

The New Royal Children's Hospital — a public private partnership



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Auditor-General

The New Royal Children's Hospital — a public private partnership

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The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *The New Royal Children's Hospital—a public private partnership*.

Yours faithfully



D D R PEARSON
Auditor-General

6 May 2009

Foreword

A new Royal Children's Hospital (RCH) is under construction on a site immediately to the west of the current RCH site in Parkville and is due for completion in late 2011. The new hospital is being built by a private sector consortium and will be maintained by them for 25 years, under the *Partnerships Victoria* framework.

The planning and business case for the new facility was sound, with the procurement exercise fair to all proponents and compliant with relevant requirements. The government was provided with robust analyses of the options to replace the existing hospital, and procurement strategies available to achieve that outcome.

The new hospital will have 50 more beds than the existing hospital and the Department of Human Services (DHS) has demonstrated that this, together with the flexibility in the design of the new hospital, should be able to handle currently projected increases in service demand. A residual risk, however, is that although a network response to paediatric services has been identified since 2002 as a key strategy to meet observed increases in service demand, DHS has not yet addressed the detail of implementing such a strategy.

The recent downturn in global financial markets has not adversely affected the project's financing arrangements, but it has created uncertainty about the receipt of promised donations to the RCH Foundation of \$35 million by one of the original private sector parties.

I encourage DHS to complete the development of its contract management systems and processes for the new hospital. This will further assure effective management of project risks on behalf of the state as well as delivery of the expected levels of service by the private sector.

The results of this audit were consistent with our recent audits of the planning and construction phases of public private partnership (PPP) projects and point to a mature PPP model in Victoria. The ongoing challenge is to deliver the anticipated value for money and other public benefits over the life of a lengthy contract.



D D R PEARSON
Auditor-General

6 May 2009

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1 Audit summary

1.1 Introduction

1.1.1 Background

In November 2007 the Government announced that it had selected a private partner to construct a new Royal Children's Hospital (RCH), on a site immediately to the west of the current RCH site on Flemington Road in Parkville. The existing research precinct building and the front entry building will be retained and incorporated into the new complex.

The new hospital is scheduled to open in December 2011, and following RCH's relocation, much of the old site will be demolished and reinstated as parkland, replacing park land taken up for the project. The Department of Human Services (DHS) has the lead role in supervising delivery of the project.

This project is the largest hospital redevelopment undertaken by the state. The project outcomes are expected to have a major impact on the quality of tertiary health services for children in metropolitan Melbourne and other regions of Victoria.

The hospital redevelopment is being delivered as a public private partnership (PPP) in accordance with the state's *Partnerships Victoria* framework. This application of the *Partnerships Victoria* procurement model involves a private sector consortium taking responsibility for designing, building, financing, and maintaining the facility. The public sector keeps full responsibility for the clinical services delivered within the hospital.

Over the 25-year operating phase of the contract—which commences after completion of construction and successful hospital commissioning—the state will make total service payments of \$3.742 billion in nominal terms to the private sector project company. According to the 2007–08 RCH Annual Report, this was equivalent to \$1.016 billion in net present value terms, as at 30 June 2008.

In addition to the service payments over the operating phase of the hospital, the government approved:

- \$27.3 million for project management costs during the planning, procurement and construction phases of the project
- \$4.6 million for park reinstatement at the end of construction.

The government committed funding for the project on the understanding that RCH will contribute \$90 million to reduce the net cost to government of the project. RCH is expected to source this funding from fundraising, borrowings and asset sales.

The objective of this audit was to assess the adequacy of the state's planning, procurement and management of the RCH PPP redevelopment.

This involved examination of:

- project planning and development documents, including the service plan and business case
- the procurement process
- contractual arrangements for the project, and documentation and data relating to the management and governance of the project.

1.2 Overall conclusion

Clear and sound advice was provided to government during the decision-making process to commit to and invest in the project. The business case was comprehensive and incorporated the key information and analysis required by *Partnerships Victoria* and other guidelines. It included transparent analysis of options, including procurement options, as well as risk and project management issues.

Service planning for the new RCH used relevant data available at the time, including the results of a model used by DHS to develop service demand projections. However, we were unable to conclude on how well that data was applied due to:

- DHS being unable to demonstrate a comprehensive understanding of the development, operation and internal logic of the forecasting model
- an absence of evidence to confirm how advice from clinicians was taken into account to enable appropriate adjustments to be made to forecasts of admitted patient activity.

The lack of a defined 'network response' for paediatric care in Victoria, and a lack of clarity about RCH's role in that network—together with delays in developing models of care for the new RCH—added to the complexity of the service planning process for the new hospital. However, this did not invalidate the planning outputs.

A competitive tender process was conducted to select the preferred consortium to deliver the new RCH project. The evaluation process at both the expressions of interest and project brief stage was well documented. The decisions were justifiable on the basis of the requirements and the selection criteria in the project brief making the process fair to all bidding parties. Relevant government requirements and guidelines were observed during the procurement process.

The state's involvement in the design and construction phase of the project is being well managed. The governance arrangements for the project provide an effective framework for communication with the relevant parties as well as assessment, monitoring and actioning of emerging issues and risks.

The project agreement includes a comprehensive performance monitoring and reporting regime for the operating phase of the new hospital. However, DHS needs to take steps to progress development of the project contract administration manual and further enhance project management documentation in place for the state's project team. Timely action on these matters will provide further assurance that the state's risks around this project are being managed effectively.

The recent downturn in global financial markets has not had any direct adverse impact on the project financing arrangements. All project finance remains in place and the state is adequately monitoring this issue.

1.3 Findings

1.3.1 Adequacy of investment planning

The investment planning for the new hospital was thorough and sound.

There was detailed analysis of redevelopment options and the government was given appropriate information and analysis at major decision points in the investment planning process.

A 'network response' to paediatric services in Victoria has been identified since 2002 as a key strategy to meet observed increases in service demand but the detail of the implementation process is still under consideration by DHS.

Delays in sufficiently developing models of care for the new RCH—and the absence of a defined network approach to paediatric care in Victoria—at the time of service planning added to the complexity of the planning process for the new hospital. However this lack of a strategic framework did not invalidate the planning outputs.

Clarity around models of care and the RCH role in the wider health network are significant for service planning as they:

- assist in defining the service delivery approach
- inform the forecasting for service demand
- ultimately define the design parameters and facility requirements for a new hospital.

Models of care were sufficiently developed by the project brief stage and continue to evolve.

Service demand for the new RCH was projected using a forecasting model. There was limited evidence to show clinician involvement in adjustments made to overcome a number of known limitations of the model.

The forecasts of future service demand in the RCH service planning process were based on a declining birth rate forecast made by the Australian Bureau of Statistics (ABS). This was the most appropriate and up-to-date data source available at the time. However, more recent ABS data indicates that the actual birth rate increased in Victoria over the period 2001 to 2005.

The new RCH has 50 more beds than the existing RCH and DHS has demonstrated that this greater capacity—together with the inherent flexibility and potential capacity for growth in the design of the new RCH—should handle currently projected increases in service demand.

However, DHS has not yet determined, or advised government, when this additional future capacity may need to be taken up.

1.3.2 Assessing value offered by the private sector bids

A competitive tender process was used to select the preferred consortium to deliver the project. An appropriate evaluation framework, incorporating a value for money approach, was in place to evaluate the bids.

Effective tools were employed to assess value for money during the procurement process, including the Public Sector Comparator (PSC), which is a theoretical estimate of the cost of the most efficient public sector procurement model. The net present cost of the bids was compared to the PSC cost in order to determine whether the project could deliver better value for money if conducted under a *Partnerships Victoria* structure.

Other qualitative value for money tests were also applied during the procurement evaluation, including a public interest test.

The planned timelines for the procurement process were met, which was a significant achievement, given the scale and complexity of the project and procurement task.

The procurement approach complied with the expected elements of Victorian Government Purchasing Board policy and guidance and the *Partnerships Victoria* guidelines, and was adequately documented. In particular, the following were observed:

- a PSC was constructed and updated throughout the evaluation process
- an output specification was produced in the form of the project brief
- appropriate sign-offs were sought and the required approvals were obtained
- the evaluation of the bids was undertaken against previously determined criteria stipulated in the evaluation plan.

The risk allocation in the project agreement is also broadly in line with *Partnerships Victoria* guidelines with no significant departures.

1.3.3 Supervision of delivery of infrastructure and services

The state is adequately managing its involvement in the design and construction phase of the project. However, development of the contract administration manual needs to be progressed and project management documentation needs enhancement to provide greater assurance about effective management of the state's project risks.

Appropriate governance structures have been established for the project. The state's actual project costs are also expected to be within approved budget limits.

The construction schedule is on target and the independent reviewer appointed for the project has recently reported that the project remains on track for the 21 September 2011 technical completion milestone.

The impact of the downturn in global financial markets on the project is being actively monitored. All debt and equity funding for the project—approximately \$1.38 billion—was contributed in December 2007 and remains in place, in authorised investments.

However, due to the impact of the recent global financial market downturn, a promised donation to RCH of \$35 million from the original private equity sponsor is now much less certain.

The project agreement adequately defines the services to be delivered by the project company during the operating phase of the new hospital and includes a comprehensive performance monitoring and reporting regime.

1.4 Recommendations

It is recommended that:

- DHS should develop and define models of care beyond high level statements at the service planning and business case stages for any future major hospital investments. This will help to make sure that investment decision-making processes are better informed by the service delivery strategy expected to be adopted. **(Recommendation 4.1)**
- DHS develop a comprehensive understanding of its service demand forecasting model—which is a statewide and not hospital specific forecasting tool. This will help DHS to better understand the model's limitations and impacts when forecasting demand for future service delivery. **(Recommendation 4.2)**
- DHS expedite the development of a strategic 'network response' framework for the future development of paediatric health services in Victoria. **(Recommendation 4.3)**
- RCH consider the implications of a strategic 'network response' framework for the future development of paediatric health services in Victoria when finalising its current service plan review. **(Recommendation 4.4)**
- DTF amend its guidance to require that agencies implementing *Partnerships Victoria* projects:
 - conduct and document quality assurance reviews of PSC estimates and related financial models—irrespective of whether they are internally or externally prepared—to reduce risks of error or inaccuracy, and to ensure that the state has sufficient understanding of these highly complex financial models
 - maintain adequate documented evidence to support all costings and PSC calculations contained in a business case. **(Recommendation 4.5)**

- DHS and RCH should promptly execute a memorandum of understanding setting out their respective responsibilities in relation to the project. **(Recommendation 6.1)**
 - DHS should complete and endorse the RCH contract administration manual and address observed gaps and weaknesses in project management documentation as a priority. **(Recommendation 6.2)**
-

2 Audit Act 1994 section 16 – submissions and comments

2.1 Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Human Services, the Department of Treasury and Finance and the Royal Children's Hospital with a request for comments or submissions.

The comments and submissions provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

2.2 Submissions and comments received

RESPONSE provided by Secretary, Department of Human Services

The Department of Human Services (DHS) considers the VAGO audit report entitled 'The new Royal Children's Hospital—a public private partnership' provides a fair representation of the development, procurement and delivery of the new Royal Children's Hospital Project.

DHS makes the following comments in relation to the recommendations in the report:

Recommendation 4.1:

DHS accepts this recommendation but notes that whilst consideration of models of care is important in service planning and they have an impact on development of hospital infrastructure, they need to be flexible to change over time in response to changes in clinical practice and workforce. One of the strengths of the new RCH design is its embedded ability to maintain flexibility so that the service can respond to clinical and organisational changes over time. The long planning time lines for major hospital investments (RCH was approximately 5 years) means that models of care developed at the beginning of the process are likely to evolve during that timeframe. As noted by VAGO in section 3 of the audit report, flexibility was identified as a key requirement in the RCH functional brief.

***RESPONSE provided by Secretary, Department of Human Services –
continued***

Recommendation 4.2:

DHS notes this recommendation but believes that it currently has, and had at the time the RCH service plan was being developed, an adequate understanding of its forecasting model. The forecasting model is just one tool that is used in estimating the future requirements for services. There are other factors that are taken into account in determining the numbers for a service plan, including an understanding of current and potential future roles of relevant providers across the statewide service system and other factors affecting future changes in need and in services to be provided.

Recommendation 4.3:

DHS accepts this recommendation. DHS has now developed a ‘network response’ framework in the form of the Strategic Framework for Paediatric Health Services in Victoria, which was published in January 2009 and provided to every Victorian health service and a number of consumer interest groups. Public consultations on the Framework have now taken place at two public stakeholder forums held on 6 and 20 February 2009. The Paediatric Clinical Network will commence during 2009.

Recommendation 4.4:

Agreed

Recommendation 6.1:

Agreed

Recommendation 6.2:

DHS notes that VAGO has concluded that the state has appropriate governance structures in place and is adequately managing its involvement in the design and construction phase of the Project. DHS acknowledges the need to address elements of its contract administration manual and will take the necessary steps to complete the manual expeditiously.

RESPONSE provided by the Secretary, Department of Treasury and Finance

DTF notes the positive findings in the report on the new Royal Children’s Hospital that the planning and business case for the new facility were sound, that the procurement process was fair and compliant with relevant requirements, and that government was provided with robust analyses of the project options and procurement strategies available.

DTF also notes Recommendations 4.5 and 4.6, which recommend that DTF amend its guidance to require agencies implementing Partnerships Victoria projects to:

- *conduct and document quality assurance reviews of PSC estimates and related financial models – irrespective of whether they are internally or externally prepared – to reduce risks of error or inaccuracy, and to ensure that the state has sufficient understanding of these highly complex financial models; and*
- *maintain adequate documented evidence to support all costings and PSC calculations contained in a business case.*

Following the introduction of the National PPP Policy and PPP Guidelines in late 2008, the Partnerships Victoria Framework now requires compliance with the new National PPP Policy and PPP Guidelines and the Victorian specific requirements outlined in the Partnerships Victoria Requirements document and annexures. DTF will review the guidance and determine the appropriate means of reflecting Recommendations 4.5 and 4.6 within this Framework.

3 About the new hospital

3.1 A new hospital for Victoria's children

3.1.1 Background

The new Royal Children's Hospital (RCH) project is the largest hospital redevelopment undertaken by the state. The project outcomes are expected to improve the quality of tertiary health services for children in both metropolitan Melbourne and other regions of Victoria.

Designed in the fifties and opened on its current site in 1963, the RCH is a key community asset. The RCH is the only hospital in Victoria solely devoted to the care of sick children and:

- provides specialist paediatric services to the whole state including tertiary, secondary and primary infant, child and adolescent health services
- is the designated statewide provider of paediatric major trauma services, paediatric intensive care and high complexity paediatric services
- treats children from interstate and overseas who require the hospital's unique and specialised care
- plays a major role in research and education, through its strong partnerships with the Murdoch Children's Research Institute and the University of Melbourne's Department of Paediatrics.

The new RCH project commenced with the development of the RCH service plan in 2004. This plan detailed the future service philosophy and needs, and also proposed new models of care for the hospital. A review of the service plan was undertaken in 2005 to incorporate further changes relating to future service profiles, trends and changing patterns of demand, as well as new service development needs and models of care.

Together, the RCH Service Plan (2004) and the RCH Service Plan Review (2005) were the planning foundations for the new RCH.

