PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO FIONA STANLEY HOSPITAL

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 25 OCTOBER 2011

SESSION ONE

Members

Mr J.C. Kobelke (Chairman)
Mr J.M. Francis (Deputy Chairman)
Mr A. Krsticevic
Ms R. Saffioti
Mr C.J. Tallentire

Hearing commenced at 9.34 am

SNOWBALL, MR KIM
Director General, Department of Health, examined:

FEELY, MS NICOLE
Chief Executive, South Metropolitan Area Health Service, examined:

JOSEPH, MR ANDREW
Director, Financial Policy Framework, Department of Health, examined:

SALVAGE, MR ROBERT WAYNE
Executive Director, Resource Strategy and Infrastructure, Department of Health, examined:

SEBBES, MR BRADLEY CHARLES
Executive Director, Fiona Stanley Hospital, Department of Health, examined:

The CHAIRMAN: Welcome. On behalf of the Public Accounts Committee, I thank you for your appearance before us today. The purpose of this hearing is to assist the committee as it gathers evidence for its inquiry into the decision to award Serco Australia the contract for the provision of non-clinical services at Fiona Stanley Hospital. You have already met the members of the committee; therefore, I will proceed with the formalities.

The Public Accounts Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the Details of Witness form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence before a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the Details of Witness form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Please state your full name and the capacity in which you appear before the committee today.

Mr Snowball: Kim Snowball, director general, health.

Ms Feely: Nicole Feely, chief executive, South Metropolitan Area Health Service.

Mr Sebbes: Brad Sebbes. I am the executive director of the Fiona Stanley Hospital.

Mr Joseph: Andrew Joseph, director, financial policy framework, Department of Health.

Mr Salvage: Wayne Salvage. I am the acting executive director of resource, strategy and infrastructure in the Department of Health.

The CHAIRMAN: We have a series of questions that we have grouped, for efficiency, in some sort of order. But I do not know, Kim, if you want to make a brief opening presentation?

Mr Snowball: Yes; if it please the committee. I have a document to pass around that I will talk briefly to. It really gives, essentially, an overview of the process that we followed from the very beginning and also some of the sorts of points of assessment, in particular the key milestones, during the process.

While that document is being passed around, I will say that I will be very brief and that because members will obviously read the document as I go through it I will not read the material.

Essentially, the state government will open Fiona Stanley Hospital in April 2014. That is the target and construction has already begun. The project is on time and on budget. In fact, I was down there yesterday with a delegation having a look through and the progress is quite phenomenal. It is good news.

It will be the pre-eminent tertiary hospital in Western Australia once it is completed with a full range of medical and surgical services as you would expect, and it will also hold some of the state's tertiary services such as the state burns service; the state rehab service; state-of-the-art emergency care with particular support around major trauma, including major trauma coming in from the country through RFDS; and comprehensive cancer services including radiotherapy treatment facilities, medical oncology and haematology. That gives members a brief take.

The document includes stats around our expectations. They are 783 beds; about 1 500 day patients with an average stay of a few hours; 80 000 emergency department attendances over the course of the year, which will make it the biggest; and 650 inpatients in the main hospital; the major logistical issue of 3 500 staff over the course of a 24-hour shift; and, we think, around 2 000 visitors a day supporting those being hospitalised. It is a very major facility for us.

The decision to award Serco Australia the contract for the provision of nonclinical services very much took, probably, 18 months from start to finish. It was overseen by a group called the Major Health Infrastructure Projects Steering Committee, which I chair. That group looks at all the major health infrastructure projects and basically looks any issues that need to be dealt with across departments. The Under Treasurer is also on that committee, as is the director general of planning and the State Solicitor. It is a very high-level committee across government. As part of the process, we also appointed a probity auditor to oversee the process, and the state tender review committee was also involved and endorsed the project along the way.

The timeline: I guess things opened up in 2007 when the Fiona Stanley Hospital business case was approved, which gave Health the responsibility to look at private sector involvement where complementary to public-funded and provided services. In 2009, there was an industry market sounding to look at the capability in industry and at other PPP projects—that is, public-private partnership projects—in other states, to look at how they went through the process; culminating in late 2009 with the endorsement to look to the private market to see if it would provide more cost-effective and better quality service than we could provide in house. Expressions of interest were

advertised in November. By February 2010, we issued a request for submissions to short-listed respondents. Originally, there were three respondents, but one withdrew. We went through an assessment process of those companies. Between July and October, we undertook a comprehensive evaluation. We actually went to the UK, where Serco operates in the hospitals, to have a look at the services and how they deliver them in those places. It was essentially testing the bona fides in terms of a similar service provision elsewhere, and we were looking at their capability to provide support services at Fiona Stanley Hospital. By October, on the recommendation of Health, cabinet approved Serco as the preferred respondent allowing contract negotiations with that company. Contract negotiations were undertaken between October and May of 2011, and ultimately a recommendation was made to government. Essentially Health and Treasury both conducted evaluations and the recommendation made to government basically said that in our view Serco represented value for money and provided the appropriate safeguards for government. Those safeguards were built into our contractual arrangements with Serco. However, all of that was predicated on a comparison against a public sector comparator—basically that being the ultimate test to see whether this company could in fact deliver the services at a better price and at a better quality than those the public sector could provide. In July 2011, the process culminated in the signing of the contract. The next page provides a list of included services, but I will not go through them all, simply to say this is, as you can see, a very significant range of support services—29 are listed. The contract arrangements for one of them—fleet management—are yet to be finalised with the company and therefore is outstanding, as is child care, but all the rest are included under the contract. It is a snapshot of the 28 hospital service lines. No medical or clinical services are involved—nor are the corporate and executive decision-making functions and so on.

The term of the contract is 20 years—10 plus five plus five—with a completion of pre-operations as well as term operations itself. I will not go through all the rest of this document, but essentially the content —

The CHAIRMAN: Does the 10-year contract start when the hospital opens? It does not start now—is that correct?

Mr Snowball: The 10 years starts from the date of the contract signing.

The CHAIRMAN: So we are all ready rolling.

Mr Snowball: Yes, we are rolling.

So the output-based contract is very heavily focused on performance standards and delivery, with quite a degree of risk for the company in terms of service quality, and asset availability for health. Obviously, with this contract we could not afford the potential for services to be held up in whatever way, so there are quite clear and heavy penalties involved for non-performance.

The total contract cost is $4.3 billion, or $2.2 billion in net present cost terms, over the term of the 20 years.

In terms of our assessment—I will go through a few of these things because I think it is a major point—out in the community, Serco is a company best known in Australia not for its hospital services but for other services, particularly in detention centres. The focus of our assessment of the company was as much about its performance in the UK, in particular in UK hospitals, which showed us that Serco had in all cases improved the service delivery from the previous arrangements. So we were comforted that this was a company that was able to perform effectively in terms of support services and FM provision in hospital settings.

[9.45 am]

In October, I should mention as well, it was pointed out to me during the tour yesterday, that in fact Serco were awarded the Excellence in a Major Project award by the British Institute of Facilities Management only a week or so ago. So this was in a hospital in Scotland. UK hospitals themselves where Serco is providing service consistently rank in the top quartile in terms of cleanliness, safety

and hygiene. So this is a major award. It was not all about price for us; it was all about price and the quality of the service that they could provide.

So what it achieves in our view—and obviously this is part of our system providing that to government—is clearly overall value for money, efficient clinical services and better performance through an enhanced clinical staff utilisation. In other words, if we get our support services working well for us, then our clinical services perform well too. So, it is about supporting total effort. Demonstrated global technology and service delivery: so there are some innovations in this contract that we would not have otherwise seen. The transfer of a considerable amount of risk to the company in terms of facility commissioning and operating means that the state could concentrate its effort on the clinical services; that is, the organisation, the logistics around getting this hospital ready so that the day you open in April 2014 is the day that everything works, so it has all got to come together. So this allows the state to focus its attention on those issues, including recruitment and staffing of those services. The contract itself delivers a quality strategic asset management framework too, so it is not just about service provision; it is about maintenance of assets. It transfers a considerable amount of ICT development and operational risk. ICT is very much at the heart of how this service delivery will work, to the point we will have central control centres about ensuring the logistics and tasking of the various services is done in real time; so strong innovation in that respect, which is recognised there as a digital hospital.

So we have now moved into a phase, having finalised that contract, around contract governance, and the reason I am pointing that out is I think it goes to the heart of how this contract is being framed. So there is a dedicated team within the south metropolitan working with Nicole Feely, and executive director through Brad Sebbes, whose responsibility it is to manage and monitor contract performance. And that ensures, obviously, contract conditions are met, customer satisfaction is achieved and costs, annual assessment, reporting et cetera. So, all the things you would expect to see in contract management we start now. It incorporates quite a significant performance regime as I mentioned, and I have got a bit of detail around that; strong provisions for defaults if there is failure; suspension with a step-in, take out and terminate for fault or convenience, and all of those provide strong controls to the principal; that is, the Department of Health.

So in terms of integrated performance management, basically there are performance indicators for each of those 28 or 29 services, including remedial periods to make good should those key performance indicators not be met. There is a points-based system for recording individual incidents of service quality failure and the points are allocated against key performance indicator levels for failure, and also the unavailability of functional units. We cannot have theatres out of operation, for example, for cleaning purposes at the wrong time. This has to be done in a way that maximises the productivity of our hospital and our theatres.

