PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE MANAGEMENT AND OVERSIGHT OF THE PERTH CHILDREN'S HOSPITAL PROJECT

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 18 OCTOBER 2017

SESSION TWO

Members

Dr A.D. Buti (Chair)
Mr D.C. Nalder (Deputy Chair)
Mr V.A. Catania
Mr S.A. Millman
Mr B. Urban

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Hearing commenced at 10.16 am

Ms TRICIA LOUISE TEBBUTT
Partner, PricewaterhouseCoopers, examined:

Mrs TANYA WEST
Director of IPMO Services to PCH, PricewaterhouseCoopers, examined:

The CHAIR: On behalf of the Public Accounts Committee, I would like to thank you for appearing today to provide evidence relating to the committee's inquiry into the management and oversight of the Perth Children's Hospital project. My name is Tony Buti. I am the committee chair and member for Armadale. To my left is Hon Dean Nalder, the committee's deputy chair and member for Bateman, and to his left is Mr Vince Catania, member for North West Central. To my right is Mr Simon Millman, member for Mount Lawley, and to his right, Barry Urban, member for Darling Range. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything you might say outside of today's proceedings. Do you have any questions about your attendance here today?

The WITNESSES: No.

The CHAIR: Just before we continue, once a transcript has been progressed, or whatever the word is, it will be put up on the webpage for public viewing, but you will receive one that you can correct, which I will talk about later.

Before we ask you questions, do you have an opening statement you would like to make?

Ms TEBBUTT: Yes, I have prepared something very briefly. I thought it would be useful just to outline our role up-front. Some background to our role: we were awarded the contract to provide integrated program management services for Perth Children's Hospital commissioning transition task force in September 2015. The appointment of the IPMO, as it is known, was in line with the July 2015 PCH gateway review, which recommended that a key function be established within the Perth Children's Hospital project, which reports directly to task force. The role of the IPMO is to prepare consolidated reporting across the program to task force by providing, firstly, regular reporting of milestones from the constituent programs and agencies and also the different multiple stakeholders involved in the program; and, secondly, regular reporting of extreme and high risks and issues which have been identified by those programs and also emerging risks from the program. Our approach to running the IPMO has been based on our experiences from other hospital commissioning programs, including the work that we undertook at Fiona Stanley Hospital and Midland Health Campus.

In closing, I would just like to say that from my experience, this hospital commissioning project has been highly unusual. The scale and complexity of the construction issues has done and continues to provide significant challenges to all of the workstreams in the commissioning program. Thank you.

The CHAIR: Thank you. You mentioned that, as you say, you have been involved in other hospital projects. Of course, this one is bigger than the other ones you referred to, obviously, and you said you found this quite unusual. Can you just elaborate on that?

Ms TEBBUTT: I think in the projects that I have done before, there are always challenges. There is no doubt that opening a hospital is an incredibly complex matter. The difference for this particular one has been the level of construction issues, which I have never seen in any hospital project that I have been involved in. So, that is the key difference. They are always challenging. They are always complex. But the actual level and the volume of construction issues has been the key difference.

[10.20 am]

The CHAIR: You mentioned you came on board, the IPMO, in September 2015.

Ms TEBBUTT: Yes, we started in September 2015.

The CHAIR: Would the project have benefited from having the IPMO established prior to that?

Ms TEBBUTT: Good question. I mean, I think the task force is always set up, same as Fiona Stanley Hospital, at the point where the real commissioning process starts. So, you have obviously building commissioning and then you have clinical commissioning and it is really when those two pieces come together. I think the challenge—and again, if you take the experience with Fiona Stanley Hospital, the IPMO was in place quite late as well for Fiona Stanley. I think the benefit that the IPMO brought was consistent and regular reporting to task force at the level required by that committee. So, prior to our involvement, my understanding is reporting to task force came directly from the PCG reporting, which was undertaken by the PCH PMO.

The CHAIR: So how did PWC define risk on this project?

Ms TEBBUTT: Tanya, do you want to answer specifically this question?

Mrs WEST: Yes. I am happy to. So, it is not necessarily the role of the IPMO to define the risks. We would look at the risks that both the programs, both the construction program and commissioning program, have identified. We might be having conversations with them that says, "Well, you have mentioned this is slipping. Do you have a risk that correlates to that and defines what you are going to do?"—the focus being on the mitigations, which we refer to as treatment action plans—"What are you actually going to do? You are talking about this thing slipping." It is action focused on how to resolve that. So, in the main part, the two programs would identify the risk. We would report those risks when they became high or extreme, and that refers to issues as well—so, a risk being something that might happen and an issue being that that has actually happened, it has eventuated, and, therefore, what are you going to do about it to manage it to closure or at least reduction in the rating of the risk?