In May 2005, the Government committed \$37.9 million in the 2005–06 budget to fast track master-planning and upgrade existing facilities prior to the redevelopment of the RCH. The new RCH was to include 340 beds, modern wards and specialist medical equipment. The planning process was to determine the future of the existing RCH buildings.

The master plan was completed in September 2005 and a final business case was submitted to government in November 2005.

In November 2007 the government announced that:

- the Children's Health Partnership (CHP) would design, build, finance and maintain the hospital for 25 years, and provide a range of extra facilities to benefit patients, their families and hospital staff
- the new hospital would be built immediately to the west of the existing RCH site on Flemington Road in Parkville, with the existing research precinct building and the front entry building to be retained and incorporated into the new RCH complex
- the new hospital was scheduled to open in December 2011
- following the relocation, much of the old site would be demolished and reinstated as parkland, replacing land taken up for the new RCH project.

The Department of Human Services (DHS) has the lead role in overseeing delivery of the new RCH project on behalf of the state.

The project is subject to review under the government's Gateway Review Process. To date the project has been subject to a strategic assessment (Gate 1) in early 2005 and the business case was reviewed (Gate 2) in October 2005.

3.1.2 Project objectives

Inadequacies of the current facilities were highlighted during the preparation of the RCH Service Plan (2004) and subsequent review in 2005. The RCH business case described these inadequacies as follows:

The current RCH buildings were designed when most hospital care was provided at the bedside and parents could only visit during designated visiting hours. The buildings are now unsuitable for the complex high technology multidisciplinary care now provided for children. The facilities do not support families in the manner expected of a world-class children's institution and have failed to keep pace with the rapid expansion of same day and ambulatory services.

(RCH Business Case, November 2005, p.(i).)

Figure 3A (overleaf) sets out the overall project objectives for the new RCH project that were initially stated in the RCH Business Case (2005) and have been refined over time.

Figure 3A
Overall project objectives

The new RCH is to be delivered as a modern facility and physical environment which:

Service delivery and care

- supports family centred care which is culturally and spiritually sensitive, and respects the dignity and needs of children of all ages
- utilises its design and location in the park to provide a healing environment for patients, families and staff, and community users of the park
- is operationally efficient, optimising the use of people and resources, capable of achieving service plan targets and sustaining service levels into the future
- harnesses evidence based design to create an environment that enhances patient safety and clinical excellence

People

- supports attracting and retaining high quality, committed and inspired staff

Future proof and flexible

- has flexible infrastructure capable of adapting to new technologies (clinical and information) and emerging trends in paediatric healthcare, changes in clinical practice and models of care and changes in government policy, legislation and standards

Teaching and research

- engenders an active learning environment and provides appropriate facilities for teaching and research within clinical areas and between the RCH and its key education and research partners (Murdoch Children's Research Institute and the University of Melbourne's Department of Paediatrics)

Business continuity

- achieves a successful relocation with no interruption in the ongoing delivery of services and minimised impact on the surrounding community and parkland during construction

Stakeholder relationships

- is achieved through a constructive relationship with users, staff, local community and communities of interest in Royal Park

Government commitment, policy and objectives

- is procured, completed and maintained in a manner which delivers value for money to the state and within the budget and other parameters agreed by Government.

Source: Victorian Auditor-General's Office, using data provided by DHS.

3.1.3 Project scope

The project will provide facilities for the provision of services in accordance with the RCH service plan and business case. In addition, it will provide facilities for the Murdoch Children's Research Institute and the University of Melbourne's Department of Paediatrics.

The RCH Business Case (2005) describes the size and scope of the project as:

- encompassing approximately 96 000 square metres in gross floor area, an increase of 9.4 per cent over the existing area of 87 200 square metres
- providing an increase of 25 per cent in gross departmental area for clinical and clinical support
- transferring services currently provided offsite into the new facility, such as parent accommodation, mental health inpatient beds, ambulatory mental health services, the Neonatal Emergency Transport Service and the Centre for Adolescent Health
- including over 20 000 square metres in space for the Murdoch Children's Research Institute and the University of Melbourne's Department of Paediatrics.

3.1.4 Using the private sector to deliver the new hospital

The new hospital is being delivered as a Public Private Partnership (PPP) in accordance with the Government of Victoria's *Partnerships Victoria* policy, which was first released in June 2000.

The *Partnerships Victoria* procurement model used for the RCH involves a partnership between a private sector consortium responsible for designing, building, financing, and maintaining a facility; with the public sector maintaining responsibility for provision of the clinical services within the new hospital. This accords with government policy that core public services should be provided directly by the public sector.

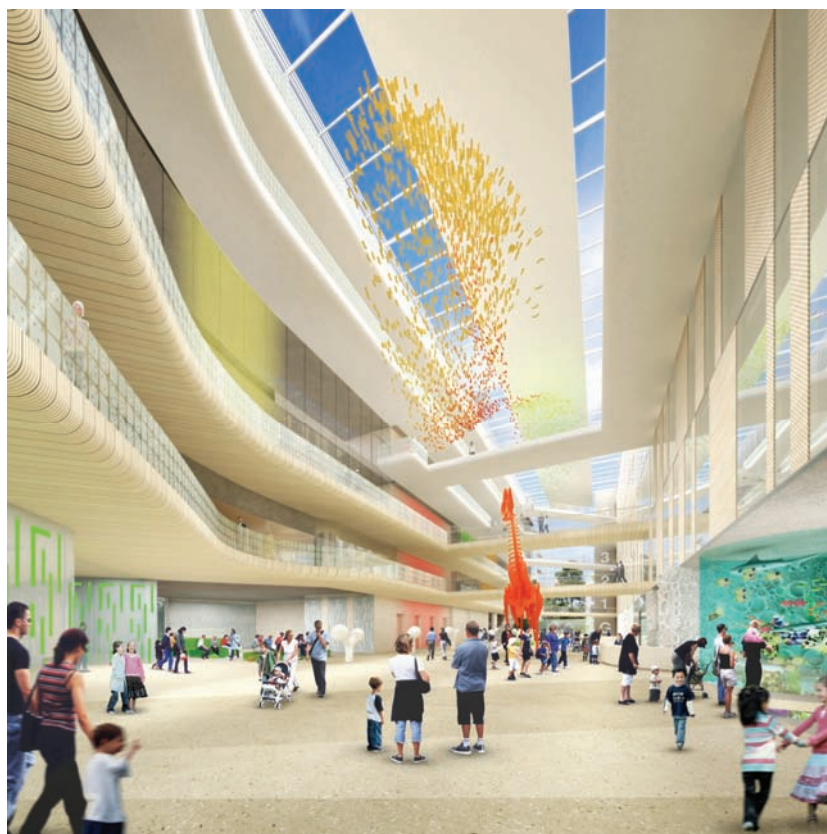
Contract for the delivery of infrastructure and services

A project agreement was executed on 20 November 2007 between the Minister for Health on behalf of the State of Victoria and Children's Health Partnership (project company) which required the project company to:

- finance, design and construct the new facility in two stages as follows:
 - stage one—construct all elements of the hospital and fully transition the hospital functions to the new facility by December 2011
 - stage two—demolish existing buildings that are not to be retained, and undertake further work on Murdoch Children's Research Institute space, commercial precinct construction and reinstatement of the existing site for handback to the state by 2014
- provide ongoing delivery of general services, help desk, building management, utilities and medical gas management, waste, security, car parking, grounds and gardens maintenance, and pest control—for a period of 25 years, from the expected completion of the facility in December 2011 to December 2036.

The project company has in turn entered into a range of contractual relationships with the following consortium partners to deliver elements of the project:

- **equity provider**—Babcock & Brown International Pty Ltd was the original project sponsor and underwrote the equity requirement for CHP, before a change in control was approved by the Minister for Health in 2008 to sell this stake to a satellite fund called Babcock & Brown Public Partnerships, which is listed on the London Stock Exchange.
- **financiers**—CHP has arranged for the involvement of a number of financiers to raise funds to pay for the construction of the hospital and other associated costs. A majority of the funding for the project has been raised from the issue of bonds into the capital market. The raised proceeds have been placed in a deposit account managed by the security trustee (Bank of New York Mellon) until funds are required for the project.
- **architects**—Billard Leece, Bates Smart and HKS (US)
- **builder**—Bovis Lend Lease Pty Ltd has been engaged to design and construct and commission the new facility and to demolish and remediate that part of the existing site that will be reinstated as park land in Royal Park
- **facilities management contractor**—Spotless P&F Pty Ltd has been engaged to provide a range of facility management related services over the operating phase of the project.



*An artist's impression of the main internal walkway of the new hospital.
(Image courtesy of Billard Leece Bates Smart and Sharp Design)*

3.1.5 Cost of the redevelopment

In November 2005, the government agreed that the new RCH project should proceed on the basis outlined in the final business case and approved the project to be delivered under a *Partnerships Victoria* model, subject to private sector bids satisfying value for money criteria.

The government committed funding for the project on the basis that \$90 million was to be provided by RCH to reduce the net cost to government of the project, broken down as follows:

- \$50 million from the RCH, on the basis of a qualified commitment given by the RCH Board to raise the funds, with any shortfall to be possibly underwritten by other fundraising by the Royal Children's Hospital Foundation (RCHF)
- \$30 million from RCH financed by a loan from Treasury Corporation Victoria (secured against future RCH car park revenues), as agreed by the RCH Board
- \$10 million from RCH asset sales, after the commissioning of the new hospital, as agreed by the RCH Board.

When approving the final business case for the project, the advice put to government said that \$30 million of this contribution from RCH was expected in 2009–10 with the remaining \$60 million expected in 2010–11.

In November 2007, other government advice said that the cost of delivering the \$1 billion RCH project through the private sector was cheaper than if it was to be done by the Victorian Government alone.

The Public Sector Comparator (PSC) for the project estimated the net present cost of the project to be \$1.016 billion. The net present cost of the Children's Health Partnership consortium's winning bid was \$946 million at financial close in December 2007 representing a saving of around 6.9 per cent when compared against the PSC.

The state will make quarterly services payments (QSP) over the 25 year operating phase of the contract. This will commence after the construction of the facility is completed, as expected, in December 2011. The QSP are expected to cover the capital cost of construction and services to be delivered by the private sector over the term of the agreement.

The state's financial commitment over the 25 year period is \$3.742 billion in nominal dollar terms or \$1.016 billion in net present value terms, as at 30 June 2008.

The 2007–08 RCH Annual Report states that the financial arrangement will be reviewed prior to the completion of the project to determine whether the lease will be recognised as a finance lease or operating lease by the RCH.

In terms of the expected contribution of \$90 million to government from RCH towards the cost of the project, DHS and the Department of Treasury and Finance agreed in April 2008 that a commitment in CHP's winning bid to secure donations of \$35 million to RCH could be used by RCH to partly satisfy its funding obligation.

Issues have subsequently emerged around the timing and certainty of receipt of the \$35 million due to the downturn in global financial markets and the enforceability of the commitment. This matter is dealt with in Part 5 of this report.

Project management and transaction costs

Approved funding for the project, excluding future quarterly service payments, includes \$27.3 million for project management and transaction costs and \$4.6 million for park reinstatement costs.

As at January 2009, a total of around \$14.6 million had been spent by DHS and RCH.



An aerial view of the RCH site, showing the new hospital under construction (left), and the existing hospital campus (right), which will be largely demolished and converted to parkland.

3.1.6 Governance arrangements

In November 2005, government approved the project’s business case and delegated to the Treasurer and the Minister for Health responsibility for conducting the *Partnerships Victoria* procurement process. This included approval of the expression of interest, the project brief, the final public sector comparator, the preferred tenderer and the project agreement.

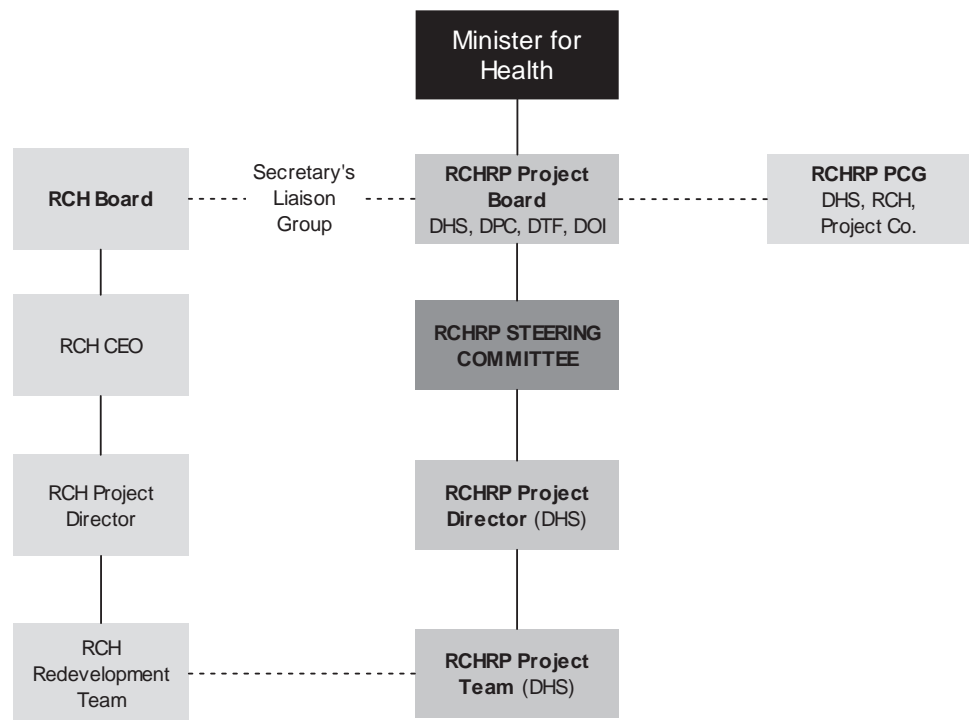
DHS has the lead role in supervising delivery of the new RCH project.

The project’s governance structure is comprised of:

- **a project board (procurement phase)**—the peak project governance body responsible for the oversight of the project and accountable to the Minister for Health
- **a steering committee (planning, procurement and construction phases)**—responsible for the effective management of the project and achievement of planned outcomes
- **a project control group (construction phase)**—the peak project interface between the state and the project company to discuss the overall progress of the project.

Within DHS, a dedicated project team has also been established. The project team is led by a project director who is responsible for management of the project on a day to day basis. Specialist project support is also provided to the DHS team by the RCH.

Figure 3B
The RCH project’s governance structure



Source: Victorian Auditor-General's Office using data provided by DHS.

3.2 Objective and scope of this audit

The objective for this audit was to assess the adequacy of the state's planning, procurement and management of the RCH redevelopment.

This audit objective was addressed by assessing whether:

- planning for the redevelopment project was adequate and included soundly based advice and recommendations to government on project financing and procurement options and methods
- procurement for the redevelopment project was conducted in accordance with relevant policies, guidance and good practice
- the state is appropriately managing its involvement in the construction phase of the project.

The audit examined project planning and development documents, including the investment evaluation, business cases and public sector comparators, the procurement process, contractual arrangements for the project, and documentation and data relating to the management and governance of the project.

The following agencies were included in this audit:

- Department of Human Services
- Department of Treasury and Finance
- the Royal Children's Hospital.

Advice provided to the government on the project was also examined as part of this audit.

The audit was performed in accordance with the applicable Australian auditing standards for performance audits.