The state is also entitled to make deductions; that is, a monthly service abatement as a result of the accumulation of failure points. So, if in this contract delivery there is consistent failure at particular levels, there will be a financial penalty on the company in terms of those areas that are not made good in terms of abatement. Event of default also occurring as a result of the accumulation of failure points over the defined period; I will not go into the detail of these with the committee, but rest assured, I guess, that there is a very high degree of performance management throughout this contract.

So, some of the things that are new to Health in this contract, and this is one of the attractions for us as well, so not only was it value for money in terms of a price, it brought with it quite a number of innovations that we have not seen in health before, certainly not in Western Australia. Some of these in fact were recognised as part of the award I mentioned earlier in other hospitals in the UK; so this would be a first for Australia, but already performing elsewhere.

The first to have hand-held computer devices, so this is really stepping up this hospital to be a contemporary hospital with all of the information networks that support the services in a direct way;

so, no more the kind of paperwork, the photocopy, the medical records and put them on chests and move patients around and so on. This is very much reliant on a system that is available right throughout the hospital at the patient's bedside in terms of those devices, whether it is for information, whether it is to support staff about where there might be a spill that needs to be fixed, or whatever.

There is a central help desk, which basically coordinates all of that activity going from requests for patient transport so that you do not have a patient waiting at a bed for hours waiting for transport, but to organise those logistics through a central help desk. There is of course equipment, patient meals et cetera. Real-time equipment tracking: that means you know where the equipment is at any point in time in the hospital, so you are not sending people off to go search for whatever piece of gear they need at the time, which drives our nurses in particular insane sometimes. Automated guided vehicles: this is kind of a robotic self-guided trolleys. These are not delivering into patient-care areas; these are behind the scenes, and in fact this is one of the areas that looks at transporting our patient meals to certain levels, linen, waste et cetera. So, basically, providing very much an automated service in that area.

I will just touch on a few of these and allow the committee to read the detail that is under it. Bedside patient entertainment systems; access to all medical records at the patient bedside, which would be a fantastic innovation for our clinicians in particular; a centralised scheduling service—this is an important one—gives the patients a choice of appointment dates, creates back-to-back appointments for them. So, basically, it cleans up all the logistics of patients trying to find the times that suit them and all the rest of it after the event. This actually links all that schedule for you. Modern cleaning equipment, including microfibre cleaning tools, minimising chemical usage and water usage; cleaning supervisors using hand-help palm computers—again auditing cleaning standards to make sure they are meeting our statewide standards; a site-wide wi-fi available to patients as well; a state-of-the-art building management system, so it is not just about the service delivery, it is also management of the building, heating, security, air conditioning et cetera; and site-wide comprehensive videoconferencing. This will be part of the role as well for Fiona Stanley around telehealth, so that is supporting particularly country areas with videoconferencing facilities. The list goes on. Ward housekeepers providing a single point of contact on a ward, so you do not go chasing people; you actually have one go-to person if there are issues on the ward. Electronic kiosks; swipe cards for security system and paying for parking; electronic meal ordering from the bedside and tracking devices on the external fleet. And a key one for us is electronic medical records, so that is the system to deliver electronic medial records. We are still responsible for the medical record ultimately, but this means that clinicians who may be unfamiliar with the patient or a clinician who wants to see the diagnostic material or whatever can do so in an electronic form. So instead of, as I said, chasing the paperwork, this is automatically available to you under this regime. And this contract provides for all the ICT that supports the provision of that service within Fiona Stanley. Finally, a centrally managed medical equipment library.

I think that gives, hopefully, a fairly succinct picture of the totality of this scope of this work, but also the benefits that are inherent in it and the process we went through, and we would welcome any questions.

The CHAIRMAN: Thank you, Kim. Before we go to the order of questions which we had pre-determined, I will come back and just get clarification on a number of things in your presentation. Taking the last five pages first, all those service innovations, could you point out to us which ones of those are not already being applied in hospitals somewhere in Australia? Are any of those actually going to be new to Australia?

Mr Snowball: In Australia? I can certainly say for Western Australia. Do you have information on other states?

Mr Sebbes: I will just quickly go through. The hand-held computer device is being used by support services staff; it is not in action anywhere in Australia as yet. A help desk has been implemented in some places. Equipment tracking and automatic guided vehicles have been. The bedside patient entertainment system is only in one hospital in the country so far and, similarly, the access to medical records at the patient's bedside is only in one hospital, which is a private hospital in New South Wales. Centralised scheduling is not implemented to my knowledge anywhere in the country.

Mr J.M. FRANCIS: Microfibre wi-fi?

Mr Sebbes: Wi-fi is, I think, starting to be rolled out in other hospitals; it is not common. I mean, none of these are common in any of the hospitals. There would only be two or three hospitals if they are in any at all. Some of the external tracking is not available at the moment, and certainly no public hospital has gone for full electronic medical records yet, but there is a private hospital that has done it.

The CHAIRMAN: Just on that, we are aware of the Auditor General report on your patient administration scheme or system. Is it system or scheme? What is the correct terminology?

Mr Snowball: System.

The CHAIRMAN: System. So, in terms of what you have said here, is that still being developed on the contract which Health has, or is that now being handed over for development by Serco?

Mr Snowball: The patient-assisted service we are developing as a total system, so the health system is looking at its implementation. First it will go into Fremantle; in fact during the course of early next year. This is integrating. So as this develops the PAS will be implemented in Fiona Stanley. At the same time it will be able to connect them to our other hospitals, particularly in the metropolitan area where, obviously —

The CHAIRMAN: So, PAS is still a project being developed by WA Health.

Mr Snowball: Correct.

The CHAIRMAN: But here, obviously, Serco has responsibility for integrating it into the total system in a hospital.

Mr Snowball: That is right, within a hospital.

The CHAIRMAN: Coming back again, just a brief comment on slide 5, "2007 — … Business case approved … '*private sector involvement shall be encouraged where it is complementary to publicly provided services* …'. Is it not also true that the health department, in terms of contracting out, made it clear that cleaning and other essential support services would not be contracted out? That was up on your website until about 12 months ago.

Mr Snowball: We were operating on a basis of this was a case that was agreed by cabinet, so obviously —

The CHAIRMAN: Yes, but in 2007; I am just trying to get a fuller explanation of where you were in 2007 with respect to contracting out.

Mr Snowball: Yes.

The CHAIRMAN: And I think it has been removed from the website, but in the last 12 months there was on your site a clear definition of what would or would not be contracted out.

Mr Snowball: Yes. The clear commitment we had from government and direction we had from government was that we were not contracting out existing services—so at Royal Perth, Charlies and the like—but we were required to test the market in terms of particularly new hospitals and new facilities and new services of which Fiona Stanley is one. So, this was about testing the market. It was not about automatically contracting out services. So, if for example, Serco or anybody else for

that matter was not able to either meet the quality standards or the price, then we would not have contracted out services.

The CHAIRMAN: I understand that. I am just relating it to the 2007 date, as opposed to now. Okay, we can move on to "February 2010 — Request for submissions … short listed." You got down to two. Are you able to disclose who the other unsuccessful bidder was, as a question of interest?

Mr Sebbes: Yes. It was a consortium of MBM and Brookfield Multiplex.

The CHAIRMAN: Also in the next point you did a comprehensive evaluation of UK hospitals where Serco and other proponents provided similar services. Could we have a list of what those hospitals were, the actual hospitals?

Mr Sebbes: Do you want me to tell you now or —

The CHAIRMAN: Yes, if you are happy to.

Mr Sebbes: Okay. The Serco hospitals were Wishaw and Forth Valley in Scotland, and Norwich in England. Then there were the other proponents: Peterborough and—I cannot think of the name but it is a hospital on the outskirts of London—Coventry were the other ones.

The CHAIRMAN: Perhaps we can get as supplementary information a full list of those hospitals.

Mr Sebbes: Yes.

The CHAIRMAN: How many were in the team that actually went? Were there different teams went to different hospitals or the same team went?

Mr Sebbes: No, There was a group of four of us that went to look at the hospitals. We did split up on a couple of the sub-components to get better coverage, but there was a group of four of us.

The CHAIRMAN: Who did you generally meet in terms of the types of people involved? Obviously you met with Serco representatives, and who else?

Mr Sebbes: We met with both the representatives of the potential providers and we met with the representatives of the trusts and we also met where appropriate with the PPP arrangement, the people financing the arrangements as well that have a more overseeing role. But most of our information was sought from the trust and their experience of what they have got.

[10.00 am]

The CHAIRMAN: Are there any other quick questions on the presentation before we go to procurement strategy? If we could then seek to get more detail on the procurement strategy. Was the procurement strategy report created by the steering committee in July 2009?

Mr Snowball: Sorry, could you repeat that?

The CHAIRMAN: In 2009 you have indicated there was a market sounding for industry, but when actually was the procurement strategy report created?

Mr Snowball: Out of that market sounding and that look at the other states and what they are doing in this area, the October–November 2009 report to EERC and cabinet was the one that made the recommendation that there was sufficient capability out there for us to go the next step in terms of looking for expression of interest from the private sector. Where we did the market sounding, that was done with consultants to basically see who is around and where the industry is going in that respect. It took roughly six months to finalise that report for government. That was kind of the key point at which the message was: there was sufficient capability in the market price to actually go to the next step and seek an expression of interest.