In addition to that, there might be risks that are discussed at the PCG level—so, at the project level—that are emerging risks that were not actually documented within the systems that they were using. So, we would not formally report them, but we included an emerging risk section in the task force reporting papers so that there was transparency about what was coming, what we were expecting to see, but also would drive the right conversation at the task force in order to be able to discuss with the people who were closest to that risk what was actually causing it, what they were doing to really identify the full scope of that risk and, therefore, what the impact was going to be, the likelihood and how they were going to action.

The CHAIR: So under the contractual arrangements, was John Holland required to deliver reports to the IPMO?

Ms TEBBUTT: Not John Holland. So, it would have been via Strategic Projects. We are actually key contacts for the construction program with the Strategic Projects team. And, then, obviously a key contact also within the PCH PMO was actually run by Ernst & Young, as well as obviously contacts within north metro, HSS and all of the other constituent areas.

The CHAIR: So the reports that you did receive, were they accurate? Did you find them to be delivering the true picture?

Mrs WEST: I would not even go as far as saying that they were reports. What we would receive from Strategic Projects is data. Our role was to turn that data into something meaningful and consistent in terms of reporting to task force. So they were getting the management information to inform decision-making. In receiving that data, we would analyse it and go back and verify it with Strategic Projects: "What we are seeing is that this has slipped and this has slipped. Is that the case?" They shared with us, in those verification meetings that would happen prior to us submitting our reports and finalising our reports, the challenges that they were having in terms of getting a robust program from the MC that they could even interrogate. Quite often, they would share with us that they would reject the programs that they had received because they did not have the level of rigour and accuracy that they were expecting.

The CHAIR: So you say you were given data and then you had to interpret that data and then report back to the task force; right?

Mrs WEST: I would not necessarily say the interpretation of that. We would take an understanding of that and verify that with them in order to inform the reporting.

The CHAIR: In that, would you give any recommendations to the task force of what needed to be done or not?

Mrs WEST: We might suggest to them that we wanted to talk or we might say to our client that we would meet with on a weekly basis in the department that actually these were the areas that we were concerned about and that therefore that would be our line of questioning within task force or that they might like to ask those questions.

Ms TEBBUTT: I think it is worth adding that one of the other things that we did say fairly early on is the IMP, which I am sure you will have heard about, was very much a scheduling tool, rather than a program management tool. We certainly were saying fairly early on when we were actually working to pull the reports together that there were challenges within the IMP in order to do what we needed to do to pull the information out.

Mr S.A. MILLMAN: Were there general themes that were coming through? For example, was delay a particular theme that was coming through in terms of the information that you were receiving?

Mrs WEST: Not necessarily in terms of specific issues, but the ongoing failure to deliver a program, failure to deliver a program when it was delivered that was considered robust and had the technical linkages and dependencies mapped within it, was ongoing. I know you have read many of the papers and you will see in our reporting quite often is "We have not received this", "Strategic Projects are still awaiting a revision of the program". So, that was the ongoing theme.

Mr S.A. MILLMAN: And in your view, what levers were available to the state in order to remediate that and then, going forward, are there other things we ought to incorporate in order to remediate that?

Ms TEBBUTT: Yes, I think it is slightly outside the scope of what we were allowed to do, but the frustration was absolutely evident. I can only really comment on what we overheard in task force. There was significant frustration about there did not seem to be the levers. Certainly, from my experience on these projects, I did not understand that process but that is not something we were directly involved in—but certainly plenty of frustration and evidence and, as Tanya said, effectively, not being able to get a program from the MC was a constant frustration.

Mr B. URBAN: I am glad you said data, by the way, not data.

Ms TEBBUTT: It is the English in me. I cannot get rid of it—sorry.

Mr B. URBAN: One of the things you did say, though, was that when you put together a scheduling tool for remedial work, I would assume from the information that you got, that then goes into a construction phase once that scheduling tool has been formulated, or you just give it an overriding comment.

Mrs WEST: We would not be involved in the scheduling of what is actually happening on the ground. That was the role of John Holland to provide their program and schedule and for Strategic Projects to oversee that from a quality assurance perspective. It was then our role to take a pull of that information and provide it to task force in a meaningful reporting way that would aid their decision-making so that they were getting a consistent report, that they knew where to look for things that might be slipping or forecasting something that might not be achieved within the timescale. We were not immediately involved in any of the scheduling.

Mr B. URBAN: So how did you define the risk that John Holland particularly was throughout the project—since September 2015? That is what you said. You give a risk level.

Ms TEBBUTT: We did not. The risks come from the constituent programs. Our role was to consolidate those and actually report to task force on the high and extreme risks that came from them. Again, as Tanya mentioned earlier on, if there was emerging risks from either discussions with those work streams or from PCG, we would actually report those to task force as well. As the IPMO, we did not actually develop the risks. We might have given suggestions from previous experience, but the risks were developed by the constituent programs.