The total cost of this audit, including staff time, overheads and the preparation and printing of this report, was \$440 000.

4 Planning for the investment

At a glance

Background

Formal planning for a replacement facility for the Royal Children's Hospital (RCH) commenced in 2003.

Defining service needs and the robust analysis of options are critical factors in investment planning. This process also helps government to determine capital funding priorities for the delivery of services.

Key findings

- The service planning framework for the new RCH was comprehensive.
- The government was given appropriate information and analysis at major decision points in the investment planning process.
- The lack of a defined 'network response' for paediatric care in Victoria, and a lack of clarity about RCH's role in that network—together with delays in developing models of care for the new RCH—added to the complexity of the service planning process for the new hospital. However, this did not invalidate the planning outputs.
- Models of care were sufficiently developed by the project brief stage and continue to evolve.
- There is limited understanding within DHS of the development, operation or internal logic of the forecasting model used in the service planning process.
- There is limited evidence that clinicians were involved in adjustments to future service demand projections to address known limitations in the forecasting model from which these projections were derived.
- The data used in the service planning studies were based on a declining birth rate forecast made by Australian Bureau of Statistics (ABS), which was the most appropriate and up-to-date data source available at the time. However, the assumptions underlying population growth forecasts have changed, and are likely to change over time. More recent ABS data indicates that the actual birth rate has increased, not decreased, in Victoria over the period 2001 to 2005.
- The new RCH will have 50 more beds than the existing RCH and DHS has demonstrated that this extra capacity—together with the inherent flexibility of the design of the new RCH—should be able to handle currently projected increases in service demand.

At a glance – continued

Key findings – continued

- A 'network response' to paediatric services in Victoria has been identified as a key strategy to meet observed increases in service demand since 2002 but the detail of its implementation is still under consideration by DHS.

Key recommendations

It is recommended that:

- DHS should develop and define models of care—beyond high level statements—at the service planning and business case stages for any future major hospital investments. This will make sure that investment decision-making processes are better informed by the service delivery strategy expected to be adopted. **(Recommendation 4.1)**
- DHS develop a more comprehensive understanding of its current service forecasting model—which is a statewide and not hospital specific forecasting tool. This will help DHS to better understand the model's limitations and impacts when forecasting demand for future service delivery. **(Recommendation 4.2)**
- DHS expedite the development of a strategic 'network response' framework for the future development of paediatric health services in Victoria. **(Recommendation 4.3)**
- RCH consider the implications of a strategic 'network response' framework for the future development of paediatric health services in Victoria when finalising its current service plan review. **(Recommendation 4.4)**
- DTF amend its guidance to require that agencies implementing *Partnerships Victoria* projects:
 - conduct and document quality assurance reviews of PSC estimates and related financial models—irrespective of whether they are internally or externally prepared—to reduce risks of error or inaccuracy, and to ensure that the state has sufficient understanding of these highly complex financial models.
 - maintain adequate documented evidence to support all costings and PSC calculations contained in a business case. **(Recommendation 4.5)**

4.1 Background

Formal planning for a replacement facility for the Royal Children's Hospital (RCH) started in 2003 when work commenced on development of the RCH service plan.

In May 2005 the Victorian Government committed \$37.9 million in the 2005–06 budget to fast track master planning and upgrade existing facilities prior to the redevelopment of the RCH. The new RCH was expected to include 340 beds, modern wards and specialist medical equipment. The planning process was also to determine the future of the existing RCH buildings.

Figure 4A provides a chronology of events in the planning of the investment in the new RCH project.

Figure 4A
Chronology of events in planning for the RCH redevelopment project

Date	Planning event
May 2004	Completion of RCH service plan
July 2004	Approval by DHS of RCH service plan
October 2004	Initial review of RCH service plan
	Completion of strategic business case (including high level options analysis)
May 2005	Premier announces funding to fast track master plan and upgrade of existing RCH facilities
August 2005	Master plan for redevelopment of the RCH completed
November 2005	Government approval of RCH business case
	Premier and Minister for Health announce go-ahead of the RCH redevelopment
December 2005	Completion of RCH service plan review
October 2006	Government approval to release project brief

Source: Victorian Auditor-General's Office, using data provided by DHS.

The RCH service plan detailed future service philosophy and needs, as well as high level proposed models of care for the new hospital. A review of the service plan was undertaken during 2004 and 2005 to incorporate changes relating to future service profiles and trends, changing patterns of demand, new service development needs, and new models of care.

The service plan and service plan review became the key drivers for the new RCH project with a view to building a facility that:

- provides the full range of services using 'state of the art' equipment and technology
- co-locates similar or supporting services together to achieve optimal functional relationships and efficiencies through sharing of facilities and a focus on effective work flows and practices

- streamlines care delivery via models of care focussed on patient needs and the co-ordination of specialist multi-skilled staff
- enhances the co-ordination of care process using information and communications technology (ICT) to collect and share appropriate information between people involved in care of a patient
- provides ease of access for patients and carers through adequate car parking and public transport, and supports parents/carers as partners-in-care.

Criteria

Criteria to evaluate the adequacy of investment planning for the new RCH project were based on:

- the *Partnerships Victoria* policy and guidance suite (including the Investment Evaluation Policy and Guidelines)
- the Gateway Review Process and better practice lifecycle guidelines, with particular focus on the project appraisal and business case development guidance.

For this part of the audit the following questions were considered:

- Was the investment planning sound and did it include appropriate evidence of a defined service need?
- Did the investment planning conform to relevant policy and guidelines?

4.2 Service planning for the new RCH

The business case for the new RCH project was underpinned by the government and department policy context, the RCH service plan, and a philosophy of care. This helped define service needs and sought to project future demand for services as well as define the services to be provided in the new hospital.

4.2.1 Government and department policy context

The RCH redevelopment was intended to support key government policy and planning statements, directions and objectives.

Underlying principles and specific relevant content in the following government and DHS policies, reviews and strategies were appropriately referred to during the development of various planning documents for the RCH redevelopment:

- *Growing Victoria Together (GVT)*, originally released in 2001 and refreshed in March 2005—which sets out how the government intends to address important issues. The GVT priority actions relevant to planning for the RCH redevelopment were:
 - build, improve and integrate hospitals and community health services
 - link and invest in services for mothers and children through pregnancy to age eight
 - reduce drug abuse and harm
 - tackle health issues linked to inequality including mental and dental health

- *Review of Paediatric Services (2002)*—this review was commissioned by DHS to inform development of the *Metropolitan Health Strategy* and the *Victorian Rural Human Services Strategy*. The review found a fragmented system of care for children and adolescents in Victoria and recommended a stronger focus on children and adolescent health in DHS, and the establishment of a new network structure for all paediatric service providers in the state.
- *Metropolitan Health Strategy (MHS) (2003)*—the MHS was released in October 2003. It set key directions and objectives for metropolitan health services over the following 5–10 years with future health services to be responsive to community needs, responsible with public funds, and provide the optimal level, distribution and mix of services to meet growing and changing demand. The MHS recommended that the RCH:
 - have a strengthened role as the major specialised tertiary paediatric service provider in the state
 - have an enhanced role in teaching and research
 - continue as the designated statewide provider of paediatric major trauma services, paediatric intensive care and high complexity low volume paediatric services
 - have a strengthened leadership and advocacy role in child and adolescent health issues
 - work collaboratively with other service providers in the provision of secondary paediatric services across the state
 - participate in the development of a statewide, specialised paediatric and adolescent rehabilitation service
 - maintain its role as a major provider of child and adolescent mental health services for the west of Melbourne.
- *Report of the Premier's Children's Advisory Committee (2004)*—this report argued for a comprehensive review and reorganisation of current services for young children and families with a new statewide, whole-of-government framework for investing in children.
- *Asset Investment Program (2004)*—in 2004, the government reviewed public sector asset management policies. The review led to the introduction of the Victorian Government Asset Management Framework for the general government sector, involving Gateway reviews and adherence to the *Partnerships Victoria* guidance.
- *A Fairer Victoria (2005)*—detailed a range of government actions and new partnerships to:
 - improve access to vital services
 - reduce barriers to opportunity
 - strengthen assistance for disadvantaged groups and places
 - give people the help they need at critical times in their lives.

4.2.2 Development of the RCH service plan

The key planning documents were the RCH Strategic Plan and the RCH Service Plan (2004), which outlined the principles of the new models of care and service delivery profile and the RCH Service Plan Review (2005) which included revised data and more up to date analysis on the fundamental inputs to the service delivery profile.

The RCH service plan provided the basis for the development of the strategic business case, the master plan study, the final business case and the project brief for the new RCH project.

The RCH service plan defined the services to be provided by RCH based on:

- demographic and activity projections to 2016
- catchments (20 per cent of inpatients are from regional Victoria, interstate and overseas, 50 per cent from the local north west metropolitan region and 30 per cent from eastern and southern metropolitan regions)
- unmet demand
- substitution of beds to provide more appropriate levels of care
- improved integration of services and models of care
- increased ambulatory services
- decentralisation of appropriate services.

Development of initial RCH service plan

In developing the initial RCH service plan, RCH established a set of service principles that were further defined by articulating existing RCH values or philosophy in relation to advocacy, care, education, health promotion, liaison, policy support and research. Both the service principles and the RCH values, in conjunction with the government and department policy context, became the framework for the development of the future RCH service profile.

A range of principles were identified to inform the new service delivery profile of the RCH drawing on the broad policy framework described above. The principles, as described in the service plan and other key RCH redevelopment documents, included:

- respect for children's needs and issues
- care coordination
- family focussed environment and facilities
- cultural, religious and social considerations
- life state and developmental issues
- chronic illness and disability issues
- access
- partnerships and linkages.

Key elements of the RCH service planning process included:

- communication—RCH staff and consumers were made aware of the service planning process via a variety of means, including consumer focus groups, staff forums, and briefings

- data collection and analysis—Australian Bureau of Statistics (ABS) information was utilised to provide an overview of the RCH catchment. Government population data, RCH admissions data and a forecasting model were utilised to analyse current activity levels and develop forecasts of future demand
- identification of the RCH current service profile (i.e. the numbers and types of patients cared for)
- development of RCH future service profile based on RCH admissions data, DHS' service planning tools—including the forecasting model—and consultation with consumers, stakeholders and staff. The future service profile considered projected demand for health services and supply issues including capacity needs of the hospital, efficiencies in service delivery, and the ability to work with other hospitals in a regional network response.

The development of the RCH service plan was a robust and comprehensive process that involved consultation with RCH clinicians, various working groups, reference groups, the RCH project steering committee and the RCH board.

Development of models of care

Models of care are dynamic concepts that should evolve over time with changes in clinical practices and as hospitals strive to deliver improved health care. Models of care refer to the models of health service delivery and are used to inform design parameters and requirements for a new hospital facility. There is a relationship between models of care and service delivery principles which impact on hospital functionality requirements and should inform the design brief for any new hospital.

RCH planning documents identified the need to develop new models of care to meet service objectives and provide a facility capable of delivering care in line with the RCH philosophy and principles and overriding government and departmental policies, strategies and review outcomes.

The RCH saw a need to change from the then-current 'medical specialty' model to a model more focussed on the needs of patients and families to provide a more flexible, streamlined, and seamless approach to the provision of care.

The development of the RCH future models of care at the service planning stage was based on the identification of the key needs of core patient groups. This was intended to enable the new RCH to refocus its service delivery model and ensure the services provided related to the needs of each patient group. Four working groups were established with staff and consumer representation to work on details of service delivery and to consider what was 'best practice' in the provision of care for each of the core patient groups to inform the new models of care.

The new models of care outlined in the May 2004 RCH Service Plan were not sufficiently developed or defined. DHS advised that the models of care developed at the service planning stage were intended as a starting point and were to be further developed and refined over time.

Gateway review of strategic business case

The Gateway Initiative was introduced in March 2003 to assist government departments and agencies to determine whether their investments are well spent, meet business and government strategic objectives and achieve value-for-money outcomes. Under the gateway process projects are independently reviewed at six 'gates' in the project lifecycle to assure successful project delivery.

The Gateway strategic assessment (Gate 1) review of the RCH strategic business case held in February 2005 concluded that the models of care were not adequately developed and recommended this be addressed prior to the subsequent business case (Gate 2) review.

Limited additional work on models of care was undertaken by the time of the Gate 2 review of the preliminary RCH business case in October 2005. That review identified the critical need to further develop the models of care before the procurement process commenced.

The final business case for the new RCH described how key government documents and policies were aligned with the four key patient groups but did not define new models of care in detail. The models of care were further developed and defined after the business case stage to inform the project brief which was released to the market.

Delays in developing models of care for the new RCH added to the complexity of the service planning process but did not invalidate the results.

Recommendation

- 4.1 DHS should develop and define models of care beyond high level statements at the service planning and business case stages for any future major hospital investments. This will help to make sure that investment decision-making processes are better informed by the service delivery strategy expected to be adopted.

RCH change management strategy and finalisation of project brief

The final business case and Gate 2 review identified the need for a change management strategy within RCH which would also consider models of care. In November 2005, DHS engaged a consultant to work with RCH to develop a strategy which would address the need for changes to RCH management, clinical and business processes and define new service delivery principles. This strategy was to assist in defining the new models of care. The progressive outcomes of this process were reported to the DHS project team preparing the RCH project brief.

After the business case stage, extensive consultation and analysis was also conducted by RCH involving clinicians, hospital administrators and DHS to further develop models of care. The outcome of this work was reflected in the functional brief component of the RCH project brief which was finalised in October 2006.

The functional brief detailed the scope, operational description, functional content, functional relationships, description of accommodation, building requirements and schedule of accommodation, for each of the clinical and administrative (support) units in the hospital. This implicitly related to and reflected the proposed models of care.

The RCH project brief was peer reviewed by the RCH executive, the RCH redevelopment committee and the RCH project steering committee and found to draw on robust models of care. The Government approved the release of the RCH project brief in October 2006.

During the course of the audit, concerns were expressed by some RCH clinicians that their views were not adequately addressed or taken into account in planning for the new hospital. This is a challenge for any major project such as the new RCH, particularly where highly committed professionals are involved in the process. The audit found that there were opportunities for clinical input during the planning stages of the project.

The functional brief stated that a key principle in the development of models of care was flexibility so that each could be altered and further developed to incorporate the lessons of new clinical research on best practices, or unforeseen changes to service need.

The RCH is currently engaged in a process to review its Service Plan with a planned completion date of mid-2009. It is planned that this process will involve on-going consultation with RCH clinicians, patient families and other health services.

Planning for service demand

The final business case included a service profile for the new RCH. This profile was determined by a service planning review undertaken in 2003–2004 and formed the basis of a planned facility configuration for the new hospital. The new RCH will have 50 more beds than the existing hospital and the design of the new RCH provides flexibility for future expansion.

The RCH service plan defined the services to be provided by the RCH, based on demographic and activity projections to 2016. The service review incorporated service demand modelling and a review of factors including:

- RCH service delivery levels and admissions data
- service demand projections based on a DHS service planning tool and forecasting model
- ABS data
- consultation with consumers, stakeholders and staff.

The service planning for the new RCH used the data available at the time as well as the results of a forecasting model provided by DHS. As with any forecasting model there were some known limitations in the model used to forecast service demand for the new RCH.

