital that wasn't able to continue to pay its expenses.

Q. Could I ask you to turn to paragraph 38 of your statement. This may be a question better directed at the CE of the hospital, in which case, feel free to tell me, but those paragraphs form part of a series of paragraphs in which you discuss various outreach and other services which are being delivered by St Vincent's Health Australia, outside of the footprint of St Vincent's Darlinghurst.
A. Yes.

Q. In respect of paragraphs 38 to 40, the DREAM program, can I ask, what discussions, if any, insofar as you're aware, happened at a ministry level when decisions were being made about where that program was to be rolled out?
A. I don't know the answer to that. Anna McFadgen would be able to give you the detail of that. I understand that she's appearing as well.

Q. Again, you may not know the answer. Do you know what the genesis of the DREAM program was?
A. The actual original funding was philanthropic, so that would not have required ministry funding, because it was an innovation, really, to take what is core expertise on the Darlinghurst campus to a regional area, both through clinical support but also education, and there was a bequest, as I recall, that was able to catalyse that, and that's one of the great advantages of the kind of organisation that St Vincent's is, because it can combine the support that it gets philanthropically for innovative and new services like that, particularly given our mission for delivering care where care isn't always available to poor and marginalised or under-served populations.

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

provided?
A. Yes, indeed, and it's been a very successful program, not just for the outreach that is provided to a regional area, but I understand a large proportion of the people who have accessed that are First Nations people as well. So it covers a number of under-served populations, and I know our clinicians are very enthusiastic about providing that kind of support. Again, given the kind of organisation that St Vincent's has been traditionally, we really do look for those opportunities, including where it requires innovative funding like philanthropy in that case.

Q. Are you aware of any formal planning process involving St Vincent's Australia or Sydney and the ministry where consideration is given to just how services offered or potentially offered by St Vincent's through those sorts of programs might be best deployed across the wider population in New South Wales, to best achieve the greatest success or benefits?
A. Indeed, we obviously advocate at multiple levels, not just for services that are funded within the state support through the ministry, but also federally. So there are services like that one. There's another service, for example, that we are presenting as a proposal to the department in - the federal department of health in relation to an innovative combination of both public, private and aged care services. So we advocate at multiple levels.

In relation to the diabetes service, that would absolutely have been presented as an option and as a service that's provided in that case through, you know, the avenues that the CEO has and that the clinicians have through the services that they connect with in the network.

Q. To the extent, if any, to which it's not happening, do you see that there may be some merit in a strategic approach which brings together providers of services like the DREAM program and others offered by St Vincent's and the public health system with a view to collaborating and coordinating the delivery of those services within the community to best meet its needs?
A. Well, indeed, I think at a time when health care is changing as rapidly as it is, and is being innovated through a whole range of drivers, not just the ones that - the obvious ones of demographics and ageing and all those kinds of things, but technology, actually requires

a different way of combining the services that are currently funded through multiple different funding mechanisms to navigate through that in a way that reconfigures those services to the community, and I think organisations like St Vincent's, which are one of the few microcosms of the whole system - so if you think about us in public health, in private health, in aged care, the delivery of virtual care and co-located with world class research institutes, organisations like that become relatively more important in the system than less important, because they are potential sandpits for reform, in particular, in those areas where you don't have to create something new to reconfigure the services across all of those settings. That is quite difficult to do in a single mono-line, single-funded part of the health care system, whether that be state, federal, private or aged care. Indeed, all of those are required in the health care system to deliver services, and, of course, that is the system, the system is not one of those parts, and I think sometimes, we fall back on the description of one part as the system, as opposed to all of those components.

Q. And these are the issues which you address in paragraph 59 of your statement as observations or ways in which the broader health system might potentially be reconfigured to deliver better outcomes?
A. Indeed. I mean, one example, of course, that I'm sure the Inquiry has heard multiple times, is that one of the biggest drivers of the costs in the health care system is ageing, and attached to that is ageing with chronic disease, so, of course, the maths of the combination of those two things means that the system is much harder to fund in all parts of the system over time.