The CHAIRMAN: Just check that I have got the terminology correct. Would you call that the "procurement strategy report", or would you have a different title of that?

Mr Snowball: Basically, in terms of the title of the report, that was the decision point at which, is there sufficient for government to test the private market? Are we wasting our time going out there, because there are no providers in Western Australia that could do it? That is the point that says: it is worth testing this market, because there is enough capability out there.

The CHAIRMAN: As you are probably aware, in terms of our terms of reference, we are really concentrating on the processes. While the time is a key element, what I am seeking to find out here is: was there actually a procurement strategy report which then was a key part of that decision-making process?

Mr Snowball: The answer to that is yes, and that is the point at which that report was produced for the government.

The CHAIRMAN: Is it possible for the committee to have a copy of that procurement strategy report?

Mr Snowball: We presume so. However, it is a document that went to ERC and cabinet, so I can check whether that can be released. I am not in a position; it is not my document.

The CHAIRMAN: I would certainly like to request it, and you can go through the required approval processes to see whether a copy can be made available to the committee.

Mr Snowball: Yes.

Ms R. SAFFIOTI: Can I just follow on? In testing the market capability from the eastern states, obviously there were companies over east delivering the same services that Serco will be providing?

Mr Snowball: This process was to look at, in terms of our services: what other states are looking to a private-public arrangement? This was part of scoping as well as looking at whether there are companies already active in this area. We got the affirmative to both of those questions.

Ms R. SAFFIOTI: Sure, and as a result of that process, any of those companies involved in eastern states market which proved market capability, were they part of that tender process that eventuated?

Mr Snowball: The subsequent tender process?

Mr Sebbes: Yes. We went through a market sounding process which involved going to all of the known providers. We identified them by going to existing hospitals that used PPP projects and that sort of stuff. Then when we came back and got our procurement strategy approved, we then went back to the market for an expression of interest and then shortlisted from there.

Ms R. SAFFIOTI: So were any of those operating the eastern states, and do they bid as part of that tender process? You were saying that one of the reasons you went forward for contracting out was because of the market capability proven up by the eastern states. I am just trying to ascertain whether any of those companies operating in the eastern states —

Mr Sebbes: They expressed an interest, yes.

Ms R. SAFFIOTI: They were not part of the final three.

Mr Sebbes: No.

Mr C.J. TALLENTIRE: On this same issue, 28 or 29 essential services, you tested the market and were able to find that there were single providers who were capable of delivering those 28 or 29 essential services.

Mr Snowball: Not just single providers, but potential for a consortium of providers to be able to provide that range of services. We looked at first of all establishing what services it was sensible to test the market with, and that was the experience of other states that helped kind of guide that, but making our own decisions then about how the grouping of those services would best work. Clearly, some of these services are connected, are integrated, so you would be looking at a single provider across them, but they are areas that you might look at individual suppliers if it got to that. Our

process here was to seek the market providing that total package of services. That is the decision that we reached basically in October, November, 2009.

Mr C.J. TALLENTIRE: So at that early stage—and it is probably an issue we will get back to—you were opening up the possibility of contracting out?

Mr Snowball: Correct.

The CHAIRMAN: Just confirming, I think, what you have just said, when in October–November 2009 you had completed your procurement strategy report, by that stage you had reached the decision that all 28 services should be contracted out.

Mr Sebbes: There were 29 services when we went to the market. We added one more very quickly around isolating out the ICT component into a separate service rather than being a delivery service.

The CHAIRMAN: Can you just elaborate a bit in terms of how it was isolated out? So it was considered as a separate part of the contracting arrangement?

Mr Sebbes: We put that in as an optional service and that went to the market as an optional service. We got substantial bids then.

Mr C.J. TALLENTIRE: With the subcontracting out, to what extent were you confident that there would be the level of integration required when people are talking about putting together consortiums that may never have worked together in the past?

Mr Sebbes: If you look at the model that we have gone to here, the whole model is around reducing the risk between different subcontractors. It is not uncommon in these things if you do it separately, if you have 20 contracts with 30 services, you actually get demarcation disputes and those sorts of things at the boundaries of those sorts of things. One of the critical things here is to actually have an overlay that one company is responsible for everything, so it does not matter whether a subcontractor performs or not. The head company is the one that gets the abatement under the regime. Very much this is about that sort of service. That does not stop them having subcontractors. There is even the options for us to change out later and replace subcontractors and those sorts of things, but very much the whole model is back backing a single service provider to provide the thing. That is why one of the services in this list of services is actually called management integration. We are actually contracting for management services.

The CHAIRMAN: Can I just refer back to your presentation, which I think leads off this? On slide 7, you have that service description. Going through that, Kim, you indicated that there were fleet management and one other where there was still some contractual issues to be tied up. The point of the question is: is everything locked away in contract, or what are some of the items where there is still some finalisation of the detail?

Mr Snowball: All of these, with the exception of fleet management, on that list are finalised in contractual terms. Child care is the other one that is not on this list but is something that is still open to us to finalising arrangement.

Mr Sebbes: In relation to child care, the contractual term there is that within six months of the signing of the contract, Serco would come with us with a series of options and a business case around the provision of child care for the hospital.

Ms R. SAFFIOTI: Do they have any experience running child care around Australia?

Mr Sebbes: I am not aware that they do. We would anticipate they would go and partner with other child care providers. The nature of the precinct is there is interest in child care from the universities, St John of God and other groups in the area, so there is a lot of opportunities there to develop.

Ms R. SAFFIOTI: I want to go back to the procurement strategy. This is a more technical issue about what you classify this contract to be—whether it is a classic contracting out or is it a PPP? From your perspective, what is the definition of this?

Mr Sebbes: That is a really difficult question to answer. This was not run under the PPP regime within the state. That is probably as much as anything a timing issue, because that was being established about the same time as this. It has many of the features of the PPP, but it is not a PPP. We have clearly segregated out the construction element. We went early to the market for a construction element. That had some advantages. It changes the risk profile admittedly. We ran this tender process concurrent with construction occurring, so that shortened the overall time frame of the process.

Ms R. SAFFIOTI: So you would not call it a PPP?

Mr Sebbes: This component of it you could classify as a PPP, but the construction component of the project I do not think you could. Whereas typically in a PPP is to design it, build it and run it.

Ms R. SAFFIOTI: So back to this contract.

Mr Sebbes: It is a variation of a PPP.

Ms R. SAFFIOTI: It is just interesting, because later on when we are talking about public sector comparators, you are using the PPP guidelines. That is why I think it is important to clarify exactly what you see this contract to be. I see it as a typical contracting out policy, but not a PPP. That is my definition of it.

Mr C.J. TALLENTIRE: I am interested in the process you use to determine how you got to those 28 or 29 services that you felt you were able to disaggregate from the actual core activity of the hospital. How did you go about that process, and what sort of public consultation was done to test whether it was a valid approach?

Mr Sebbes: As part of the markets sounding process, one theme we got put back to us by all parties and not just the potential proponents was that the scope of services is actually very important in this definition. Generally the view was the scope of services in a typical PPP project was not broad enough. Having a demarcation between in this case the publicly-run services and the privately-run services inside complex services, it was better to have a definition that is most easily defined. There was almost a principle that the easiest definition of what is clinical and nonclinical is the clearest point in the hospital—even though it is not absolutely clear by any means, but that was a clear point. We went back and said that is what we have found and that is what we believe, so that was the process that was approved there. That is why we have got the broad range of services.

Mr C.J. TALLENTIRE: Were you conducting a process where medical experts could say, "Sterilisation, normally that is not removed from the core business of the hospital"—that is something that you would not contemplate contracting out. Where was the transparency? Where can we see the submissions that different specialists would have made on these decisions to outsource these 28 essential services?

Mr Sebbes: We had clinical people involved in the process. We had, as part of a team—the same in the group that went to the UK—clinical people involved in that process. Then we just went through and sat down with equivalent people in the other projects.

Mr C.J. TALLENTIRE: My question is: where can we see the comments that were made on that process?

Mr Sebbes: There is a summary of those comments, from memory, in the proposal that we put to the ERC.

Mr Snowball: In the document.

Mr Sebbes: In the procurement strategy.

Mr Snowball: The documentation describes what services we thought that the market soundings had indicated were appropriate. Those market soundings were not just about, "Is there capability in the market?"; it was also about, "What potential value-add could we get by looking at these services

in a different way and as bunch of services?” In terms of the distinction of clinical services, we already have in Health a whole variety of circumstances where the private sector provides clinical services as well, so we got private hospitals and the like. But even the sterilisation, we will subcontract at times—other hospitals will provide our sterilisation services. This concept was not new to Health. What was new to Health was bundling these services together and then putting them out as more of a whole rather than contracting this service and that service. It was quite a different process in that sense, but in every one of those cases there was the test around: from a clinical safety quality point of view, are these services ones that we are prepared to see provided by another provider?

Mr C.J. TALLENTIRE: Is there somewhere I can go where I can see comments made by leading surgeons on the validity of, say, sterilisation—outsourcing sterilisation? Or whoever else made submissions—I am just curious to see the submissions.

Mr Snowball: Obviously as part of this document, my memory actually says it was there, too, but this was 2009. We would have to have a look at: does that adequately describe what clinical input was advanced to each of those services? We are happy to provide that as supplementary information.