These limitations related to issues around:

- assumed maximum lengths of stay for patients
- assumed bed occupancy rates
- moderation (or capping) of the allowable levels of increase and decrease in annual admission rates.

DHS advised us that forecasting models are only the start of the service planning process, and that in applying the forecast model, DHS indicated that it reviews actual experience and consults with clinicians to identify areas where the output of the model needs to be adjusted.

DHS and RCH could not provide evidence confirming how any advice from clinicians and other experts was taken into account to address limitations in the forecasting model to enable appropriate adjustments to be made to forecasts of admitted patient activity for the new RCH.

However, notwithstanding the lack of evidence of the basis for adjustments to the model forecasts, it is clear that adjustments were made.

A similar issue arose in relation to the forecasting of future activity for non-admitted patients (such as those patients using outpatient clinics). The DHS forecasting model was not used for these forecasts and another method was applied. RCH could not provide evidence that RCH clinicians were given the opportunity to review whether the forecasts for non-admitted activity were appropriate.

We also observed issues around the extent to which DHS understands the development, operation, and internal logic of the forecasting model. The model used by DHS is a proprietary model owned by a consulting firm and is used for statewide service demand forecasting by DHS. DHS advised that the model has been validated in other jurisdictions but was unable to provide specific details about the development and operation of the forecasting model.

While it is clear that service planning for the new RCH used the data available at the time, in the absence of relevant evidence, we have been unable to conclude on how well that data was applied in developing service demand forecasts for the new RCH.

Recommendation

- 4.2 DHS should develop a comprehensive understanding of its current service forecasting model—which is a statewide and not hospital specific forecasting tool. This will help DHS to better understand the model's limitations and impacts when forecasting demand for future service delivery.

Forecasting future service demand and recent experience

RCH service demand projections were based on forecast numbers in the RCH Service Plan (2004) and Service Plan Review (2005). These service plans reflected the broader forecasts of future service demand in the 2003 *Metropolitan Health Strategy*.

A key data source used in the service planning process to forecast future service demand was a declining birth rate forecast made by ABS. This was the most appropriate and up to date data source at the time.

However, the RCH Service Plan (2004) did not specify the actual forecast decline in the birth rate applied, and DHS was not able to confirm the rate used. The 2004 service plan also indicated that while historical evidence showed a decline in the birth and fertility rates over the last few decades, this was due to an increase in the total population of Victoria, not a decline in the total number of births. So while the birth **rate** was dropping, the **overall** population was increasing—meaning an **overall increase** in the total number of births.

Our review of more recent population trends found that the assumptions underlying population growth forecasts have changed since the time of the RCH service planning and are likely to continue to change over time:

- The actual birth rate over the five years from 2001 to 2005 increased rather than decreased. ABS data suggests that based on the number of registered births in Victoria, the average birth rate increased by 1.39 per cent per year in that period.
- The birth rate has historically fluctuated in a cycle and is currently at a peak but may subsequently decline.
- Levels of immigration and economic growth in Victoria are linked, and can fluctuate rapidly, and therefore can have a rapid impact on the birth rate.



*An artist's impression of the Flemington Road frontage of the new hospital.
(Image courtesy of Billard Leece Bates Smart and Sharp Design)*

As part of the audit we sought analysis by DHS or RCH of the impact of new census data on the projected demand for paediatric services and the number of beds required on a statewide basis and at RCH. DHS was awaiting updated detailed population forecasts from the Department of Planning and Community Development, expected in early 2009, before undertaking detailed work in this area, but did provide the results of preliminary analysis undertaken in October 2008.

That analysis involved a simple projection, using 2006 ABS census data and ABS data on the 0–14 age population, to forecast demand for paediatric services and the number of beds required on a statewide basis. The projection indicated that the state will need an additional 50 beds, over and above existing capacity, to meet expected future demand by 2016, when service demand is expected to plateau.

DHS is confident that this projected demand increase can be accommodated on a statewide basis given that the new RCH will have 50 more beds than the existing hospital and there is sufficient flexibility, 'shell space' and other design options for capacity expansion in the new RCH to provide a further 53 beds.

This is before taking into account any other investments in paediatric services in Victoria apart from the RCH.

DHS' October 2008 analysis did not address how many of the additional required beds would be provided by RCH and other providers of paediatric services in the state.

DHS has demonstrated that flexibility in the design of the new RCH should be able to handle currently projected increases in service demand that were not anticipated during the service planning stages for the new RCH.

However, DHS has not yet performed any analysis, or provided any advice to government on when any additional beds provided by the expansion capacity of the new RCH (such as fitting out shell space or reconfiguring the internal design), may need to be delivered.

Network response and statewide paediatric service strategy

A coordinated 'network response' and approach to paediatric services in Victoria was identified in 2002 as a key strategy to meet expected increases in future service demand and better coordinate existing services. This strategy is still being considered by DHS.

The delay in introducing a coordinated network response and statewide approach to paediatric services may have impacted on the service planning for the new RCH. Clarity around the role played by a particular hospital in the wider health care network and system is important when planning a redevelopment of that hospital facility. While the service planning documents for the new RCH were clear in articulating the RCH role in the wider system, this was not underpinned by a clear statewide paediatric service strategy promulgated by DHS.

The Review of Paediatric Services was commissioned by DHS in 2002 as a component of the *Metropolitan Health Strategy* and the *Victorian Rural Human Services Strategy*. Its purpose was to identify existing health services for Victorian children and adolescents, potential gaps in service level and usage, and provide advice on future directions for paediatric health service provision on a state wide basis. The final report on the review was published in December 2002 and included a range of recommendations that focused on a coordinated approach for planning, developing and enhancing paediatric services in Victoria.

Although several of the recommendations have been implemented, other key recommendations relating to a network response and statewide paediatric services strategy have not been addressed. In September 2007, DHS commenced a project to progress a coordinated approach to planning and developing statewide paediatric services. This project is planned for completion in June 2009.

The first phase in the current DHS project involves developing a strategic framework for paediatric services in Victoria. A discussion paper on the framework has been developed but not released for public consultation, despite the original intention to finalise the framework by November 2008. DHS advised that the discussion paper has been the subject of 'targeted consultation' and was expected to be finalised in early 2009.

The discussion paper provides a suggested framework for the future development of paediatric health services in Victoria, outlining the role of a proposed new body, the Paediatric Clinical Network, to promote and ensure the delivery of paediatric models of care in Victoria. The discussion paper also recommends that health services work together to formalise and build upon existing partnerships and to ensure a statewide system of integrated and coordinated care. Following the development of the strategic framework for statewide paediatric health services, updated demand projections and capacity analysis and planning will need to be undertaken.

Phase two of the project involves defining the roles and responsibilities between RCH and the Monash Medical Centre in the provision of high complexity low volume paediatric services. This phase has commenced and was planned for completion in April 2009.

The final phase in the project is to establish a Paediatric Clinical Network to progress any priorities arising from the development of the Strategic Framework for Paediatric Services in Victoria.

In summary, DHS has yet to develop a statewide approach to the delivery of paediatric health care despite a recommendation on this matter in 2002. A better approach would have been to develop a statewide strategy on paediatric health services concurrently with the service plan for the RCH redevelopment.

The RCH is currently engaged in a review of the RCH service plan which involves consultation with key stakeholders, including clinicians. This process is planned for completion in mid-2009. Clearly it will be important for the RCH service plan review process to be informed by, and provide input into, the DHS whole of system framework for the future development of paediatric health services in Victoria.

Recommendations

- 4.3 DHS should expedite the development of a strategic 'network response' framework for the future development of paediatric health services in Victoria.
- 4.4 RCH should consider the implications of a strategic 'network response' framework for the future development of paediatric health services in Victoria when finalising its current service plan review.

4.3 Investment planning

The objective of public sector investment is to produce service outputs that achieve desired outcomes. Identification of the service need to be addressed by the investment proposal should therefore be the starting point for any investment proposal and evaluation.

The May 2004 RCH service plan examined service demand and models of care at a high level to inform detailed investment analysis and planning. The service plan was approved by DHS in July 2004.

The service plan indicated that the business case for the new RCH would be developed progressively, commencing with a strategic business case and followed by detailed examination of capital development options (via a feasibility study) to form the basis for a preliminary, and then final, business case.

4.3.1 Strategic business case

In October 2004, a strategic business case (SBC) for the new RCH was endorsed by DHS, the RCH steering committee and the RCH board.

The SBC included an assessment of service needs, the need for a redeveloped hospital and high level exploration of several options to achieve the objectives of the RCH redevelopment project.

The SBC re-iterated the need for RCH to respond more effectively to changing patterns of demand and the changing needs of patients and their families. It concluded that this could only be achieved with new models of care and key facility changes.

In terms of options, the SBC presented six potential high level solutions or redevelopment options, including a base case or 'do-nothing' option for the RCH. Preliminary redevelopment costs for each of the options were included in the SBC.

Key points raised in the preliminary analysis of options and associated costs included:

- The 'do nothing' option should not proceed as it was considered to be inconsistent with government policy for children's health services and because the existing RCH infrastructure would require ongoing upgrades to retain functionality and safety. New models of care could be developed to a limited extent only and access problems, particularly car parking would remain unaddressed.
- The 'non-asset' solution was discarded because it was considered that clinical services provided by RCH were required to service the paediatric patient population with no alternative public or private provider available with the capacity to provide these services. The location of acute services elsewhere would require new infrastructure at comparable or greater cost.
- The remaining five options identified would be carried forward into master planning and feasibility stages.
- The business case for the RCH should further evaluate the *Partnerships Victoria* approach as one of the procurement options for the project.

Conformance of the strategic business case to guidance

We assessed the SBC against the *Investment Evaluation Policy and Guidelines* released by the Department of Treasury and Finance (DTF) in September 1996 as well as DTF's Gateway Business Case Development Guidelines (August 2003) and the *Partnerships Victoria* Policy (June 2000) and the *Partnerships Victoria* Practitioners Guide (June 2001).

The SBC was generally in line with these government policy and guideline documents. There were some minor departures from the DTF guidelines but these were subsequently addressed and did not invalidate the conclusions reached in the SBC.

The SBC for the RCH project underwent a strategic assessment (Gate 1) review in February 2005. The review concluded that the SBC was sufficient as a high level overview of the project. However, it identified that there was a need for new models of care (style of service delivery) and a 'network response' (statewide approach in the service delivery of paediatric services) to be developed and implemented prior to the next Gateway review to properly inform planning for the new RCH project.

Clarity around models of care and the RCH role in the wider health network are significant for service and investment planning as they assist in defining the service delivery approach, and inform the forecasting for service demand and ultimately the design parameters and facility requirements for the new hospital.

4.3.2 Feasibility study for the new hospital

A feasibility study is typically a preliminary study undertaken to determine a project's viability. The results are then used to make a decision on whether or not to proceed with the project.

The RCH service plan indicated that a feasibility study was to be prepared detailing the capital development options after the SBC or investment evaluation but prior to the development of the preliminary and final business case.

A feasibility study which formed part of a larger development options report was completed in November 2005, at the same time the business case was finalised and approved by government. A Gateway review in October 2005 of the preliminary business case found that the feasibility study remained incomplete but this was addressed by November 2005.

While the feasibility study was not finalised until November 2005, the government considered the outcomes of the feasibility study progressively from September 2005, as they related to selection of a preferred site.

The development options report formed the basis for the final business case submitted to government and included detailed and comprehensive analysis of the various options for the redevelopment of RCH.

There were five site redevelopment options considered in the feasibility study. Each of the five redevelopment options provided for approximately 96 000 square metres of hospital space and 2 000 car spaces.



*An artist's impression of the RCH campus after construction and park reinstatement.
(Image courtesy of Billard Leece Bates Smart and Sharp Design)*

The options considered are outlined in Figure 4B along with preliminary cost estimates presented to government in early October 2005.

Figure 4B
Outline of RCH redevelopment options

Site option	Option outline	Preliminary cost estimate (\$ million)
Docklands	A new facility on a four hectare site on Footscray Rd at Melbourne Docklands.	831
New west	An entirely new facility built on the Royal Park oval adjoining the western boundary of the existing site. On completion, all existing RCH buildings and car parks would be demolished and the site returned to parkland with no net loss of parkland.	755
New west variant	A new facility built on the Royal Park oval adjoining the western boundary of the existing site. Approximately 10 000 square metres would be retained in the existing RCH/MCRI research building and front entrance building. On completion, some existing buildings and the RCH car park would be demolished, and the eastern half of the current site restored to parkland with no net loss of parkland.	721
West integrated	New clinical areas built on the Royal Park oval adjoining the western boundary of the existing site with research and non-clinical functions retained in existing buildings. On completion of construction, the existing RCH car parks and south east building would be demolished, and the eastern half of the current site restored to parkland. There would be no net loss of parkland.	711
East integrated	Similar to the West Integrated option and involves construction of new clinical areas on the eastern side of the existing site with research and non-clinical functions retained in existing buildings.	779

Source: Victoria Auditor-General's Office, using data provided by DHS.

The preliminary cost estimates for each of the options shown in Figure 4B are net of an expected funding contribution of \$90 million from the RCH. The RCH funding contribution was expected to be sourced from a combination of borrowings (\$30 million), asset sales (\$10 million) and a funding commitment of \$50 million from the RCH Foundation.

These preliminary cost estimates were presented to government in early October 2005 as part of a submission recommending selection of a site option for the new RCH. On the basis of that submission, on 6 October 2005 the government approved the selection of the 'new west variant' as the preferred site option.

This approval was subject to finalisation of the business case and a number of conditions relating to:

- funding
- capping of gross floor area and site boundaries
- the return to parkland of an area at least equivalent to the parkland to be used for the redevelopment
- potential use of existing buildings in the redevelopment.

4.3.3 Final business case

The business case for the new RCH evolved from the SBC and the development options report detailing proposed site redevelopment options, required capital funding and procurement options. The business case went through preliminary and final phases in October and November 2005.

The government considered the analysis and recommendations arising from the business case and made decisions progressively during that period.

In November 2005, the government approved the new RCH project proceeding on the basis outlined in the final business case dated November 2005. By approving the project, the government also approved the project to be delivered under a *Partnerships Victoria* model, subject to private sector bids satisfying value for money criteria.

The final business case contained evidence of:

- defined need—building upon the findings of the 2004 RCH service plan and various government and departmental reviews and policy objectives
- consideration of future growth requirements and needs—based on the findings of the RCH service plan
- analysis of site options—detailed evaluation of five proposed site redevelopment options, which considered both financial and non-financial factors (socio-economic, strategic and project objectives)
- analysis of possible procurement options.

Evaluation of redevelopment site options

An evaluation of the site redevelopment options was undertaken in the final business case in accordance with DTF's *Investment Evaluation Policy and Guidelines* (1996). When evaluating the proposed options, the framework applied in the business case focused on the financial and non-financial or socio-economic factors with weightings assigned to each evaluation criteria based on judgements made about their relative importance.

Key issues considered during the evaluation process were the:

- ability to meet government's commitment to provide all new clinical services in a world class, state-of-the-art facility, within the announced timeframes
- overall financial evaluation (taking into account capital costs and impact on recurrent costs)

- best value for money investment and affordability
- stakeholder impacts and views, including facility users (patients, carers and families), the local residential community, conservation groups, staff and benefactors.