There are two ways to approach that. One is to think about increasing the funding in each part of the system. The second is to reconfigure it, and I think one of the things we're saying is that there are ways of reconfiguring it without building something new, and I think the example I gave in my witness statement, for example, is the potential for reconfiguring the delivery of healthy ageing not just in a public hospital but combining the services in a public hospital with potentially step-down settings in facilities that already exist but are funded simply through federal aged care models but aren't necessarily connected to the other stages - sorry, the other components of health care. An organisation like St Vincent's has the

opportunity to reconfigure those because they are all in one ecosystem, and in fact, that could be done quite rapidly and potentially much more rapidly than exists in other parts of the system.

Q. There are two elements to it, the first is in a physical sense they're all in the one St Vincent's ecosystem?
A. That's true.

Q. The physical?
A. Yes.

Q. The second sense is, in a financial sense, St Vincent's has access to the various streams, disparate streams of funding which feed into each of those parts and is able to effectively pool them and distribute them in the way that it perceives will deliver the best outcome for the community served by that little ecosystem?
A. Yes, I would say that the joint assets could be used more efficiently. The funding itself doesn't necessarily get pooled but could be navigated carefully into that reconfigured system. So the public funding that goes to the Sydney public hospital, for example, that is captured only in that public setting, but that doesn't mean that you could not deliver a public step-down care, to get an old person out of the hospital faster into a more appropriate setting, including in the home or a repurposed residential aged care facility, or, indeed, to a remote or a satellite hospital ward, by reconfiguring the assets and being able to navigate the funding into where that care is, because, of course, you're talking about one person.

There is not an aged care patient and a public hospital patient and an at home patient through virtual care; they're actually one patient. What we're talking about is the potential for organisations like St Vincent's - and there are others, but St Vincent's is certainly the largest and has the two largest public hospitals in the system - organisations like St Vincent's could be a partner in reconfiguring that funding for where that care is delivered, because of course, what you're really trying to do is re-navigate the way the funding lands in the most appropriate place for that care to happen at the lowest cost. But it's not just the lowest cost. Sometimes the most appropriate place actually does drive efficiencies, because if you're an older person receiving

care, the reality is the last place you want to end up is in a public hospital, and be stuck there because there is no other place for you to go. It's very - without those other assets, it's very hard to reconfigure the system to provide another place to go.

Q. How is it that an organisation like St Vincent's can break down some of those funding demarcation lines, though, just dealing with that example? There is, we heard, a tension on the one hand between a patient, who probably should not be in an acute ward in a hospital, being sent out to an aged care facility, and that tension really flows from the fact that it's a different funding source to the state, who has got the capacity to discharge someone, which is responsible, then, for picking up and meeting the care of that patient in the aged care facility.
A. That's true. I would say, though, that there is a role of reconfiguring the funding around the place of the care, and at the moment, the system is structured by the funding, not the care.

Q. How is it that St Vincent's as an organisation has the capacity to be a Petri dish, as it were, for a reconfigured mindset around that funding in the context of a program like the one you've told us about?
A. Well, I think it's clear that a system that has all the component parts is a system that has the opportunity to reconfigure the parts and to work with the funders as partners to work out how to reconfigure those parts. An organisation - I mean, every single part of the system is important, including the private health care, because it takes pressure off the public system, but an organisation like St Vincent's has all of those parts and has, as its purpose, the delivery of health care without a profit motive. So basically, the reconfiguration happens to determine the best possible place for the most efficient care and the best care, in that location, without necessarily having to share any of those resources with anyone outside the system.

Q. Does the absence of a profit, the need for a profit margin, also combine with the fact that if St Vincent's has each of these disparate parts of the ecosystem under its control, and each of the funding streams feeding into them, it matters little to St Vincent's whether costs are shifted from one silo to the other because it ultimately is all its money?