[10.15 am]

The CHAIRMAN: If you would. Could I come at the same issue in a slightly different way? As an outsider not involved, it would seem to me that you would list your 28 or 29 services and you would assess the benefit of contracting them out individually. But even if say 20 out of the 28 are clearly better off having been contracted out by your assessment and eight are worse, you might decide that for the overall efficiency and integration of services that you still put the whole lot together. Was that an issue that arose and, if so, do you have a checklist where you can see the benefits or disadvantages of each individual one and the net gain overall of doing a bundling operation because so many of these services are interrelated?

Mr Sebbes: You are correct in what you are saying. There were some services that, because they had not been done before, we were keen to explore, so we ran internal workshops on those things within Health. We went through what is the best way to deliver the service and whether we should pull it out of the scope or leave it in the scope. In every case out of that process we decided to leave it in the scope and test the market against the scope and then make a decision based on the submission we got rather than have a predetermined outcome.

Mr Snowball: At that point we did not make a decision about whether that individual service was going to add value by being part of a bundled set of services. We allowed the companies, when we put out the expression of interest, we just said, “Here’s the range of 28.” You may well have got bids coming in for all 28, but our assessment may have said that only 20 of those were actually of value for the state. That was always an option open to us to decide what of that scope we would accept in terms of what came from the market.

Mr A. KRSTICEVIC: You talked about, in this case, bundling the services, as opposed to the individual contracts. Obviously in other hospitals you have some individual components that are contracted out. Can you just explain which ones they are across the range of hospitals and how you found them to be working?

Mr Snowball: I suppose in answer to your question—I am happy to get these guys to talk about the individual hospitals, as well —

Mr A. KRSTICEVIC: At a broad level.

Mr Snowball: At a broad level, one of the different things with Fiona Stanley is this is a greenfields site. It is brand-new tertiary facility that you could either say, “Let’s pick up all the stuff that we’re currently doing and the way we have been doing it historically,” and all the tradition that goes with that. This was an opportunity to actually look in a new way at how we could provide this service.

That was part of the thinking around the design for the support services at Fiona Stanley. Here was an opportunity to actually look at the whole range of services, not just the individual component parts. It becomes much more difficult in our existing hospitals. As I said, there are circumstances where we contract out sterilising services, linen, radiology and even clinical services. Hospital by hospital, some of that has, over time, evolved that way. This is a much more planned, organised and disciplined process to look at what will be the best configuration of the services and what we want to see by way of performance out of these services in terms of cost as well as quality and safety measures. That is, I guess, the difference between an existing hospital deciding it needed to contract out a particular service, for whatever reason—it could be the workforce or whatever—to this one, which is a new site where we can do things quite differently.

Mr Sebbes: One of the features of this contract, which is not typical in PPP contracts, is if, for example, we go down this path and in four or five years' time one of the services is not working properly but the rest of the services are working well, we have two options—well, we have three options; we could leave it as it is. We have the option of instructing Serco to subcontract the services or for them to stop providing the services and go and get a subcontractor to provide that service, all within the same performance regime. So, we can replace bits, which is not easily done in an existing PPP arrangement, or we can choose to say to Serco, "Stop operating that service and we will replace that with public sector employees and run that service ourselves."

Ms R. SAFFIOTI: Sorry, can you just explain that? So at any time you can ask Serco to stop providing a service and replace it with other contractors.

Mr Sebbes: If they are providing a service that is not meeting the standard. It may be that you have a large bundle of services here and it may be that most of them are working very well but one is not. We actually have the option of going to Serco and instructing them to replace that service; so, to go to the market and subcontract that service by getting another provider —

Ms R. SAFFIOTI: Serco has to do that?

Mr Sebbes: Serco has to do that, and they have to maintain the whole key performance regime. They have to subcontract and still step up to the performance regime.

Mr Snowball: So they carry the risk of the performance of those services.

Ms R. SAFFIOTI: Sorry, but if Serco is not performing a service up to the standards that you have for this continuing performance—or they are not meeting their performance indicators, then they have to—you cannot stop them from providing that service? Do they have to keep providing the service?

Mr Sebbes: No. The other option is to say to Serco to stop providing that service and we will provide that service ourselves. We have that option as well. Or, if it is a big enough service, it could eventually lead to default regimes and much larger penalties. One of the things we have noticed with PPPs is that it is not uncommon to get a range of 20 or 30 services. Generally, it is working well but two or three of them are not quite up to standard. We are actually in the process of rectifying that.

Ms R. SAFFIOTI: Can I just ask about performance indicators and who will be overseeing those and who will be covering the cost of overseeing those performance indicators?

Mr Sebbes: In the presentation we went through the contract management. That is part of the South Metropolitan Area Health Service cost.

Ms R. SAFFIOTI: How much would that cost, for example, per annum, and who is picking up the bill?

Mr Snowball: That is built in. Part of the cost of running Fiona Stanley Hospital will be the contract management of the support services.

Ms R. SAFFIOTI: I am sorry, so who will be doing it? Who will be performance reviewing it? Will it be Health?

Mr Sebbes: It is part of my role.

Ms R. SAFFIOTI: So it is part of the $4.3 billion.

Mr Sebbes: No, that is the cost of running the services. In the evaluation we factored in an amount of money against that as to the anticipated cost of the contract management unit. The $4.2 billion is the actual cost of the services.

Ms R. SAFFIOTI: How much is the cost of the performance management?
Mr Sebbes: It is estimated to be in the order of $2.5 million per annum.

The CHAIRMAN: Can I just come back to one point you mentioned? If a decision is made, for whatever reason, to pull a service out of a contract and bring it in for direct management, what are some of the contractual issues and liabilities you would have in removing that particular service from Serco?

Mr Sebbes: If it is based on poor performance, Serco has to live with the outcome of that in terms of any cost that incurs on them or any cost of profit or anything else that is the equivalent.

Mr Snowball: But bear in mind that there is a period for abatement. Serco has an opportunity to make good the problem or issue. Ultimately, as Brad described, if there is a failure to do that, and it obviously is an issue for Health, we have the option of either directing Serco to subcontract that service to someone else to deliver against those same performance standards or, alternatively, we bring it in-house and provide it ourselves.

The CHAIRMAN: But the point I am getting at is that if you decide to bring it in-house, I take it from what you are saying that if the opportunities for Serco to rectify or bring it up to standard are not met, then you can bring it in and they bear the cost.

Mr Snowball: Yes.

The CHAIRMAN: But it may be something that falls short of that where—because we have not seen what your KPIs are—there may be a great degree of unhappiness that is impacting on other services and you really want to bring it up but Serco has not fallen over according to the KPIs, then you are in a situation where I presume there will be a liability on the state if that service is removed from Serco.

Mr Sebbes: It is probably worth having a bit of a discussion around the KPIs.

The CHAIRMAN: We can leave that to later.

Mr J.M. FRANCIS: I have a question on the liability of the state. The leader of the Labor Party said, "If the Barnett government tries to contract to Serco, a future Labor Party will do whatever it can do to reverse the decision, including negotiating with Serco to bring an early end to the contracts." If a future government were to go down that path, say after the March 2013 state election, what effect would the decision have on the proposed opening date? Will reversing the outsourcing decision, replacing all Serco's employees, systems and procedures with those of the public sector cause major delays in opening the hospital, and what would be the cost to Western Australian taxpayers?

Mr Snowball: There are several questions in there.

The CHAIRMAN: I am happy if you accept his premise that he will not be in government after the next election!

Ms R. SAFFIOTI: Compare it to unwinding the carbon tax.

Mr Snowball: I will ask Brad to talk through the impacts of making that decision at that point in time, bearing in mind that Fiona Stanley Hospital will open in April 2014, and so that is the

timetable we are working to. In terms of the contract itself, it does provide for, should a decision of the government be that you wish to terminate the contract, there is a clause in the contract allowing that, but there are penalties associated with it. Those penalties, as you would expect, are highest early on in the contract and tail out as the 20 years progresses. So there is an opportunity for that to occur, if necessary. If there was a decision—we would have to take some of that on notice in terms of the actual costs—but there would need to be a significant lead time for us to obviously not only gear up the services that would need to be geared up, but equally in order for Serco to have time to manage the process from their end too. I would say nightmare territory —

Mr J.M. FRANCIS: Nightmare territory?

Mr Snowball: From an operational service delivery perspective at such a critical time, as you know, we hand a level of risk across, so timing would be critical around that decision.

Mr J.M. FRANCIS: So let us say roughly it was some time close to after 13 March if the government did change. Is it in the ballpark of billions of dollars?

Mr Snowball: Look, it would certainly delay the opening and delivery of the services—no question, from a Health operational point of view, this has been 18 months in the planning. For us to turn on a 5c piece to switch providers, the cost would be significant and the disruption to our ability to provide the Fiona Stanley service would be majorly impacted. As I said, to quantify that, to give you timing and so on, it is very difficult for me to do off the cuff, but I can tell you around the table that I suspect it would be a very difficult thing for us to deliver. Notwithstanding if there was a timetable so you allowed for that planning and recruitment, sure, it can be delivered, but at a cost.

Mr J.M. FRANCIS: Can I ask you to take that question on notice and give me some estimates on what the cost and the impact would be in say mid-2013, three months after the state election? If the government was to change and the Labor government was to bin the contract with Serco, I would be curious to know what the cost to the taxpayers would be and what would be the delays in rescheduling the opening with government services.

Mr Snowball: In answer to one part of that, the contract cost is —

Mr Sebbes: The highest amount under the contract is $60 million.