Based on this evaluation the business case recommended the ‘new west variant’ as the preferred option because it:

- scored highest on the overall financial evaluation
- scored highest on overall value for money
- delivered equal socio-economic benefits to the ‘new west’ option at a lower cost
- made maximum use of new buildings to achieve the operational and clinical efficiencies, and strategic and project objectives, while also retaining the benefit of recent investments in existing RCH buildings, specifically the front entry building and a research building.

Financial evaluation of options

The financial evaluation of options in the business case included final updated estimates of nominal construction costs for each option and a preliminary public sector comparator (PSC) for each option in net present cost terms. Figure 4C provides a summary of these figures.

Figure 4C
Development options—Nominal construction costs and preliminary PSC (\$ million)

Option	Estimated nominal construction cost	Preliminary risk adjusted PSC (net present cost)
Docklands	959	1042.5
New west	856	985.9
New west variant	823	979.4
West integrated	796	984.8
East integrated	898	1047.8

Source: Victorian Auditor-General's Office, using data provided by DHS.

The nominal estimated construction costs were based on expert external advice and had been refined from the preliminary estimates provided to government in October 2005.

The preliminary PSC estimated the hypothetical risk-adjusted net present cost if the project were to be financed, owned and implemented by government. The PSC incorporated both capital construction costs and lifecycle facility maintenance costs over a 25 year period together with a risk adjustment based on the nature of risks associated with each option.

The ‘new west variant’ option, which was recommended in the business case, had the second lowest estimated nominal construction cost and the lowest preliminary PSC.

We were generally satisfied with the level of documentation and analysis supporting the nominal construction costs and preliminary PSC for each option in the business case.

The inflation and discount rates used to calculate the preliminary PSC for each option were consistent with relevant DTF and *Partnerships Victoria* guidance. However, the following process and documentation issues were identified in relation to the preliminary PSC:

- DHS engaged a consultant to develop the preliminary PSC analysis but did not perform their own quality assurance review of the preliminary PSC financial model produced by the consultant
- unlike the 'new west variant' option, DHS was unable to provide documentary evidence to support the construction cost assumptions included in the preliminary PSC financial model for the other four asset options.

We have noted similar issues in other recent reviews of PPP projects and believe that DTF should amend its *Partnerships Victoria* guidance accordingly.

Recommendation

4.5 That DTF amend its guidance to require that agencies implementing *Partnerships Victoria* projects:

- conduct and document quality assurance reviews of PSC estimates and related financial models—irrespective of whether they are internally or externally prepared—to reduce risks of error or inaccuracy, and to ensure that the state has sufficient understanding of these highly complex financial models.
- maintain adequate documented evidence to support all costings and PSC calculations contained in a business case.

Socio-economic evaluation of options

Consistent with *Partnerships Victoria* guidance, the business case also assessed the options against a number of non-financial or socio-economic factors including:

- socio-economic impacts on patients, paediatric care and the health industry
- achievement of strategic objectives
- achievement of project objectives.

The socio-economic evaluation indicated that the new west and new west variant options performed equally well across the socio-economic criteria. This was due to the similar nature of the two projects in terms of the final outcomes achieved. These two options were the highest performing options—scoring as much as 30 per cent higher than the east integrated option.

Analysis of procurement models

The final business case included analysis of the respective advantages and disadvantages of a traditional procurement model, based on a managing contractor arrangement, and a Partnerships Victoria procurement model.

The business case concluded that a PPP under the Partnerships Victoria model was the preferred procurement approach for the new RCH project as it would:

- maximise design innovation, as the design brief is output based rather than input based
- effectively transfer design, construction, commissioning and whole of life facilities based risks to the private sector
- improve hospital maintenance by effectively locking in minimum maintenance investment and standards which would be policed through an enforceable payment mechanism and abatement regime
- reduce whole of life costs by encouraging an optimal mix of upfront capital for construction and ongoing maintenance and refurbishment expenditure
- prevent scope creep due to the complex commercial structure and a perception that this would be less susceptible to scope changes and variations than a traditional public sector construction project.

Approval of business case

The final business case was approved in November 2005. In approving the business case the government:

- ratified its earlier decision to select the 'new west variant' option as the preferred site option
- noted the proposed gross floor space and site boundaries for the project and the commitment provided by the RCH board to cap the gross area in the new hospital at 96,000 square metres, provided there were no material changes to the service plan for the hospital
- approved the project to be delivered under a Partnerships Victoria model, subject to private sector bids satisfying value for money criteria
- approved funding for the project and noted that \$90 million would be received in offset funding from RCH towards the cost of the redevelopment via:
 - \$50 million from the RCH, on the basis of a qualified commitment given by the RCH board to raise the funds with any shortfall to be possibly underwritten by other fundraising by the RCH Foundation
 - \$30 million from RCH borrowings, secured against future RCH car park revenues
 - \$10 million from RCH asset sales after the commissioning of the new hospital
- approved funding of project management and transaction costs of \$24 million made up consultants fees, DHS project team costs and RCH redevelopment team costs

- delegated to the Treasurer and the Minister for Health responsibility for conducting the Partnerships Victoria procurement process including approving of the expression of interest, project brief, final public sector comparator, preferred tenderer and the project agreement.

Gateway review of business case

The project underwent a business case (Gate 2) review in October 2005 prior to finalisation of the business case. The review supported the project proceeding to the procurement phase on the basis that a number of recommendations were implemented quickly.

Key Gateway recommendations focused on the need to further develop the new RCH models of care to fully inform development of a project brief and design and the need to progress the planning, resourcing and implementation of the RCH 'change management' process to a point where it could usefully inform development of the project brief and design. These recommendations were implemented.

The business case was generally in line with the principles of DTF's *Partnerships Victoria Practitioners' Guide* (June 2001), as well as DTF's *Gateway Business Case Development Guidelines* (August 2003).

4.3.4 Conclusion on investment planning

The investment planning documents:

- were comprehensive and consistent with DTF guidance
- provided a transparent analysis of options—including procurement options
- show that the government was provided with comprehensive information at each major decision point or milestone of the new RCH project planning process.

Overall, the government was provided with clear and sound advice during the decision-making process to commit to and invest in the project.

5

Assessing value of bids

At a glance

Background

The long-term nature, and high dollar-value, of a Public Private Partnership (PPP) contract warrants a rigorous assessment of private sector bids and an effective procurement process.

This provides assurance that the process to appoint the successful bidder is beyond challenge and that the state has achieved value for money.

Key findings

- The procurement approach complied with the expected elements of Victorian Government Purchasing Board policy and guidance and with the Partnerships Victoria guidelines.
- The planned timelines for the procurement process were met, which was commendable, given the scale and complexity of the project and procurement task.
- The risk allocation in the project agreement is broadly in line with Partnerships Victoria guidelines.
- Expected standards of probity were maintained and enforced throughout the procurement process.
- The impact of the downturn in global financial markets has created uncertainty about whether \$35 million in promised donations will be paid to the RCH Foundation.
- The final adjusted Public Sector Comparator was determined as \$1.016 billion with the net present cost of the successful bid at financial close at \$946 million, representing a cost saving for the state of \$70 million, or 6.9 per cent, over 25 years.

5.1 Assessment of value for money

5.1.1 Background

Due to the long-term nature, and high dollar-value, of a Public Private Partnership (PPP) contract, it is important that the value for money assessment, as well as the procurement process, is conducted effectively, and in line with relevant rules, policies and guidelines.

This provides assurance that a rigorous assessment of the private sector bids has occurred, and that the process to appoint the successful bidder is beyond challenge.

5.1.2 Criteria

To determine the adequacy of the assessment of value for money offered by private bidders for the new RCH project, criteria were derived from the following *Partnerships Victoria* documents:

- *Partnerships Victoria* Guidance Material Practitioners' Guide
- *Partnerships Victoria* Public Sector Comparator Technical Note and Supplementary Technical Note
- *Partnerships Victoria* Risk Allocation and Contractual Issues Guide
- *Partnerships Victoria* Contract Management Guide.¹

Relevant government policies and guidance on probity in procurement were also used to assess the probity process used to monitor the procurement phase.

For this part of the audit the following questions were considered:

- Were effective tools developed to help assess value for money provided by private sector bids?
- Did the procurement process follow the rules and guidelines?

¹ All these documents are available from the Partnerships Victoria website: <<http://www.partnerships.vic.gov.au>>.

5.2 Assessing value for money of private bids

5.2.1 Framework and approach used

Figure 5A shows the planned timing of key stages in the procurement process for the new Royal Children's Hospital (RCH). These planned timelines were met, which was commendable, given the scale and complexity of the project and procurement task.

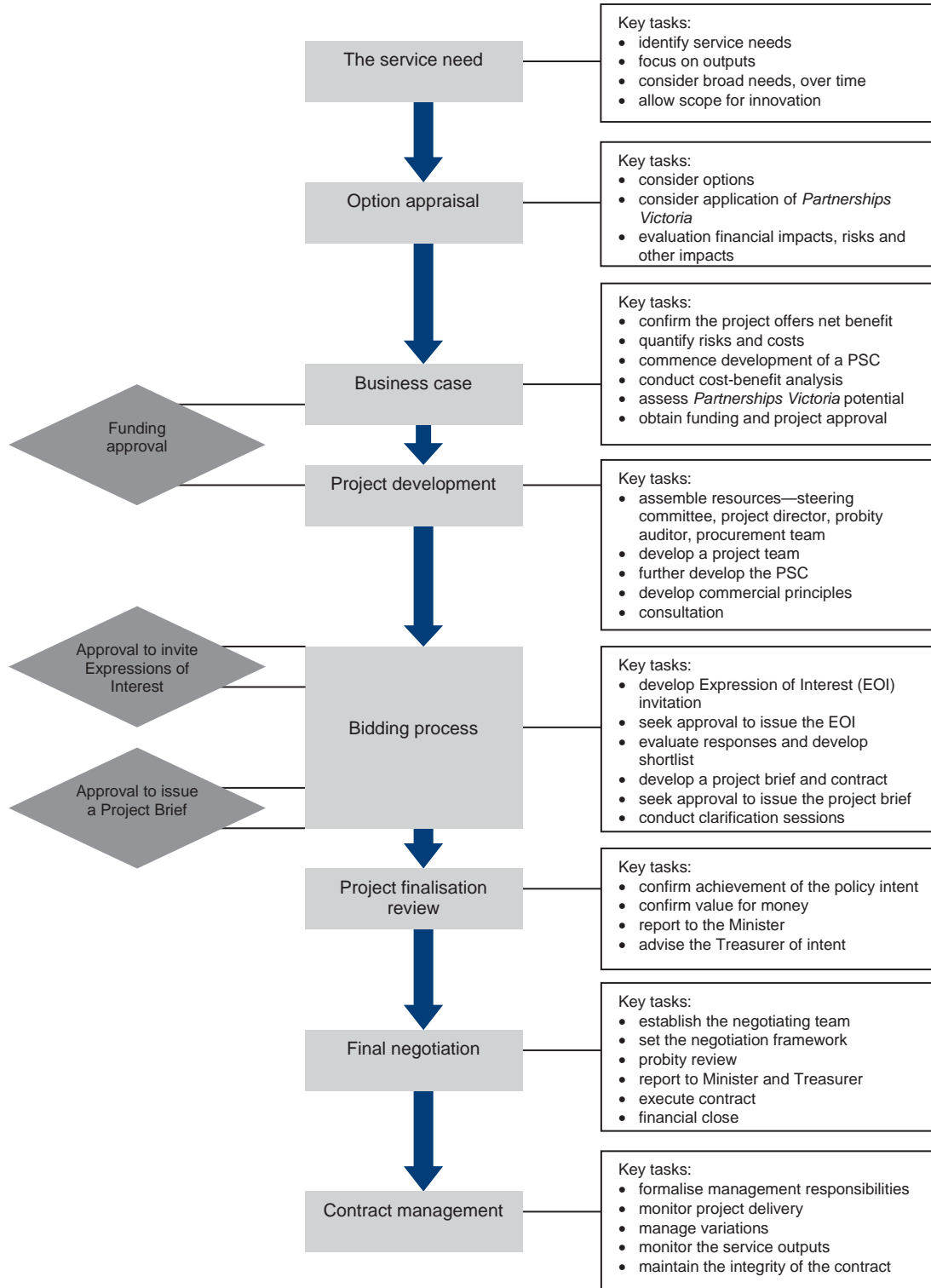
Figure 5A
Planned timing of key stages in RCH procurement process

Stage	Planned timing
Expression of interest (EOI) phase	
Release of EOI	10 May 2006
Closing date for submission of EOI proposals	8 June 2006
EOI evaluation and short-listing of respondents	31 July 2006
Request for proposal (RFP) phase	
Release of project brief (for RFP)	11 October 2006
Closing date for responses to RFP	8 March 2007
Structured negotiation phase (SNP)	
Release of SNP brief	1 June 2007
Technical and commercial workshops	5 June - 6 July 2007
Revised proposals due	26 July 2007
Evaluation and clarification	August 2007
Endorsement of recommendations	September 2007
Negotiation and completion phase	
Contractual close	November 2007
Financial close	December 2007

Source: Victorian Auditor-General's Office, using data provided by DHS.

Figure 5B (overleaf) shows the major stages in developing a Partnerships Victoria project. The procurement process extends from the bidding process through to final negotiation.

Figure 5B
Stages in developing a *Partnerships Victoria* project



Source: Victorian Auditor-General's Office, using data from *Partnerships Victoria Contract Management Guide*, page 31, figure 5.1.

5.2.2 Use of a Public Sector Comparator

The Public Sector Comparator (PSC) is one of a range of assessment criteria used during a *Partnerships Victoria* procurement process. The PSC estimates the hypothetical risk-adjusted cost if a project were to be financed, owned and implemented by government. The PSC is also based on the most efficient form and means of government delivery.

The PSC is used at key points such as the decision whether or not to deliver a project under the *Partnerships Victoria* model and in the comparison of private sector bids.

The PSC comprises four components:

- **The raw PSC**—provides a base costing under the public procurement method. This includes all capital and operating costs, both direct and indirect, associated with building, owning, maintaining and delivering the service or underlying asset over the same period as the term under the *Partnerships Victoria* proposal and to a defined performance standard as required under the output specification
- **Retained risk**—any risk not to be transferred to a bidder. The cost of retained risk is included to provide a comprehensive measure of the full cost to government in a PSC.
- **Competitive neutrality adjustments**—these remove any net competitive advantages that accrue to a government business by virtue of its public ownership, allowing a fair and equitable assessment between a PSC and bidders
- **Transferable risk**—any risk transferable to a bidder such as construction costs, construction delays and materials cost escalation.

Preliminary PSC

A preliminary PSC for each of the five redevelopment options under consideration was developed at the business case stage in mid-2005 before the start of the procurement process. The preliminary PSC financial model had all the features required by *Partnerships Victoria* guidance.

Assumptions in the preliminary PSC in relation to inflation and discount rates were in line with *Partnerships Victoria* guidance. Assumptions in relation to construction costs for the ultimately selected redevelopment option (the new west variant) were in line with supporting documentary evidence.

The quantification of risk for the purposes of the preliminary PSC followed an approach in line with *Partnerships Victoria* guidance.