A. Well, I wouldn't characterise it as shifting the cost. What I would do is making sure that the reconfiguration of the funding stream can be navigated to the care, without necessarily - so if you're a public patient, the reality is that has to be funded through the public system. But that doesn't mean that you can't come up with an innovative arrangement to ensure that the part of care for that public patient in an integrated setting is paid for out of the public system in a fair way. That is simply just another way of thinking about a service level agreement for the value of care that's provided in a lower cost setting in a different way.

Those things are possible. They need to be worked through. I think the point that I'm making is that you don't get to design that system easily if you don't have all the parts of the system, and I think if - you often hear that there is a divide between the state and federal funding, through the different components of funding - Medicare, NDIS - through the state funding system, through the private health insurers, and indeed philanthropy, because philanthropy is an important part of funding for some parts of the system, that actually the system itself is only structured around each of those. So you have to be playing in every single part of that value chain of health care to be able to reconfigure it, and the point is that there aren't many organisations that can do that. St Vincent's is one. There are others.

Q. Can I ask you one last question about the philanthropy that you have just raised. To the extent that an organisation like St Vincent's, which has the benefit of significant philanthropy, might be delivering care within the public system or as part of the public system --
A. Yes.

Q. -- do you have a view on what role, if any, philanthropy should play in the funding of the strictly public component of that care?
A. Well, my view as the group CEO is that public services should be funded out of the public system. Philanthropy is extraordinarily valuable when you're looking to innovate, and I think that's where it should be used best, and I think, you know, that is where St Vincent's has historically used philanthropy best. If you look at the pathway out of the public hospital into, for example, research institutes, it's usually been that bit of

philanthropy that has enabled something to happen in a mixed setting - public/private research. That is harder to do in a single setting, either because it doesn't fit within the priorities of a purely publicly funded system, or if you are a purely privately funded system without philanthropy, the reality is if you are a for profit, then doing something new and innovative, particularly if you can't do it at scale quickly, is not something that you would necessarily choose to do, because there's no margin in it for the system.

We don't have that issue. And philanthropy is a critical part of being able to provide that, if you like, innovation funding that enables the connection across all of those, and it's what makes Darlinghurst - also in Victoria for us, Fitzroy - such a unique place to be able to do that, because, of course, you have the collocation on those sites of the public, the private, and, of course, the world class research institutes like Victor Chang, Garvan, all large in their own right but also globally recognised.

MR MUSTON: Thank you, Mr Blake.

Commissioner, I have no further questions for this witness.

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

MR CHIU: I don't have any questions.

THE COMMISSIONER: I take it you don't have any questions?

MR JONES: I don't, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Mr Blake.

THE WITNESS: Thank you.

THE COMMISSIONER: We're very grateful. You are excused.

<THE WITNESS WITHDREW

MR MUSTON: Tomorrow we can adjourn until 10. There was at one time --

THE COMMISSIONER: Can you just give me a rundown of who is giving evidence tomorrow? I've got Ms McFadgen at 2, but on my list there is a range of tentatives.

MR MUSTON: Yes. I think we've got two clinicians' statements that have come in. I confess, for my part, I haven't had an opportunity to absorb them.

THE COMMISSIONER: All right, tell me later.

MR MUSTON: I think it is unlikely we will be requiring any oral evidence from them, but no-one should stand down just yet.

THE COMMISSIONER: Is there a chance that Ms McFadgen is the only witness tomorrow?

MR MUSTON: Yes, there is. A good chance.

THE COMMISSIONER: Do we adjourn until 10 anyway, but is she listed at 2 for a convenience reason?

MR MUSTON: She is now at 10.

THE COMMISSIONER: Oh, she is now at 10, okay.

MR MUSTON: So she was at 2 in the expectation that some of these other statements might more usefully have resulted in oral evidence given before hers. I think it is now 10 o'clock, and I think it is likely --

THE COMMISSIONER: Undoubtedly, the thing I should have just done is adjourn until 10 o'clock tomorrow, so we'll do that.

MR MUSTON: Trust the process, Commissioner. Trust the process.

THE COMMISSIONER: Yes. Thank you. We'll adjourn until then, thanks.

AT 3.46PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 13 JUNE 2024 AT 10AM

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