Mr Snowball: So you would be pretty close to $60 million, purely on the termination of the contract issue, notwithstanding all the other stuff about costs.

Mr J.M. FRANCIS: And you would then have to redo it all yourself anyway?

Mr Snowball: Yes, that is right.

Mr A. KRSTICEVIC: While you are providing that information, I know that at the last day of the ALP conference it changed the platform around health. It was not just around Fiona Stanley Hospital; they were talking about the Peel Health Campus, Joondalup Health Campus and Midland as well, going into public hands. While we are looking at Fiona Stanley, can you bundle all those in at exactly the same time? Because the commitment is far beyond Fiona Stanley, if that is the case. That is the current ALP policy. I am wondering if you could factor those in.

The CHAIRMAN: You would need to stick to our terms of reference. You can ask what the contractual arrangements are for the government breaching the contract, but I think the rest goes well beyond our terms of reference.

Mr A. KRSTICEVIC: I assumed it would be an additional cost and headache for the Department of Health to have to include those other hospitals.

The CHAIRMAN: I am just suggesting you phrase it within the terms of reference. We are looking at what the costs, inefficiencies and delays would be if the state wanted to cancel —

Mr A. KRSTICEVIC: For Fiona Stanley if you had to incorporate the public system running all those other hospital services as well as Fiona Stanley Hospital at the same time and whether the health system would fall over or whether you would be able to manage that.

Ms R. SAFFIOTI: You are asking him to do political work. It is out of order.

The CHAIRMAN: Let us just keep it to the terms of reference. We need to keep it to the terms of reference—just Fiona Stanley.

Mr A. KRSTICEVIC: Just in terms of costing.

Ms R. SAFFIOTI: No, you are asking them to do paid political work, and it is out of order.

Can I just go back to the issue of if they are not meeting the performance criteria in one of the services? What is the ultimate dispute resolution mechanism? There may be a situation where Serco believes they are performing well and Health believes they are not performing according to the set criteria. Who is the ultimate arbitrator and what dispute mechanism is there to try to sort that out?

Mr Sebbes: There is a formal dispute mechanism built into the contract that involves, depending on the circumstances, a number of things, including the use of independent experts if that is an appropriate way to resolve things. But there is quite a detailed resolution procedure. Ultimately, obviously if you cannot get a resolution, you would potentially end up in the courts. That dispute resolution procedure—I do not have the whole detail in my head—involves escalating it within the organisation, so it might go to the senior Serco person in this state and someone might get together and make sure it is not a contract management dispute issue. It just escalates up through the process.

Ms R. SAFFIOTI: So ultimately it could end up in the courts.

Mr Sebbes: I think any dispute could end up in the courts.

Ms R. SAFFIOTI: Could we have a copy, by way of supplementary information, of that dispute resolution mechanism?

Mr Sebbes: Yes.

The CHAIRMAN: If I could get back to some key questions on the actual procurement and evaluation. When was the public sector comparator developed, in terms of the time line? Was it back in October or November in 2009, or was it developed after that?

[10.30 am]

Mr Salvage: In terms of timing, it was before we sought expressions of interest from the two short-listed players.

The CHAIRMAN: Did you actually go back and modify the public sector comparator in light of the information you received from interested parties?

Mr Joseph: Yes, we did.

The CHAIRMAN: Could you give us some indication of some of the changes which were then taken into account because you had tested the market or discussed matters with the market?

Mr Joseph: The government's policy guidelines require the department to establish the public sector comparator before receiving bids. That process was gone through as a result of the expressions of interest process and the identification of preferred respondent. The public sector analysis was updated to reflect the bid that was on the table.

The CHAIRMAN: Can you give us some indication of the specific changes that were made in that updating?

Mr Snowball: It is simply scoping. It is around the scope of services that we were getting expressions of interest on, so that we were able to then have apples for apples. Whilst we do the public sector comparator in advance, we also tailor that so that when we are considering a bid, we

are testing like for like; basically, the adjustments that were made prior to the expression of interest being called, and post that.

The CHAIRMAN: Did that amount to some of these 28 or 29 services not actually being in your public sector comparative at the start?

Mr Sebbes: No; it did not change any of the scope of services. The things that changed were things like at the time we started this process we did not have the $255 million from the commonwealth to build the state rehabilitation service, so that was an additional service on the side. They were the sorts of things that changed the scope of services.

The CHAIRMAN: With respect to the request for proposals, what initially went out, and then when you tested the market were there changes to that?

Mr Sebbes: I am sorry; I missed the question.

The CHAIRMAN: You went to the market with a request for proposals; is that the correct term?

Mr Sebbes: We went for an EOI, and then request for proposals, yes.

The CHAIRMAN: Then, when you had spoken to the market and got feedback, did you then change what you were looking for in the contract? Were there changes to some aspects of it?

Mr Sebbes: I am sure we would have, but nothing comes to mind. We did not change the public sector comparator in relation to that, if that is what your question is. There are examples of the way services were being run that we had not anticipated. But I do not know if that changed our position on things. That was just a benefit that we got out of the process.

Ms R. SAFFIOTI: At what time did you develop the public sector comparator through the whole evaluation process?

Mr Snowball: Is the question about the timing?

Ms R. SAFFIOTI: You have this whole procurement strategy, and I am asking what time during that strategy did you develop the PSC, and then the PSC, including all those other adjustments for risks that you have included?

Mr Snowball: I hope I am reading the question right. Essentially the public sector comparator was prior to the finalisation of the contract in our procurement strategy that went forward. That was part of the strategy; in other words, we took to government what we thought we should test the market with and how we would compare what came forward. The subsequent changes, as Brad Sebbes described, really relate to what are we asking the market to provide a service for, whether that has changed since that initial procurement strategy was put together; and what was the adjustment then that was done to the public sector comparator. That adjustment would follow the expressions of interest, 2009, in which we looked at scope. Prior to that, the public sector comparator basically does not change in terms of what it is looking at and how it is assessed; and the methodology is one that we obviously put together consistent with the PPP and with advice we got from Treasury and others.

Ms R. SAFFIOTI: I refer to the actual numbers that are contained in your submission. Can we refer to that number?

Mr Snowball: We included those in the submission.

The CHAIRMAN: We have an issue that the submission you presented to us was commercial-in-confidence.

Mr Snowball: Correct.

The CHAIRMAN: On the surface, it does not appear that much in there should attract that; but we are respecting your wish in that we are not making this a public document. It would help at this stage if you could clarify what you believe should be considered as commercial-in-confidence; that

is, of what you have already given us as a written submission. Ms Saffioti would like to use some of the figures you have presented, but we do not want to breach what you are saying is commercial in confidence.

Mr Snowball: We will clarify. Clearly the key area is in fact the numbers around the public sector comparator, given we have existing running processes with the private sector using similar but not exactly the same public sector comparators in those processes. If I could take advice in respect of that particular area, otherwise —

The CHAIRMAN: I am not sure what Ms Saffioti was going to ask, but can you provide us now with what is the net present value of the public sector comparator?

Mr Snowball: Yes, we can.

The CHAIRMAN: So, that is?

Mr Snowball: Do you mind if we take two minutes to ensure I get this right, because it is important? I am advised that based on Treasury advice that public sector comparator will be made available six months after the signing of the contract, so that will be year's end for that to be made available and public.

The CHAIRMAN: That is part of existing policy.

Mr Snowball: That is the advice.

The CHAIRMAN: We will pass over that for the moment. We might want to come back in an in-camera session or in-confidence session. But you are willing to put on the record that the present cost for the Serco contract is $2.2 billion?

Mr Snowball: Correct.

The CHAIRMAN: Are you willing to put on record that the net present cost of the public sector comparator was north of that?

Mr Snowball: Yes, hundreds of millions. The issue for us is that in terms of commercial-in-confidence we need to ensure that that information is not made readily available to other commercial entities that we are in negotiations with.

The CHAIRMAN: We do not want to jeopardise that at all.

Mr Snowball: No.

The CHAIRMAN: But, as you are aware, I was the minister for nearly eight years and we were cleaning up the mess of projects we were told were going to save the state hundreds of millions of dollars, but they were hundreds of millions more expensive to contract out. So we want to see some clarity on the numbers to protect the taxpayers' interest, and not just accept the gloss that goes on, as has happened to previous governments, and we are getting a dud deal. We do not know whether it is a good deal or a dud deal if you cannot lay out the numbers for us.

Mr Snowball: I guess what I am trying to do is reassure you that, throughout this process, that has been a very clear focus of attention for us. We have gone through a very disciplined assessment against the public sector comparator; we have organised those costs. We are confident that this represents significant cost benefit to the taxpayer in WA.

The CHAIRMAN: I can also refer you to academic reports and reports of committees of the House of Commons, that point out the process does not necessarily deliver best value for money in terms of the way it is stacked up. So there are plenty of examples in England, in health, where they are now, with the economic situation, finding that the PFIs, the PPPs, are costing them a lot more. That was not the way the particular projects were sold. The only way we can establish the facts is to get some of the numbers that underlie it. We will be seeking to do that, but we respect that you have other matters that are in negotiation, and we do not want to put those in jeopardy.

Ms R. SAFFIOTI: I will not refer to the numbers, just the timing. When the final numbers on the public sector comparator that are in front of us were presented, when were they finally settled down? Was it October–November or was it ultimately changed up to the final decision?