Progressive development and refinement of the PSC

The PSC was developed progressively from the business case onwards, with the final PSC completed in November 2007, at contractual close. This was consistent with the *Partnerships Victoria* policy and guidance. It requires the progressive refinement of the PSC as a project moves through the various stages of development from initial option appraisal and the decision on whether or not to pursue a PPP procurement approach, through the procurement phase, and if required, prior to contractual and financial close.

There were various changes to the PSC between November 2005 and December 2007 and changes were considered, documented and appropriately approved in line with government requirements. The PSC for the project was approved by government in September 2006 and was \$1.057 billion when the project brief was released to the market in October 2006. Inputs to the PSC financial model at the project brief stage were valid and supported by appropriate documentation.

To use the PSC appropriately in the evaluation process, adjustments are made to both the total PSC and the bid valuations where necessary. This enables 'like-for-like' comparisons of all bids.

The net present costs (NPC) of private sector bids are compared to the PSC to assist in determining whether the project, if conducted under a *Partnerships Victoria* structure, would deliver better value for money than the PSC.

The PSC was used as part of the procurement process. Adjustments made to the PSC to enable a like-for-like comparison with bids included:

- retained risk adjustments, as the state holds this risk under either scenario
- cleaning services adjustment, which were included in the preliminary PSC and the PSC approved by government in September 2006, but subtracted from the PSC at the project brief stage and the final PSC following a government decision in early October 2006 to remove these services from the scope of services to be delivered under the project agreement
- additional space adjustments, as estimated cost impacts associated with the provision of additional space to the University of Melbourne and the Murdoch Children's Research Institute were added to the PSC to make it comparable to the bids.

Removal of cleaning services from the PPP arrangement

One of the adjustments to the PSC related to the removal of cleaning services from the scope of services to be delivered under the Project Agreement following a decision by government in early October 2006.

As part of this decision, the government determined to exclude cleaning services from the *Partnerships Victoria* arrangement and to activate steps under agreed protocols in place with the applicable union for the benchmarking and potential outsourcing of cleaning services.

This decision resulted in a reduction to the PSC of around \$75 million reflecting the impact of the removal of cleaning services on operating costs over the 25 year contract term.

In other recent public hospital PPPs, cleaning services were included within the scope of the services to be delivered, such as the *Partnerships Victoria* Project Agreement for the Royal Women's Hospital.

The decision to exclude cleaning services from the scope of the RCH project agreement may have adverse value for money consequences for the state if the results obtained from benchmarking of the potential outsourcing of cleaning services at RCH do not yield positive results.

Final Public Sector Comparator

The 'final adjusted PSC' is the PSC used to make the final evaluation of the bids received, and also excludes the state's estimate of its retained risk.

The final adjusted PSC was \$1.016 billion with the NPC of the adjusted bid at financial close in December 2007 at \$946 million. The adjusted bid at financial close was under the adjusted PSC, representing a cost saving for the state of \$70 million or 6.9 per cent.

The government publicly disclosed the final PSC and the NPC of the winning bid in a project summary of the project in early 2008.²

5.2.3 Assessment of bids

Expressions of interest

The expression of interest (EOI) document was released on 10 May 2006. The closing date for submission was 8 June 2006.

The six EOI responses were evaluated against a range of appropriate selection criteria including experience and capability, commercial and contractual structure, innovation and service delivery, financial capacity and the extent to which responses demonstrated understanding of the project vision, goals and objectives.

The EOI evaluation process was well documented, and the three short-listed respondents were invited to submit a proposal in response to the project brief.

Project brief evaluation

The project brief was approved and then released to short listed respondents on 11 October 2006. The project brief was comprehensive. Its objectives and required outputs were consistent with the business case.

² The RCH project summary can be found on the *Partnerships Victoria* website at: <[http://www.partnerships.vic.gov.au/CA25708500035EB6/WebObj/080228-RCHProjectSummary_FINAL/\\$File/080228-RCH%20Project%20Summary_FINAL.pdf](http://www.partnerships.vic.gov.au/CA25708500035EB6/WebObj/080228-RCHProjectSummary_FINAL/$File/080228-RCH%20Project%20Summary_FINAL.pdf)>.

The project brief set out the criteria to evaluate proposals. These were more specific than the criteria used at the EOI stage, and were tailored to the specific requirements of the redevelopment project. The evaluation criteria and sub-criteria were allocated weightings to determine their relative importance in the overall evaluation of bids.

DHS advised that the weightings allocated to each of the criteria reflected discussions between DHS and RCH. However, these discussions were not recorded and there is no documented rationale for the weightings.

As the allocation of weightings to evaluation criteria is a matter of judgement we have no concern with the weightings applied in this instance, but suggest that the underlying rationale should be documented to maintain the transparency of the procurement process.

A project brief evaluation plan was finalised in February 2007 documenting the methodology to be used in the evaluation of proposals. It outlined the formation of an evaluation panel to assess the proposals with advice from technical, commercial and service sub-panels. These, in turn, could access expert advisers to assist in the evaluation process. For example, there were 10 RCH advisory groups convened to support the evaluation of the technical sub-panel. These RCH advisory groups were from a range of functional and clinical areas within the hospital.

The evaluation panel received three proposals at the project brief stage by the closing date of 15 March 2007. Each proposal was rated, ranked or scored by the sub-panels on the basis set out in the evaluation plans. Sub-panel assessments of each proposal were used as the basis for the detailed report by the evaluation panel that documented its overall appraisal of each proposal and explained the scores and rankings awarded. The evaluation panel report ranked two proponents ahead of the third-ranked bidder.

The probity auditor signed off on the evaluation report on 21 May 2007. It was subsequently agreed by the project steering committee and government that the two highest ranking proponents would be invited to participate in a structured negotiation phase (SNP) to address key issues associated with their proposals. On 30 May 2007 the Minister for Health publicly announced that the shortlist of consortia had been reduced to two proponents.

The evaluation process at both the EOI and project brief stage was well documented and fair to all proponents. The decisions were justifiable on the basis of the requirements and the selection criteria declared in the project brief.

Structured negotiation phase and further evaluation

Following the assessment of responses to the project brief, two of the proponents were invited to participate in an extended bidding process or SNP. An evaluation plan was developed for this stage of the evaluation process and signed off by the project steering committee and the probity auditor.

The SNP was conducted over a period of eight weeks during which time there was significant interaction between the state and proponents to address design, commercial and technical issues identified during the evaluation of proposals in response to the project brief. Interactive tender process protocols remained in place and were adhered to during this phase.

Key differences between the SNP evaluation process and the project brief evaluation phase included that:

- the state was able to respond directly to the bidders' designs and proposals, as opposed to merely referring back to the project brief
- a key objective of this phase was to reach agreement, as far as possible, on the terms of the project agreement and ancillary contracts.

As part of the SNP the two proponents submitted revised offers on 26 July 2007. These revised offers were assessed by the evaluation panel and relevant sub-evaluation panels in accordance with the evaluation plan. The SNP evaluation report was finalised in late August 2007 and recommended that the offer submitted by CHP be selected as the preferred solution.

The evaluation panel concluded that the SNP was beneficial to the overall outcome for the state with both bidders submitting revised offers that included significant improvements over the proposals submitted in response to the project brief at the RFP phase, in relation to both design and commercial terms.

Both revised offers were considered to represent value for money in comparison to the public sector comparator of \$1.016 billion, with the recommended offer having a risk-adjusted net present cost of \$953 million.

The government endorsed the evaluation panel's recommendation in early September 2007. The state then entered into a period of exclusive negotiations with CHP. In order to maintain some competitive tension during this period the state also retained the right to revert to negotiations with the other proponent.

Government approval of procurement recommendation

The exclusive negotiation period was initially four weeks but this was extended to 31 October 2007 to enable all issues to be addressed. The issues addressed during this process related to design, legal, and commercial matters associated with the revised offer.

Following advice in early November 2007 on the outcome of the exclusive negotiations with CHP, the government approved execution of the project agreement by the Minister for Health and also authorised the project director to complete the financial close stage of the process on behalf of the state. The project agreement was executed on 20 November 2007 and financial close occurred in early December 2007.

CHP proposal to underwrite donations to the RCH Foundation

Part of the CHP offer included a proposal to secure donations of \$35 million to the RCH Foundation from investors in the project. This commitment was underwritten by Babcock & Brown International Pty Ltd (BBIPL), a member of the CHP consortium.

This commitment was not factored into the calculation of the net present cost of the CHP offer for comparison with other offers and the PSC and DHS advised that it was not a decisive factor in the selection of the CHP proposal as the preferred offer.

Advice to government in early November 2007 on the outcome of the exclusive negotiations with CHP made reference to the \$35 million in underwritten donations as an **additional benefit** of the CHP offer. The government was advised that the \$35 million in donations would greatly assist the RCH in meeting its commitment to government to contribute \$50 million towards the cost of the project.

A deed poll was executed by BBIPL on 26 November 2007 in favour of the Minister for Health on behalf of the state, and the RCH Foundation, in an effort to provide the state with certainty that the \$35 million in underwritten donations would be paid. The primary obligation of BBIPL as stated in the deed poll was to 'undertake to procure' the payment of the donations to the RCH Foundation over a four year period, with the full amount to be paid by June 2011, subject to the terms of the deed poll.

Due to the downturn in global financial markets, issues have subsequently emerged around the timing and certainty of receipt of the \$35 million, as well as the practical enforceability of the commitment.

Legal advice obtained by the state in January 2009 indicated that BBIPL's obligation to underwrite third party donations to the RCH Foundation are unsecured and that in the event BBIPL became insolvent the state and the RCH Foundation would be entitled to lodge claims as unsecured creditors of BBIPL.

BBIPL did not pay the first instalment of the \$35 million due on 30 June 2008 and sought permission to delay payment. This is allowable under the terms of the deed poll. Given the downturn in global financial markets in 2008, and the detrimental impact this has had on the financial position of BBIPL the \$35 million in donations expected to be paid to the RCH Foundation is now far less certain.

The state is monitoring BBIPL's financial position and considering its options if the expected donations do not eventuate.

Failure by BBIPL to procure the \$35 million in donations may result in RCH having to fund the entire \$50 million contribution which was expected by government to be generated from fund-raising activities. Ultimately, however, if RCH is unable to raise these funds, the state will have to meet any shortfall.

5.2.4 Other value for money considerations

Partnerships Victoria guidance material indicates that a PPP bid evaluation process should be focussed on value for money and address both qualitative factors and quantitative considerations. Qualitative factors, by definition, are not fully priced in the PSC as they cannot be accurately quantified.

The value for money qualitative assessment of RCH proponent bids drew on extensive evaluation criteria on issues including service delivery, design amenity, and sustainability. This was in line with *Partnerships Victoria* guidance.

Examples of qualitative issues addressed in the evaluation include:

- service delivery in terms of the quality of services offered
- functionality and operational efficiency of the submitted designs
- design amenity and the flexibility and expansion capability of the facility
- environmental values and sustainability issues offered by the submitted designs
- construction methodology, management processes, and proposed strategies for working with the state and RCH to achieve a seamless transition to the new facility.

As required by *Partnerships Victoria* policy, a public interest test was also conducted.

We are satisfied that the qualitative assessment of value for money of the RCH proponent bids was adequate.

5.2.5 Quality review of consultants' work

The DHS project team worked closely with consultants and relied on their expertise during development of the investment evaluation and business case including the PSC, as well as the project brief, bid evaluation and project agreement phases of the project.

Unlike the development of the preliminary PSC, the project team advised that there were quality reviews of paperwork and output produced by consultants that were completed as part of their internal monitoring process, however, no documented evidence of such reviews could be provided.

DHS should undertake and document sufficient quality review processes in relation to key information, analysis and advice relied on in planning and executing significant projects such as the new RCH.

A quality review would reduce risks of error or inaccuracy, and ensure that the state has sufficient understanding of highly complex and integrated financial models that underpin a PSC.

5.3 Procurement rules and guidelines

This audit assessed whether the procurement for the redevelopment project was conducted in line with relevant policy and guidance, focussing on whether:

- the procurement approach complied with *Partnerships Victoria* Guidelines
- any post-tender project scope changes or proposed contractual terms materially impacted on the tender put to market
- the project agreement allocates risk between the parties in line with the *Partnerships Victoria* guidelines and protects the state's interests (including professional indemnity, dispute resolution, and abatement/liquidated damages clauses)
- probity was enforced and maintained through all key procurement stages, including any structured negotiations and prior to awarding the contract
- the state was provided with soundly based assurance that the conduct of the procurement process met probity and other relevant government procurement requirements.

5.3.1 Compliance with *Partnerships Victoria* guidelines

The *Partnerships Victoria* Practitioner's Guide provides the framework for the establishment of partnerships with private sector entities for the provision of public infrastructure and related services.

Documentation relating to all of the required procurement milestones was available and the procurement process was conducted in line with *Partnerships Victoria* guidelines.

In particular, the following was observed:

- a PSC was constructed and updated throughout the evaluation process
- an output specification was produced (in the form of the project brief)
- appropriate approvals were obtained
- the evaluation of the bids was undertaken against previously determined criteria stipulated in the evaluation plan.

The state conducted a competitive tender process to identify the preferred private sector consortium to deliver the new RCH project.

The procurement approach complied with the expected elements of VGPB policy and guidance and the procurement exercise complied with the *Partnerships Victoria* guidelines.

5.3.2 Fairness and equity of tender processes

Changes to the scope of the project both prior to and after the signing of the project agreement were reviewed to determine if there were any material impacts on the output requirements set out in the project brief put to market.

Some changes were made to the project's scope in terms of functional design, and contract terms between issuing of the project brief and signing of the project agreement. There have also been some agreed design modifications made subsequent to the signing of the project agreement. This situation is common to projects of this size and nature.

The changes to the scope of the project have not materially impacted on the output requirements in the project brief put to market in 2006. DHS advised that all minimum design features, facility requirements and contract terms agreed at the time of the project agreement have been met. Any changes agreed subsequently have been approved by the steering committee and reflect improvements or enhancements on these minimum design features. We sighted the modifications register and reviewed the descriptions of all changes made.

The changes made prior to, and since execution of the project agreement, have been minor and have not materially impacted on the output requirements encapsulated in the project brief put to market.

The project agreement permits the parties to amend or vary the project agreement provided that such amendment or variation is made in writing executed by both parties. There have been no deeds of variation to the project agreement since its execution in November 2007.

5.3.3 Risk allocation between the parties

One of the principles of the *Partnerships Victoria* policy is the allocation of key project risks to the party who can best manage those risks, in order to achieve value for money and the best outcomes for the state.

The *Partnerships Victoria* risk allocation and contractual issues guide provides further guidance, including government preferred risk allocations in PPP projects.

Risk allocation in the RCH project agreement

In *Partnerships Victoria* projects, the state seeks to achieve best value for money by allocating particular risks to the party best able to manage them at the least cost. This process results in risks being either:

- retained by the state
- transferred to the private sector
- shared between the parties.

The project agreement is the mechanism used to establish the obligations of each party in relation to these risks.

We reviewed the risk allocation in the project agreement for consistency with *Partnerships Victoria* policy and guidelines. The risk allocation was endorsed by DTF, DHS and expert legal advisers. We conclude that the state's interests were protected and that the risk allocation in the project agreement was broadly in line with *Partnerships Victoria* policies and guidance.

DHS advice shows that there have been 17 departures from *Partnerships Victoria* risk allocation principles in the RCH project agreement and that a number of the departures were subsequently incorporated into a revised version of the *Partnerships Victoria* principles.

Our review of the 17 departures indicates that a number of them did not improve the risk allocation in favour of the state. In these instances the outcome seems reasonable given the realities of the positions adopted by bidders for the new RCH project and the commercial dynamics of the negotiations.

We accept that these departures were appropriate and justified, with none representing a fundamental departure from the *Partnerships Victoria* principles.

Indemnity, dispute resolution and liquidated damages

The project agreement requires the project company to indemnify and keep the state and the state's associates indemnified from and against all claims, and the project agreement stipulates the method for dealing with disputes.

In terms of construction, if final completion does not occur by the required completion date the project company must pay the state liquidated damages determined in accordance with a formula in the project agreement.

During the operating phase, in the absence of negligence or any other default event trigger, on the part of the project company, abatement of the service payment is the main remedy available to the state for a failure to meet service standards.

The payment and abatement regime reflected in the project agreement supports the risk transfer objectives of the state and provides appropriate financial incentives for the project company to deliver the project on time and to meet its obligations during the operating phase.

5.3.4 Probity throughout key procurement stages

To assist public sector agencies in conducting their commercial transactions with probity, DTF has produced *Best Practice Advice on Probity* and the Victorian Government Purchasing Board (VGPB) requires a probity auditor to be engaged for all procurements in excess of \$10 million. The procurement process for the new RCH project was assessed against the probity guidelines and requirements set out by DTF and the VGPB.

A probity auditor was appointed for the new RCH project procurement process and a probity plan was developed and approved. The primary task of the probity auditor was to independently assess whether the state ran an open and fair process that complied with the probity plan.

The key principles to be assessed were:

- fairness and impartiality
- use of a competitive process
- consistency and transparency of process
- security and confidentiality
- identification and resolution of conflicts of interest
- compliance with government policies as they apply to tendering.

In order to assess whether appropriate records were maintained, we examined probity reports and steering committee minutes.

We viewed all steering committee meeting minutes over the procurement period and are satisfied that the probity auditor was involved at all key stages including the development and finalisation of evaluation criteria, plans and final reports.

Minutes were taken for all briefing meetings with project proponents. These minutes listed topics discussed but did not include a detailed record of discussions held to ensure fairness in the treatment of proponents can be independently monitored and evaluated. This is inconsistent with *Partnerships Victoria* guidance, which recommends that all meetings be recorded and transcribed.

The probity auditor was invited but was not present at these briefing meetings or workshops with project proponents. This is consistent with *Partnerships Victoria* guidance which specifies the probity auditor may, but is not required, to attend all proponent meetings.

We reviewed three reports by the probity auditor to the project director. All three reports confirmed that the procurement process had been conducted in accordance with the probity principles established for the tender. We also noted that the reports were consistent with the format specified by the VGPB. In addition, steering committee minutes note that the probity auditor was present at all meetings of the evaluation panel at both EOI and RFP/SNP stages.

We therefore conclude that, overall, the expected standards of probity were maintained and enforced for this major public sector project procurement.

6 Infrastructure and services

At a glance

Background

The *Partnerships Victoria* approach focuses on the purchase of service outputs within agreed quality, quantity and timeframe parameters. This approach differs from traditional public sector procurement methods which usually focus on delivery of an asset or a specified service input.

It is important for the state to effectively manage its involvement during both the construction and the operating phases of the new RCH project to achieve the expected outcomes and value from the PPP arrangement.

Key findings

- The Government is adequately managing its involvement in the design and construction phase of the project.
- The timing of development of the state's contract administration manual is not consistent with the Partnerships Victoria guidelines and needs to be progressed. Also, project management documentation requires enhancement, to give more assurance that project risks are being effectively managed.
- The governance framework for the project allows effective communication between relevant parties, as well as assessment, monitoring, reporting and actioning of emerging issues and risks.
- The state's actual project costs to date are on target and are forecast to remain within the approved budget.
- The project company's construction schedule is on target and the independent reviewer appointed for the project has recently reported that the project remains on track for the 21 September 2011 technical completion milestone.
- The state is actively monitoring any impact on the project of the downturn in global financial markets. Approximately \$1.38 billion in debt and equity funding for the project was contributed in December 2007 and remains in place, in authorised investments.
- The project agreement adequately defines the services to be delivered by the project company during the operating phase of the new hospital and includes a comprehensive performance monitoring and reporting regime.

At a glance – *continued*

Key recommendations

- DHS and RCH should promptly execute a memorandum of understanding setting out their respective responsibilities in relation to the project. (**Recommendation 6.1**)
- DHS should complete and endorse the RCH contract administration manual and address observed gaps and weaknesses in project management documentation as a priority. (**Recommendation 6.2**)

6.1 Introduction

The government's *Partnerships Victoria* approach focuses on the purchase of service outputs within agreed quality, quantity and timeframe parameters. This approach differs from traditional public sector infrastructure procurement methods which usually focus on delivery of an asset or a specified service input.

Contracts entered into by the state with the private sector for *Partnerships Victoria* projects differ from traditional 'design and construct' contracts because they are long-term service contracts with ongoing performance-based payments for services, instead of upfront milestone payments for the construction of an asset.

As the focus of public private partnerships (PPPs) is on the long-term, effective contract management—including performance monitoring—is critical to the state's achievement of the expected value from the arrangement during both the construction and the operating phases.

To assess whether there is adequate supervision of the delivery of high quality infrastructure and services for the RCH redevelopment project, the audit examined:

- the state's management of its involvement in the design and construction phase of the project
- arrangements to supervise the long-term role of the private sector partner during the operating phase of the arrangement.



Excavation and early construction works at the new RCH site in August 2008.

6.2 Design and construction phase

In assessing the state's management of its involvement in the design and construction phase of the project the audit examined whether:

- there are effective governance arrangements in place to enable the state to effectively oversee, manage and govern its involvement
- there are effective management systems and processes in place to enable the state to effectively oversee and manage its involvement
- key performance criteria and standards for the construction phase exist and are monitored and enforced by the state
- incentives and sanctions/penalties relating to non-performance during the construction phase exist and are able to be enforced where necessary
- risks during the construction phase are comprehensively identified, documented and actively managed.

6.2.1 Project governance

The new RCH project is a major project and the Department of Human Services (DHS) has the lead role in supervising delivery of the project.

A governance structure for the project has been established as described in Part 3 of this report.

A dedicated project team has also been established within DHS and is led by a project director, who is responsible for management of the project on a day to day basis. Specialist project support is provided to the DHS team by the RCH which has set up its own project team.

A project control group (PCG) provides a focus point for the state and the private sector project company to meet and review the overall progress of the project. The PCG is chaired by the DHS project director and includes representatives from RCH, the project company, and the company engaged by the project company to build the new hospital.

The PCG meets monthly and is a consultative forum only, with no binding powers under the project agreement. The PCG reviews monthly progress reports and reviews issues associated with the project such as progress of design and construction activities, safety, demolition, resourcing and personnel, public relations and community consultation on the project, quality assurance, and design modifications.

Overall, the governance framework for the project provides for effective communication between relevant parties as well as the assessment, monitoring, reporting and actioning of emerging issues and risks.

Memorandum of understanding between DHS and the RCH

DHS has prepared a draft memorandum of understanding (MoU) to provide a governance framework between DHS and the RCH to manage the state's interests and responsibilities under the project agreement with CHP.

The content of the draft MoU deals primarily with the design and construction, and completion phases of the project. The draft MoU also sets out the requirement for RCH to contribute \$90 million towards the cost of the project to reduce the net cost to the state.

DHS advised that the draft MoU has been agreed at officer level at both RCH and DHS, and that both parties are working within the framework it establishes. However, neither party has executed the MoU.

Recommendation

- 6.1 DHS and RCH should promptly execute a memorandum of understanding setting out their respective responsibilities in relation to the project.

6.2.2 Management systems and processes

A dedicated project team is in place within DHS to manage the state's involvement in the project on a day to day basis. The state's role during the design and construction phase of the project is to manage the contract or project agreement in place with the project company and to manage its involvement in the design and construction process in accordance with the provisions of that agreement.

Consistent with other PPP arrangements, responsibility for the construction of the new hospital rests with the project company, not the state.

The role of the state's project team encompasses both contract management and project management activities. The audit sought to assess whether adequate management systems and processes are documented and in place to enable the state to effectively oversee, manage and govern its contract management activities as well as its involvement in the project.

On this basis, the audit examined whether there is clarity and documentation to support the 'what', 'how', 'who' and 'when' relating to the discharge of the state's role.

Contract management

The *Partnerships Victoria* guidance requires development of a contract management plan (CMP) as the first step in developing and maintaining an effective contract management strategy. Specifically, the CMP covers all material areas of contract administration under the project agreement and is the precursor and foundation for the development of the contract administration manual (CAM).

The guidance requires:

- an initial CMP to be developed (and with sign-off obtained from senior management) early in the procurement process prior to the commencement of the CAM
- a final CMP (even before the completion of the CAM) should be completed as soon as possible after the execution of the contract and during the transition from procurement to contract management
- a final CMP, including details of the CAM, should be submitted to government within three months of contract execution to inform government of the proposed contract management strategy.

These requirements were met for the RCH project and a final CMP, including an outline of the CAM, was submitted to government in early 2008, which was within three months of completion of the contract for the project.

The *Partnerships Victoria* guidance states that the implementation of a CMP—by the development of an effective CAM—is a key activity for the state during the procurement phase of the project and the transition from the procurement phase to construction and service delivery.

The guidance is equally clear that a CAM should be developed to assist the contract management function during the design and construction phase of the project. This was reinforced in an addendum to the *Partnerships Victoria* Contract Management Guide during September 2008 which was made in response to a recommendation made in our June 2008 report to Parliament on the new Royal Women's Hospital PPP project¹.

The CAM is a centralised collection of documentation for all the tools and processes used in managing the contract and should cover:

- governance, probity and compliance
- contract administration
- performance reporting and monitoring
- communication, relationship management, issue management and dispute resolution
- design, construction, and commissioning planning
- risk management
- knowledge and information management
- change management
- contingency planning
- records and document management
- ongoing review and development.

While a CAM outline was included in the CMP which was provided to government in February 2008, there has been no further development of the CAM. This is a departure from the guidance and many of the target completion dates included in the CAM outline provided to government.

¹ Victorian Auditor General's Office (2008), 'The New Royal Women's Hospital—a public private partnership', Victorian Government Printer, Melbourne, 25 June.

A review of the CAM outline indicates that all components, as defined in the *Partnerships Victoria Contract Management Guide*, will be included.

Developing the CAM is an evolutionary process and some elements of the CAM may not need to be finalised until closer to the operating phase for the new hospital. However, other elements of the CAM are clearly relevant and required during the design and construction phase of the project. During this audit DHS advised that resources will be assigned to complete the CAM.

The available evidence indicates that the project team's management and administration of the contract has been effective to date and has protected the state's interests. Addressing the development and implementation of the CAM in a timely manner will provide further assurance that the state's risks around this project can be managed effectively.



Construction progress on the new hospital in late January, 2009.

Project management

Some activities undertaken by the DHS team managing the state's involvement in the project are in the nature of project management activities. Accordingly a project management budget has been approved by government. At the end of the design and construction phase the project team will hand over management of the state's involvement in the project to a contract management team.

In these circumstances and particularly given the absence of a fully developed CAM, we sought evidence of conventional project management documentation to support the 'what', 'how', 'who' and 'when' relating to the discharge of the state's role during the design and construction phase.

Typically, these activities would be captured in key documents such as a project management plan, a project work breakdown structure, and a project schedule. Such documentation is relevant because not all of the important tasks and activities to be performed by the state's project team are set out in the project agreement.

We found minimal project management documentation, with management of the project heavily reliant on the use of informal processes and the knowledge of key staff. While these key staff clearly have significant relevant expertise and experience in managing PPP projects and contracts, a lack of project management documentation is a significant risk to project continuity in the event that any of the key staff either left the project or became unable to work.

The following project management systems and processes—based on the Project Management Body of Knowledge (PMBOK) developed by the Project Management Institute²—were assessed for the design and construction phase of the project. This assessment was made in the context of the state's involvement in the 'larger' project that encompasses the construction of the new hospital and involves parties other than the DHS project team:

- **integration**—effective and accountable governance/supervision systems in place
- **scope**—well defined and specified in detail, with variations actively managed
- **time**—realistic and achievable milestones and deadlines in place
- **cost**—budget versus actual costs are analysed and variations minimised wherever possible
- **quality**—active quality assurance of materials, design and construction
- **human resources**—capable and skilled personnel employed in key areas
- **communications**—effective strategy for all identified stakeholders
- **risk**—comprehensively identified, documented and actively managed.

² More information about the Project Management Institute can be found at <<http://www.pmi.org>>.

Integration

Project relationships, roles and responsibilities of the parties, groups and committees involved in the design and construction phase have been well defined and articulated across the project documents.

The project is operating in an integrated manner with all the various stakeholders, both internal and external to the project, periodically consulted on the project.

Scope

The overall scope of the construction of the new hospital has not changed materially since the approved business case, with all the high-level objectives of the project captured in the project agreement.

The project agreement permits the parties to amend or vary it, provided that amendments or variations are in writing and executed by both parties. The project agreement has not been varied to date.

Despite the lack of key project management documents, there was considerable evidence demonstrating that the DHS project team has established effective management processes covering the state's involvement in the design process, design modifications and scope variations.

Time

The project agreement sets out clear milestones for the construction phase. The project company construction schedule is on target and the independent reviewer appointed for the project has recently reported that the project remains on track for technical completion by the 21 September 2011 milestone.

The PCG monitors the project schedule by receiving a report from the builder and the project company at monthly meetings.

Cost

Design and construction costs for the hospital—other than for state attributable variations—are to be fully met by the project company during the construction phase of the project. As the project is a PPP, funding for the delivery of the facility is an agreed sum, disbursed over the life of the agreement in accordance with the payment schedule contained in the project agreement.

The project agreement requires the project company to deliver a 'fit-for-purpose' facility that has been constructed in accordance with a set of detailed design requirements. Under this arrangement, the majority of the construction risk has been transferred to the project company. To deliver its construction obligations the project company has engaged a builder under a fixed time and price arrangement.

The project company is only entitled to capital cost variation under a limited set of circumstances clearly defined in the project agreement and it is not entitled to receive any payments before the final completion milestone date of 22 December 2011 has been achieved.

The state will commence payment of quarterly service payments (QSP) when the building is commissioned. The QSP cover the build cost and the cost of delivering services over the life of the agreement. The QSP will be managed through the performance monitoring and abatement regime discussed earlier in this report.

Figure 6A sets out amounts approved by government for project costs relating to the new RCH—excluding QSP—as well as actual costs, as at January 2009.

Figure 6A
Approved budget items and actual costs for the RCH project

Funding	Approved budget (\$M)	Actual expenditure at 30 June 2008 (\$M)
Project management ^(a)	27.26	14.60
Royal Park reinstatement	4.60	0.00
Total	31.86	14.60

(a) The initial budget approved in November 2007 for project management costs was \$24 million based on a four year construction period. This budget was increased by \$3.2 million in April 2008 to reflect the five year construction period.

Source: Victorian Auditor-General's Office, using data provided by DHS.