Mr Sebbes: From memory, by the end of December 2009 we had locked down the public sector comparator, including adjustments for the state rehabilitation service. There may have been some minor changes after that, but I am not aware of any changes after that.

Ms R. SAFFIOTI: In the evaluation of private versus public there are a couple of issues. I think competitive neutrality is something that I can talk about. I do not think that is in confidence. I refer to the application of competitive neutrality in this instance. Is that something that is applied universally to contracting out arrangements? I have a bit of experience and I thought it was mainly GTEs and where government is running a business that is charging for services and in competition with other businesses. Can I ask someone about the application of competitive neutrality cost in this instance?

Mr Salvage: I am happy to answer that and I think it relates to your earlier question about whether this is a PPP. Whether it is or not, we followed the PPP national guidelines in the way that we constructed the public sector comparator. Those guidelines relate that we need to take a view about competitive neutrality and therefore equalise costs on both sides of the comparator for things like tax advantage in the state sector.

Ms R. SAFFIOTI: Sure. I have read those guidelines too and I honestly thought they applied to government businesses and generally GTEs, and in instances where you have GTEs charging for a service in direct competition to the private sector. That is why I was quite surprised that has been applied in this instance. I was wondering whether it has been applied to other contracts that health has issued over recent years.

Mr Salvage: The same approach has been applied in relation to the procurement of the Midland Health Campus, so we have just regarded them as an acceptable set of standards to gain a comparison between the public and private sector.

Ms R. SAFFIOTI: In relation to the allocation of risks in relation to the PSC, the allocation presents a lot of risks in relation to developing the PSC. In the reverse, contracting out presents a lot of risks as well; for example, the government structure and the company you contract out to and all the risks associated in respect of how companies are structured and companies are run and things like that. Is there an allocation of risk the other way?

Mr Salvage: In the submission we put forward to the committee we identified the specific risks that we sought to transfer through the contract negotiations largely related to the state offloading risk to the private sector deliverer of those services, and that was a significant part of the public sector comparator. I think your question goes to the reverse of that: if there is any risk carried by the state in having a third party deliver those services. That is not explicit in the public sector comparator in those terms.

The CHAIRMAN: It is already on the public record that you are claiming $300 million saved due to transfer of risk. Can you put some flesh on that? How do you save $300 million on the transfer of risks?

Mr Salvage: It relates to the specific risks that the state has identified and wishes to have carried under the arrangement with Serco and the quantification of those risks using the approach we adopted.

The CHAIRMAN: That does not satisfy me. The limited academic papers that I have read suggest that transferring out services in health is high-risk business to government, because medical technology changes all the time and medical practice changes all the time. If you are stuck in a contract, you can only vary it if you pay Serco what they demand. Is that not correct in terms of variations to contract?

[10.45 am]

Mr Snowball: No, that is not case. The issue around the sharing and transfer of risk—I will ask Wayne to go through the nature of that transfer—actually goes to those areas of risk that we have transferred; and that probably answers the question. The issue about to what degree are we beholden to Serco in terms of the provision of these services, the nature of the contract is very, very clear about performance and delivery on performance, and very, very clear about remedial action that are in our hands as the contractor for the very reason you have pointed out.

The CHAIRMAN: Kim, the point that I am trying to get information on is not if they meet current KPIs. What I am saying is that medical practice and medical technology changes fairly rapidly. If there is change that you want to implement to get better health outcomes, which goes beyond your current KPIs, my understanding from your document is you therefore have to make a proposal to Serco to change matters which are in the contract. They will offer you a price to enable you to make that change. You cannot make the change unless you can negotiate the price with them—is that correct?

Mr Sebbes: It is partially correct. It is more complex than that. We have recognised in the contract that over a period of 20 years the world will change. We have built in some performance requirements and annual review of services so that we update along the lines of contemporary practice. That does not generate additional cost to us. Serco are obliged to continually improve their processes around that. There may be completely new things that were not dreamed of that would inevitably attract a cost, as it would attract a cost if we were running it ourselves.

The CHAIRMAN: Has that been factored into your risk costs on the state?

Mr Sebbes: There is a list of retained risks which I think we have provided. The retained risks are identified in that table you have.

The CHAIRMAN: Perhaps we can come back to talk about those risks. We were talking about competitive neutrality. Again, it is on the public record that $70 million is an adjustment for competitive neutrality. Can you give us some of the component parts that add up to that $70 million that is already on the public record?

Mr Sebbes: I think we have covered that in the submission. Going through the normal elements of competitive neutrality, the only element there that is of any benefit to the state is Serco paying payroll tax.

The CHAIRMAN: Most of that $70 million is payroll tax?

Mr Sebbes: I think it is all payroll tax. I think it is the only one that came up under the criteria.

The CHAIRMAN: How do you create a saving of $148 million of cash by going to this Serco model?

Mr Sebbes: On the cash component of the PSC?

The CHAIRMAN: Yes. It is already on the public record that there is a saving on cash outlays of $148 million.

Mr Sebbes: It is probably worth explaining how the public sector comparator was built up in terms of that. The public sector comparator was taken by a group of consultants to review the existing costs at similar hospitals in Western Australia. Essentially, that was Royal Perth and Sir Charles Gairdner Hospitals. They ran through a process of identifying the costs against these services as they currently run initially and taking the best of those two; so taking a “best of” approach. Then they effectively interviewed and went through with the supervisors and the executive staff of those two hospitals and said, “What would you do different in a new hospital?”, recognising that Fiona Stanley was always going to be somewhat different to the existing hospital. “What would you do different? What services would you improve? What cost savings would you make?”—factoring

those into the public sector comparator. That formed the basis of the direct costs that are associated in here. What we got from the tender process then are the savings against that.

The CHAIRMAN: Thank you for that, but I do not understand how that creates a saving over Serco doing it as opposed to the government doing it. The government surely would achieve those same cost savings if it was done in-house.

Mr Sebbes: Potentially if we can provide the same technology in the same time frame, yes.

The CHAIRMAN: You are basically saying because Serco is offering it on a plate that is worth $148 million as opposed to having to develop it in-house.

Mr Sebbes: We have built into the public sector comparator those improvements we knew we could make. That is against an improved version of what we currently do, which is what we believe we would achieve. There are other things in here that is unlikely we would ever achieve in this time frame.

Mr Snowball: Part of that cost benefit comes with the innovation; what you are getting by way of the package that was offered. That is a pure cash saving against what we saw as, "Here is the public sector, don't leave it at the static. What could we improve?" Pick the best and what could we improve, and that became the public sector comparator for cash comparison terms.

The CHAIRMAN: I think Mr Sebbes just alluded to the fact consultants were used in helping prepare the public sector comparator. Can we know which consultancy helped establish the public sector comparator?

Mr Sebbes: Paxon Group.

The CHAIRMAN: The figures that we are using in terms of the public sector comparator and the Serco contract, is this all over the 20-year period or is some of it the 10-year period? I do not want to get mixed up, but we are not comparing apples with apples. Are all these numbers relating to the potential 20-year period of the contract?

Mr Sebbes: The benefits we are recording are over the 20-year period. You may see in the public record Serco recording a different set of numbers because they report against the initial 10-year period.

Mr J.M. FRANCIS: Kim, I think the question was asked about the impact on the contract if new technology was developed. Let us say someone invents a new machine that does something to help people much better than whatever, or a new chemical that kills germs or whatever it is, surely the increased cost in that would apply to all hospitals throughout the world as they adopt new technologies. It is almost like asking you to predict the future, to find out the cost of something that has not been invented yet.

Mr Snowball: That is why really within this contract it is my view that there is sufficient scope for us to negotiate those things. Bearing in mind this is not a clinical service area as well. Most of the advances we are seeing are in the clinical —

Mr J.M. FRANCIS: In the non-clinical services.

Mr Snowball: Exactly. What this offers is a step up in terms of the support service to allow us to do the clinical job better. While we have done it from the best view, the best experts, about what the future entails, I think what we have got here is very much a contemporary, forward thinking set of arrangements and services. That is why we were pleased not only was it in terms of price a better arrangement, but it is actually the nature of the service. This is going to be quite unique. A patient in one of our rooms in Fiona Stanley is going to enjoy access not only in terms of their own amenity and the hospitality available to them, but also their clinical service. They are going to get now, at the bedside, clinical information. As a patient, you can actually see what is going on; you can have stuff explained to you. We do not have that in any—we would love to have that. That is why this is,

as far as possible, predicting what the future holds for us. It generally takes five to 10 years for Health to actually implement a major change. The point is that that will be incurred at every hospital we have, not just where we have got a service contract with another provider.

Mr J.M. FRANCIS: If I have to go to hospital, or someone in my family has to go to hospital, I would want them to go to Fiona Stanley?

Ms Feely: We provide a first-class service across all our hospitals.

Mr A. KRSTICEVIC: In terms of the submission that you gave, you talk about a new benchmark being set by Fiona Stanley and this benchmark then, I suppose, being used potentially across the state public hospitals. Can you give me a bit of detail about how you see that happening?

Mr Snowball: One of the residual benefits of this process for the state is that we have set our public sector comparator. At this point in time that is the best we can do in terms of our support services. We have now had the private sector say, "We can deliver that better at a better price"; there is no reason for us to then look at how can we get the sorts of benefits we are getting through that private service into our other public hospitals. It does not necessarily mean you have to privately contract it, but you can take some of what has come out of this contract and look at changing, in Charlie's and Royal Perth and so on, to improve that service. That is where I say when there is a new benchmark. The new benchmark is you can deliver this service better at a better price with an external provider; what can we do internally to improve to start to meet that benchmark? That is the benefit I see; it is a residual benefit basically.