Under the project arrangements, the state must fund reinstatement works relating to Royal Park upon completion of the construction of the new hospital and the decommissioning and demolition of buildings on the existing RCH site. Funding of \$4.6 million has been approved for this task.

The project company's contractual responsibilities in this area do not extend beyond remediating the existing hospital site to a standard suitable for park reinstatement. A brochure issued by the state in relation to the project in its early planning phase indicated that the park would be reinstated by 2011, however park reinstatement activities are only planned to commence in late 2013.

To date, the state's actual project costs are on target.

Quality

The project brief specified detailed project outputs, including quality expectations. The project company is contractually obliged to satisfy the performance and functionality requirements, and provide a facility that is 'fit-for-purpose' at final completion.

The project agreement establishes a rigorous regime to monitor, verify and report on quality matters during the construction phase. This regime requires the project company to develop a quality management plan and implement a quality program. There is evidence to indicate that the quality management plan is in place and that the quality program is working effectively.

Under the project agreement, an independent reviewer is appointed to ensure that scope requirements, as outlined in the project agreement, are met. The independent reviewer is required to provide an endorsement on final completion, to ensure that the final design satisfies the project's objectives.

Human resources

Descriptions of the various key roles and responsibilities for organisations and individuals involved with the project are provided in the project agreement.

Position descriptions have been produced by the various state entities that have staff allocated to the project, detailing accountabilities, knowledge and skills, expertise, desirable qualifications, and selection criteria for these roles.

The personnel assigned to the project by the state have the skills necessary to undertake the various project roles and have considerable experience in managing PPP projects.

Communications management

A communication strategy for the new RCH project was completed by DHS in August 2007. The strategy provides a comprehensive approach and action plan for the effective engagement of key stakeholders. The project team has publicly released a RCH project summary and launched a project website³. These media provide general information on the history and status of the project.

To provide clear and consistent messages, the project team has developed a communications protocol that covers the release of information to stakeholders during the construction phase. This protocol is being observed by state parties with an interest in the project and is working effectively.

Risk

Risk management is an integral part of the management of the project. It was evident from our review of the PCG meeting minutes that risk analysis and risk management are being integrated into the overall management of the construction activities being undertaken by the project company.

In addition, monthly reports prepared by the independent reviewer play an important role in the overall management of project risk. These reports form part of the PCG report and are reviewed at each PCG meeting.

³ The new RCH project website can be found at <<http://www.newrch.vic.gov.au>>.

Introducing risk as a separate agenda item at the monthly PCG meeting and including a separate risk section in the monthly PCG reports would place the PCG in a better position to focus on risk with consolidated information.

The DHS project team has established a risk register, and the review of the risk register is a standing item on steering committee meetings, which are held quarterly. The risk register is updated by the project director with input from the PCG and the steering committee. The project director attends both the steering committee and PCG meetings.

There are adequate risk management arrangements in place and operating. Even so, the consolidation of risk reporting within PCG reports would assist overall risk management.

6.2.3 Incentives and sanctions/penalties

The main incentive for the project company to achieve construction milestones is that it will not receive QSP until final completion has been achieved and certified by the independent reviewer.

The project agreement includes an abatement program that will reduce the QSP as a result of performance issues with the service provider, including building maintenance. This encourages the project company to ensure the facility is 'fit-for-purpose' as any building maintenance issue could result in reduced QSP during the operating phase of the arrangement.

6.2.4 Transitioning to the new hospital

The project agreement sets out requirements for a transition process when construction of the new hospital is completed. The project company is required to develop a transition plan and a training plan in consultation with the state and the RCH. The company also needs to submit these plans to the state for approval at least 12 months before the target date for stage one technical completion (21 September 2011).

In addition to the requirements of the project agreement, the RCH is expected to develop a 'move' plan to facilitate the relocation and associated organisational change. That plan will outline how RCH will move patients, staff and equipment from the current hospital site to the new hospital as well as how they will deliver hospital services during that transition period.

6.2.5 Monitoring of project financing arrangements

Approximately \$1.38 billion in debt and equity funding for the project was contributed at financial close in December 2007 and is still in place, invested in authorised investments with two major Australian banks.

The project agreement and related project documents establish clarity around the project company structure and control and project financing arrangements and provide the state with considerable rights and powers in the event that changes occur or are sought in these areas.

There is clear evidence that the state is actively monitoring the impact of the recent downturn in international financial markets on the project company and related companies. The project agreement and finance documents include important powers and protections for the state and the project's financiers. In short:

- The state has security over the project's assets in order to secure performance of Children's Health Partnership's (CHP) obligations under the project agreement. The security enables the state to appoint a receiver over all or part of the secured assets.
- The project's financiers hold, via a security trustee, a number of securities in relation to the project, including a fixed and floating charge over the assets of CHP.

The respective rights and priorities as between the state and the security trustee are set out in the financier direct deed.

Financing arrangements

Babcock & Brown International Pty Ltd (BBIPL) was the original project sponsor of CHP's successful bid for the new RCH project and was the original owner of the equity investment in the project. CHP is the project company and the entity that has contracted with the state to deliver the project.

The project funding was provided to the project company by a combination of subscriptions for units in the CHP Unit Trust, of which the project company is the trustee, and loans from other companies within the project funding structure, where the money lent by those companies was in turn financed through unit subscriptions and the proceeds of three bond issues.

The Babcock & Brown group has been adversely affected by the recent downturn in international financial markets. The state obtained legal advice in late 2008 and early 2009 indicating that:

- all debt and equity funding for the project was paid to the project company on 27 November 2007

- Babcock & Brown International Pty Ltd (BBIPL)—the original project sponsor—and Babcock & Brown Public Partnerships (BBPP)—the subsequent sponsor after a change in control was approved by the Minister in 2008—were the underwriters of the equity requirement for CHP. Neither party has any on-going obligation to provide funding to the project, so accordingly there is no risk that funding already paid can be recovered.

The legal advice concluded that the project's construction costs are fully funded and that the state is a secure credit risk in terms of meeting future quarterly service payments once the hospital is completed and operating.

Babcock & Brown Limited (the Australian listed entity) is currently in voluntary administration while BBIPL (the ultimate parent company) continues to trade.

Change in project company control

During 2008 the state consented to two requests for changes in control over the equity interest in the project. The requirement for state consent is set out in the project agreement.

In addition to being the project sponsor, BBIPL was the beneficial owner of the equity investment in the project via a number of interposed corporate entities and trusts created for the purposes of the project.

The project vehicle, CHP, is the trustee of a unit trust, CHP Unit Trust, of which the units were owned by Children's Health Partnership Holdings Pty Ltd (CHP Holdings) as trustee for the CHP Holdings Unit Trust. Ultimately, the units in the CHP Unit Trust and the CHP Holdings Unit Trust were owned by Pinnacle Infrastructure Pty Ltd as trustee of the Pinnacle Infrastructure Unit Trust. BBIPL is the ultimate holding company of Pinnacle Infrastructure.

As part of its tender submission, BBIPL proposed that it would transfer its equity interest in the project to its satellite investment fund, Babcock & Brown Public Partnerships Limited (BBPP). BBPP is listed on the London Stock Exchange and was established by BBIPL specifically for the purposes of investing in public infrastructure assets. It has equity in a number of Australian PPP projects including the Royal Melbourne Showgrounds redevelopment project. Around 92 per cent of shares in BBPP are owned by public investors with the remaining 8 per cent held by BBIPL.

In May 2008, BBIPL sought the state's approval to transfer ownership of the project by transferring the units in the CHP Holdings Unit Trust from the Pinnacle Infrastructure Unit Trust to BBPP (Aust) Limited, a subsidiary of BBPP. BBPP would thus become the beneficial owner of the equity in the RCH Project by virtue of its ownership of BBPP (Aust) Limited.

The Minister for Health approved the sale to BBPP in June 2008, based on advice from DHS. DHS did not obtain documented legal advice to support its advice to the Minister for Health on this matter.

Although the equity in the project (via the units in the CHP Unit Trust and CHP Holdings Unit Trust) was transferred to BBPP in mid 2008, there was no concurrent transfer of control/ownership of the respective trustees of the two unit trusts (CHP and CHP Holdings). These two companies are owned by Babcock & Brown Transactions Pty Ltd (BB Transactions), and through a range of intermediary organisations, are ultimately controlled by BBIPL.

DHS analysis indicates that the shares in the two trustee companies should have been transferred to BBPP at the same time as the sale of the units in the unit trusts. However, this did not occur.

In November 2008, CHP wrote to the state's project director requesting that the state consent to the transfer of BB Transactions' interest in both trustee companies to BBPP (Aust) Limited—a wholly owned subsidiary of BBPP.

DHS analysis indicated that the sale of the shares in CHP and CHP Holdings would effectively place both the unit trusts and their associated trustee companies in the control of BBPP. This would then complete the sale and allow the ownership structure of the RCH project to move from BBIPL, which would then retain a very small indirect interest via its minority shareholding in BBPP.

The Minister for Health consented to the transfer of the shares in Children's Health Partnership Pty Limited and Children's Health Partnership Holdings Pty Limited, to BBPP (Aust) RCH Limited in December 2008 based on advice from DHS. DHS did not obtain documented legal advice to support its advice to the Minister for Health on this matter.

The DHS advice to the Minister in December 2008, which recommended that he give this consent, indicated that BBPP was a solvent and reputable entity. DHS made reference to an external audit report dated 14 March 2008 and further advised that BBPP is listed on the London Stock Exchange with a market capitalisation in excess of £300 million.

The currency of the information put to the Minister could be queried due to the present global financial market uncertainty. More up to date information on the financial position and outlook for BBPP should also have been obtained. This is because under the project agreement the solvency and reputation of BBPP are relevant considerations for the Minister when assessing the request for consent to the transfer in ownership.

6.2.6 Conclusion on the construction phase

Overall, the state's involvement in the design and construction phase of the project is being well managed. The governance arrangements for the project provide an effective framework for communication with the relevant parties as well as the assessment, monitoring and actioning of emerging issues and risks.

DHS needs to address the slow progress of development of the CAM and further enhance the project management documentation in place for the state's project team. Timely action on these matters will provide further assurance that the state's risks around this project are being effectively managed.

Based on our review of the state's current assessment of actual project costs we accept that they should remain within approved budget.



*An artist's impression of a single inpatient room in the new hospital.
(Image courtesy of Billard Leece Bates Smart and Sharp Design)*

6.3 Operating phase

To assess the adequacy of arrangements to supervise the long term role of the private sector partner the audit examined whether:

- key performance criteria and standards can be measured for compliance
- performance monitoring and reporting arrangements are appropriate
- contract management and contract administration plans are in place and supported by suitable governance arrangements and expertise.

6.3.1 Key performance criteria and standards

The project agreement specifies a number of services to be provided by the private sector during the operating phase, including:

- general services (management and corporate activities)
- helpdesk (for building faults and service issues)
- building management services
- utilities and medical gases management

- waste management
- security
- car parking
- grounds and garden maintenance
- pest control.

Each service has a ‘minimum service specification’ set out in an attachment to the project agreement. Every output described in the service specification has a corresponding ‘performance parameter’.

A performance parameter describes the level of performance (i.e. an agreed pass or fail benchmark) that the project company should achieve to comply with the output specification.

Performance against documented benchmarks will be used in the second and subsequent years of operation to set annual key performance indicators which are directed at driving service improvement.

The project company must agree the ranges for each service with the hospital operator and the state’s contract administrator.

6.3.2 Performance monitoring and reporting

The project agreement includes a robust performance monitoring and reporting regime for the operating phase of the arrangement.

The project company is required to develop a performance monitoring program and report against this program as a means of monitoring its own performance in providing the services. The reporting requirements include the creation and provision of a monthly performance report and a quarterly performance report.

The project company is required to notify the state’s contract administrator promptly if it identifies any risk to its ability to continuously provide the services to at least the services specifications.

The project company’s monthly performance report must provide sufficient information to enable the contract administrator to calculate the QSP for each operating month and must also specify any failures and the project company’s estimate of the deduction to be made from the QSP.

The project company must also report half-yearly on its performance against each key performance indicators to RCH and the contract administrator, together with an action plan to improve performance if it falls below acceptable levels.

Under the project agreement, the state may also monitor, review or conduct audits of the project company’s performance or its performance monitoring system and program. The project company is required to provide any assistance and documents required for these processes.

A facility management committee, chaired by the contract administrator, will be set up to examine matters relating to the provision of services during the operating phase of the arrangement.

6.3.3 Contract management and administration plans

Effective contract management by the state during the operating phase of a PPP is critical to realising and maximising the value from the arrangement.

Specific guidance on contract management is provided in Chapter 4 of the *Partnerships Victoria* Contract Management Guide. The guidance requires a contract management strategy and a contract management team to be established at the beginning of the procurement stage, with transfer of their responsibility to the contract director/administrator at the completion of the procurement process.

The CMP for the RCH project was developed within the required timeframe but the CAM has not been completed. This needs to be addressed by DHS.

The project agreement specifies that a contract administrator for the RCH project must be appointed at least three months prior to the stage one completion date (22 December 2011). Prior to this date the state is represented by the project director.

The role of the contract administrator is to exercise the powers, duties and discretions detailed in the project agreement on behalf of the state, and monitor the project company's compliance with the obligations detailed in the project agreement.

6.3.4 Conclusion on operating phase

The information contained in the project agreement and schedules about expected service delivery specifications is reasonable in terms of the required services to be delivered. The project agreement also includes a comprehensive performance monitoring and reporting regime.

Partnerships Victoria guidelines were not fully complied with in terms of the timing of development and finalisation of the CAM, with the CAM remaining incomplete at the time of this audit report.

Recommendation

- 6.2 DHS should complete and endorse the RCH contract administration manual and address observed gaps and weaknesses in project management documentation as a priority.
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Auditor-General's reports

Reports tabled during 2008–09

Report title	Date tabled
Managing Complaints Against Ticket Inspectors (2008–09:1)	July 2008
Records Management Checklist: A Tool to Improve Records Management (2008–09:2)	July 2008
Investing Smarter in Public Sector ICT: Turning Principles into Practice (2008–09:3)	July 2008
Private Practice Arrangements in Health Services (2008–09:4)	October 2008
Working with Children Check (2008–09:5)	October 2008
CASES21 (2008–09:6)	October 2008
School Buildings: Planning, Maintenance and Renewal (2008–09:7)	November 2008
Managing Acute Patient Flows (2008–09:8)	November 2008
Biosecurity Incidents: Planning and Risk Management for Livestock Diseases (2008–09:9)	November 2008
Enforcement of Planning Permits (2008-09:10)	November 2008
Auditor-General's Report on the Annual Financial Report of the State of Victoria, 2007–08 (2008–09:11)	November 2008
Local Government: Results of the 2007–08 Audits (2008–09:12)	November 2008
Management of the Multi-Purpose Taxi Program (2008–09:13)	December 2008
Results of Audits for Entities with 30 June 2008 Balance Dates (2008–09:14)	December 2008
Preparedness to Respond to Terrorism Incidents: Essential services and critical infrastructure (2008–09:15)	January 2009
Literacy and Numeracy Achievement (2008–09:16)	February 2009
Administration of the <i>Flora and Fauna Guarantee Act 1988</i> (2008–09:17)	April 2009
Access to Public Hospitals: Measuring Performance (2008–09:18)	April 2009
Management of School Funds (2008–09:19)	May 2009

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