Mr A. KRSTICEVIC: Is that working internally or is that looking at potentially using some of the contractors and processes that Serco is using, and implementing them in the rest of the public health system, or is it purely rebuilding the public health system in that private —

Mr Snowball: It is basically ensuring that we have good, contemporary, high-quality service in all our hospitals regardless of whether they are provided privately or publicly. My point is this provides a new benchmark that, internally, I want all of our public hospitals to look at this and go, "Gee; what could we do differently to deliver that? That looks fantastic. How do we manage?" That is what I want to see out of this sort of process.

The CHAIRMAN: I will just come back to the public sector comparator. I understand this was based on a reference project?

Mr Snowball: On two major hospitals.

The CHAIRMAN: In terms of developing your public sector comparator, you had a reference project?

Mr Snowball: Yes.

The CHAIRMAN: With outcomes that you wanted?

Mr Snowball: Yes.

The CHAIRMAN: Is it possible for us to have a copy of that document as to what the outcomes were for the reference project?

Mr Sebbes: My understanding is that the current Treasury policy around the release of that is six months after financial close, which is what we mentioned before, the summary of the outcomes of the public sector comparator are released, but the policy for that is not to release the full public sector comparator. That information is in the detail of the public sector comparator, which is, I do not know, a 100-page document.

The CHAIRMAN: Basically, some of those documents we would have to wait until January to be able to get them?

Mr Snowball: Yes, the end of the year. What Brad is saying is that will represent the summary; it will not go into the level of detail you have just asked about individual —

The CHAIRMAN: Is there a problem in giving us that level of detail even if it is on a confidential basis?

Mr Snowball: Can I take that on notice just to talk to our Treasury colleagues about that? Obviously, it is a public sector-wide position, it is not just a health position.

The CHAIRMAN: If you would, and let us know, please; I would appreciate that.

My final question with respect to the public sector comparator is that Paxons were the consultants that helped develop that. With respect to the use of the probity auditor, do you have assurances that Paxon was not also doing work for Serco in other areas?

Mr Sebbes: With all of the people working on the Fiona Stanley project, whether this component or other components, they all have gone through and signed confidentiality and conflict-of-interest statements and we have reviewed those.

The CHAIRMAN: That does not preclude that Paxon was not also doing other work for Serco?

Mr Sebbes: We are certainly not aware of any work they were doing. We specifically asked them the question: are they doing any work for any other people, and they said no.

Ms R. SAFFIOTI: I think we are running out of time. Back to the risk issue, and maybe I did not explain it properly before. There are risks that have been identified, but my question is: in relation to risk related to contracting out, has that been identified in any of the analysis? I am talking about the fact that when you contract out, there are risks. There are risks that the dispute mechanism does not work and it has been elevated through the courts. In my view that is a risk. Has there been any attempt to try to identify that type of risk or give a value to that risk?

Mr Salvage: In terms of the risk transfer issue, the risks that were transferred under the agreement with Serco are as detailed in the submission. That did not include consideration of risks that the state would carry under that regime.

Mr Snowball: But having said that, the list of risks are pretty exhaustive.

Ms R. SAFFIOTI: I saw those, but ultimately there is always going to be the issue of government contracting to a company, and that company, in some cases, changing its governance, its company structure, not performing, and taking you to court. There are always those risks in contracting out. I am wondering whether there was any effort to value it. Also, in relation to the performance management of the contract and monitoring the contract to ensure that the KPIs have been achieved, the cost of $2.5 million per annum, is that quantified in any analysis as in comparing the PSC to the Serco contract? Is that included in any of that analysis?

Mr Sebbes: Yes.

Ms R. SAFFIOTI: It is?

[11.00 am]

Mr Sebbes: We have the public sector comparator that stays stable and then the cost of services as provided by Serco; and on top of that we have added the cost of contract management and then we have made that comparison to get the public sector analysis in terms of the benefit.

Mr Snowball: And —

Ms R. SAFFIOTI: Does the published figure—what was it for, Serco?—of the contract, $4.3 billion, include the cost of managing that contract?

Mr Snowball: No.

Mr Sebbes: No; that is the money that flows out of government by the contract.

Ms R. SAFFIOTI: Okay.

Mr Snowball: But it is included in the current comparison to the public sector comparator. There is, as you describe, if you are moving to a contractual arrangement you have got cost to manage that contract. That is included. When we did the comparison back to the public sector comparator it included the cost of Serco providing the services plus our cost for contract management. I liken the contract management as the risk mitigation. There are risks associated with the contracting out of services, as you described, and the risk mitigation is how well you manage that risk with a contractor and how tightly you performance manage the contractor. That is what we put in spades in this contract. We wanted reassurance as well that the premier hospital in this state is going to work really well. That is an important investment to us. I do not see it as a cost; it is an investment to get good return.

Ms R. SAFFIOTI: Sure. But there are always things out of your control including how Serco runs its own business and how it structures its company. It is a risk that is not quantified and that always exists when you contract out because you are not governing the company. There is always that risk which has not been quantified.

Mr Snowball: That is right.

Mr J.M. FRANCIS: But the same risk would apply if it were kept in-house. I mean, you could have problems with negotiating contracts for staff. Government can have just as many problems. We see that with police and teachers on all the other issues associated with direct government employment.

Ms R. SAFFIOTI: I am talking about the governance structure.

The CHAIRMAN: Are the KPIs tied down—the i's dotted and the t's crossed—and finalised, or is there still work to be done on KPIs?

Mr Snowball: The KPIs are settled.

Mr Sebbes: They are all completed. They were all completed prior to contract signing.

The CHAIRMAN: And when will they be made public?

Mr Snowball: May we take that on notice?

The CHAIRMAN: I request them, even if we have to have them in confidence.

Mr Snowball: Yes.

The CHAIRMAN: If we can have the KPIs and the various measures that will be used to certify that they have been met.

Mr Snowball: Yes.

The CHAIRMAN: With respect to the contract there is an inflation factor or a growth–cost factor: how is that structured in the contract?

Mr Salvage: There is a reference to movements in prices as reported through the Australian Bureau of Statistics.

The CHAIRMAN: Is that the Perth CPI or a more complex or medical-based inflation factor? What is actually used?

Mr Salvage: It is a labour force index and a general price index; it is not specific to hospital service delivery.

The CHAIRMAN: Is it possible for us to have the clause that lays it out? Is it the same throughout the contract or does how it is applied vary over time?

Mr Salvage: It will be as it is, published from time to time.

The CHAIRMAN: I am sorry. The numbers may change but is the actual mechanism a stepped mechanism that changes through the life of the contract or is it a standard formula which varies only because the inputs vary?

Mr Salvage: It is the latter. It is reflected in the contract as the formula that will be applied.

The CHAIRMAN: Is it possible for us to have a copy of that formula?

Mr Snowball: If we can take the same in terms of the KPIs and so on.

The CHAIRMAN: Serco subcontracts to Siemens for the equipment required in the hospital. In the hospitals that you currently manage, is the equipment a recurrent cost or a capital cost or is it a bit of both?

Mr Snowball: A bit of both. We have cash limits on some of that equipment and it is operationally replaced and renewed. Some health items can be in the region of millions of dollars and are treated as capital. If you like, we can provide that differential; that is, what we classed as —

The CHAIRMAN: If you would for existing publicly run hospitals.

Mr Snowball: Yes.

The CHAIRMAN: With respect to Fiona Stanley Hospital and the Serco deal through Siemens: what is the anticipated capital cost of fitting out the hospital with all this extra equipment?

Mr Snowball: Are you relating purely to the Siemens' component of the contract?

The CHAIRMAN: If you could explain to the committee. It is my limited understanding that there is a subcontract such that Siemens will be responsible for all the major equipment.

Mr Snowball: Yes; that is right. That is correct.

The CHAIRMAN: In which case there will be less purchase costs that have to be met by Serco for Siemens to deliver and maintain the equipment. I am trying to understand the cost structures that will have to be passed on to Siemens to provide that equipment.

Mr Snowball: We can provide that, but we will provide it —

The CHAIRMAN: Can you give us a ballpark figure for the upfront cost if you were to purchase that equipment? You see, at one stage the minister was saying that Royal Perth Hospital equipment will be transferred. Does that get caught up in the mix? I mean, will some equipment now be transferred from other hospitals or is it a totally new build in terms of the essential and major equipment?

Mr Snowball: This relates to the equipment that we have asked to have included in the contract— including replacement over the period of the 20 years of the contract. Wherever possible, we will transfer equipment. For example, the burns unit will, as I have said, go lock, stock and barrel to Fiona Stanley Hospital. That unit will take its equipment with it. This represents the residual equipment costs over 20 years including replacement and it is—I mean, I have a ballpark number but can I take the question on notice?

The CHAIRMAN: On its website, Siemens suggests that it is $1.3 billion. That is potentially capital costs plus running costs replacement—if that is correct. But that is the figure on the Siemens website.

Mr Snowball: If I could, I will take that on notice. I would prefer —

The CHAIRMAN: So you cannot give us an upfront cost?

Mr Snowball: I prefer not to give you a number only to find that it is not right. There are a couple of categories here. One is the cost to start up—that is the fit-out costs; and another is the cost of equipment replacement and so on. I am not sure whether the number I am looking at is a

combination of those two and that is why I would prefer a question on notice. We can find that information very quickly.

The CHAIRMAN: If you could. I mean, again, the reports coming out of the UK suggest that they are having major problems and are cutting services because they cannot meet the contract costs. The figures that I have seen from the UK and the House of Commons Treasury committee suggest a three to four per cent difference between the cost of government capital and that of private sector capital. So if Siemens, to meet its requirements, has $1 billion of capital expenditure with high borrowing costs, that would have to produce considerable efficiencies for the government to come out in front. I simply say that because I do not want to see just a number. I want to get some explanation about the cost to Siemens including how it will be structured and how the benefit will be delivered to the taxpayer.

The CHAIRMAN: Leaving KPIs, I turn to variations and terminations of contract. Can we have some explanation of these? I mean, there is an outline in this document, but how will it work if Health decides it wants a major variation? I am not talking about meeting the current KPIs: medical practice has moved, changed or suddenly has huge efficiencies forced upon it and has to cut back, resulting in you having to make changes that move you outside the contract. How do you handle those and what are the rules within the contract when you have to negotiate with Serco for a variation to contract?

Mr Sebbes: Putting aside the continuous improvements information that I spoke about before and the expectation built into the contract that this evolves, we are talking about a single event that would generate a climate for change across the system—as we spoke about before. The process is, in essence, that we then approach Serco to say that this change needs to be accommodated; this is what we require out of it; these are our anticipated KPIs around the new regime and that it give us a price for that. If, when Serco comes back saying it will meet the KPIs and give us a price, and we are not happy with that price, we can take it the way we said before: we can go back to Serco and say we are not happy with the price and ask it to go and get another subcontractor for the new service. We can put it back into the market and test it. Again, if we are not happy we can actually push that service out. We do not have to accept Serco prices is what I am trying to say. If we are unhappy with that price, for whatever reason, we have other options as to how to deal with that.

The CHAIRMAN: And those other options are?

Mr Sebbes: Well, the other options are what I just said: we can ask Serco to find a new subcontractor—find a new provider to provide that specific service.

The CHAIRMAN: But if the area is already covered by the contract with Serco you cannot bring another contractor in, I assume, to take over part of the —

Mr Sebbes: We have the ability, if they are not prepared to meet certain criteria, to benchmark that price and say that price is too high and they are not meeting the benchmarked price. We can develop some criteria that says you are not meeting our standards and requirements and therefore you have to subcontract or you will be replaced.

The CHAIRMAN: Okay. If I could come back to a question that I forgot to ask about Siemens. I understand that Siemens will be the provider of the high-tech equipment. Is that correct?

Mr Snowball: Yes.

The CHAIRMAN: So what happens if your senior medical officers want fantastic black box A, but Siemens produces fantastic black box B which does most of what you want but not all, and they want to provide their own machine, how do you sort that one out if Siemens is the provider rather than GE or some other company?

Mr Sebbes: In broad terms, the tendering process is to be run around generic specifications. There is a process whereby the senior clinicians in consultation with us and Siemens set those standards.

We monitor those standards to make sure they are about what we want. And there are always requests for additional toys in public health—that is not unique to this contract. If it is a piece of equipment that Siemens provides—it will not provide all equipment—it is required, against those standards and output performance requirements to put in place a tender before we go to the rest of the market. So Siemens puts its bid on the table and then it goes to the market on our behalf and we get tenders from the rest of the market. Siemens' price is known before the process starts so that it cannot, if you like, manipulate the process. That is the basic way that that works.

The CHAIRMAN: In terms of the anticipated cost of this equipment through the next, say, 10 years, have you arrived at a ballpark figure? Will it depend on the actual cost of equipment or is that locked? Who bears the risk of increasing costs in expensive equipment, whether it is MRIs or whatever.

Mr Sebbes: For the ongoing replacement—assuming we continue to run this for 20 years—at the end of each lifecycle is a set of, I cannot remember the terminology we use, classifications of equipment—bands of equipment—that we look at. If that technology that we are replacing is still within that band, albeit within the contemporary environment in the future—that is, we know that an MRI machine today and an MRI machine in ten years' time will be different, but if it is still the equivalent machine, it will be automatically replaced under this contract. If we want to upgrade that to something new, there is potentially a cost to us.

The CHAIRMAN: Is it your experience that the equipment you buy is often, on the shelf, the same as you have? Or is it generally expected that there will always be upgrades?

Mr Sebbes: All equipment has upgrades available. We are endeavouring to put into this to ensure that the upgrades—well, the add-ons, not upgrades—are only relevant to the services provided. Any machine can have a lot of add-ons that are irrelevant. We have actually gone through the process before we signed this contract to identify those to the extent that we could.

The CHAIRMAN: I assume that the clinicians will be knocking your or the appropriate officer's door down wanting the add-on. I want to know how the risk is borne in terms of the cost of the add-ons, which your top clinicians will want.

Mr Snowball: We will not automatically apply those through. I think that is the point Brad is making. We have a responsibility as part of this process to manage the expectations of our clinicians within the costs that we have available from government to provide a service. And all of that is part of managing the hospital; it is not just —

The CHAIRMAN: Kim, if you weaken a bit and you give in to the clinicians, who carries the cost of the add-ons? Where does the risk sit?

Mr Snowball: We do. That is why we manage it well.

Mr Sebbes: But I must add that we have already specified for our most expensive clinical equipment. We have already gone through and had an independent group give us a set of specifications that we have agreed to, which was the basis of this going forward. So that is in the contract.

Ms R. SAFFIOTI: I have one last question about the risks retained by Health in relation to the contract and the demand for clinical services. I think it has been noted that if the demand for clinical services is higher than anticipated, Health will carry the risk. How will that be determined? Is the contract based on services per visit to the hospital? How will clinical demand be determined in that sense?

[11:15 am]

Mr Sebbes: Most of the services in this contract have been fixed price and not volume-based. In some of those there are limits. If the fixed volume doubles, then we get to review it, so it is not absolutely fixed price; there is opportunity down the track. Essentially most of them are fixed price,

so the volume does not change the price of the service. There are some, however, that are variable, completely volume based. There are some that are a bit of both. For example, the linen service within the hospital is fixed price, but the volume of linen which is done through a contractor is a variable, as it is in our existing hospitals.

Mr Snowball: The way we manage our activity demand across Health is we have what is called the "clinical services framework" which projects basically 10 to 15 years out what the activity levels are going to be, given our population, its demographics and so on. A lot of the science sits behind that prediction. This design around Fiona Stanley is based on that, so the number of beds is based on our knowledge about what the activity is likely to be at that time. The risk we are carrying is, if we have got that badly wrong, and for Fiona Stanley Hospital it is if one element of the services is twice the demand, it is our responsibility to basically manage that risk, which goes from: do we redirect those services to those other facilities to even it out, or do we buy additional services both from Serco and obviously in terms of the clinical services, more clinicians and so on into the service? Our hospitals are now funded on activity. That includes the total cost of providing a service. It is bundled and weighted for the complexity of the activity and so on, but every one of those services we know the cost that sits behind it.

Ms R. SAFFIOTI: In relation to the Serco contract, those are not being determined by volume. Is there a price determined at the start of the contract? For example, if there was a 100 per cent increase in volume through EDs or something impacting the facilities, how is that price determined? Is it determined currently? Is there like cost per presentation? How would you determine that?

Mr Sebbes: I can give simple example of external telephone calls. There is a fixed price for answering the telephone, personalised answering service, 95 per cent within 15 seconds of the call coming in and 100 per cent within 30 seconds. That is the performance criteria. That is fixed up to a certain volume, when that volume, from memory, is about 30 000 calls a month—this is external calls only, which is a reasonably high number. If that was to go above 30 000, then we have the choice of paying more money or reducing our standard. So we could say, "Okay, we do not want 95 per cent within 15 seconds. We want 90 per cent within 15 seconds or something like that", so the choice is there for us. But there is a ceiling on it. Most of these things have a band. The risk goes the other way too. If something drops off, we want to be able to get the money back.

Ms R. SAFFIOTI: Is there a service provision of that, too?

Mr Snowball: There is provision to that.

Ms R. SAFFIOTI: Are those prices, are they determined now or are they determined at the time?

Mr Snowball: Yes, they are already determined.

The CHAIRMAN: In terms of your answer then, that detailed modelling, can you give us actually the Western Australian population projections, which obviously would be part of the underpinning of that in terms of the next 10 years or whatever the projections were done for?

Mr Snowball: Yes, we can do that.

The CHAIRMAN: In terms of the public sector comparator and the successful bidder, was the numbers exactly the same in terms of what was the expected demand, or were there issues potentially that the successful bidder put in demand management issues or something so that they could actually deal with demand in a different way?

Mr Joseph: They were based on the same clinical service parameters.

The CHAIRMAN: Thank you very much. We do have some brief formalities to close this hearing. Again I thank you for your evidence before the committee today. The transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections made in the transcript must be returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned in this period, it will be deemed to be correct. New material cannot be added via

these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. We also thank you for the supplementary information which you either promised or are willing to have a look at to see if you can provide it to us. Thank you very much for your evidence and your help here today.

Hearing concluded 11.19 am