The CHAIR: Were identified by them.

Ms TEBBUTT: Yes.

Mrs WEST: Identified and rated. So we might provide some challenge and say, "Do you really think that is only a medium risk, having thought about the fact that it might impact this, this and this?" That would be a two-way conversation but, ultimately, the accountability and ownership of that risk sat with the two programs—either construction or commissioning.

The CHAIR: As you said, you have worked on other projects and other hospital projects. Was the number of defects that were identified in this project unusual? Also, there was an assurance practice here. Was the assurance process stringent enough, do you think, in this project?

[10.30 am]

Mrs WEST: There are two parts to that. I certainly can talk to the first part in regards to the number of defects. Obviously, the opening of a hospital is complex and requires both of those—construction and commissioning—at some point in time to come together and drive through to open the hospital. There are some defects that you can open a hospital with. Some scuffs on the wall are not going to stop you opening a hospital, but you might be looking to the MC to correct those. To have the number of defects at this late stage has seemed unusual in comparison to the other commissioning projects that I have worked on. We would look to see a reduction in the same as we would look to see a reduction in risk. It is all about, at this stage, getting things behind you. To still have that number of defects feels high.

Mr V.A. CATANIA: So what other hospitals have you worked on?

Mrs WEST: Trish and I worked together on both the Fiona Stanley Hospital, where we ran the program management office on the ground, which is slightly different to the IPMO because that is working at the workstream level with the people who are commissioning the hospital, and also on the Midland campus.

Mr V.A. CATANIA: But in terms of the scale of the PCH, you have not worked on —

Ms TEBBUTT: Fiona Stanley is a very similar size. I worked on Barts in London in the UK as well, which was a massive redevelopment.

The CHAIR: Okay. Do you want to get back to —

Mrs WEST: The second part of your question referred to quality assurance. Are you talking about the quality assurance of products or the building or —

The CHAIR: For instance, the asbestos issue.

Ms TEBBUTT: Not directly. Anything I would say to you here would be via conversations that we had heard at task force. Our role was not to verify whether those checks were done correctly at any point. I could not really comment on that. Just to go back to the number of defects, I think there always is a huge number of defects. As Tanya said, they can be solved, some of them, post-opening. I think it is probably the severity of some of the defects which links into my earlier statement about how unusual this project was.

Mr S.A. MILLMAN: What has been the attitude of the MC in terms of remediating those defects? Have defects been notified and they have been remediated immediately? Or have defects been notified and you have had difficulty making sure —

Ms TEBBUTT: Again, I will comment but I can only comment from discussions that we have overheard, because we have had no direct dealings with the MC whatsoever. All of our contact was via Strategic Projects. Again, an observation, from listening to conversations, would be that there seemed to be a little bit more challenge in actually deciding whether it really was a defect or not. It appeared to me that there seemed to be a slightly more convoluted process of getting them signed off, but I am only commenting from what I have heard.

Mr B. URBAN: Did you have to produce reports to strategic planning particularly?

Ms TEBBUTT: To where, sorry?

Mr B. URBAN: To strategic planning.

Mr S.A. MILLMAN: Strategic Projects.

Mr B. URBAN: Strategic Projects—sorry.

Mrs WEST: No. We would receive the data from them and we would turn that into a report. Then we would verify with them that it was an accurate reflection of their understanding of where the defect position was, for example. A defect is something that we would report.

Mr B. URBAN: Can you produce those reports?

Ms TEBBUTT: They are all in the task force papers. There is a weekly IPMO report which would have gone to each of the task force meetings. Yes, certainly, they would be within the papers.

Mr B. URBAN: I just want to have a read of one, that is all.

The CHAIR: From your experience as a professional service firm, do you have any observations on the effectiveness of the dual governance structure used in the PCH project? Was it an appropriate governance model in your view?

Mr S.A. MILLMAN: Can I ask a supplementary to that? In answering that question can you also allude to Fiona Stanley Hospital, if that is relevant?

Ms TEBBUTT: The dual governance structure was certainly the same in Fiona Stanley but there was one key difference around the program director who reported via Fiona Stanley rather than—there always has been on the projects that I have worked on here the involvement of two different

agencies. That is consistent. Midland was different because it was a PPP. Again, Tanya and my role in Midland was working on the client side, not on the health side. My comment is that it was not inconsistent with Fiona Stanley. The operation of that on the ground was slightly different, with the reporting role of the program director who—Tanya and I were both on site at Fiona Stanley—was part of the commissioning team, as opposed to the difference for Perth Children's Hospital.

The CHAIR: Do you have a view of which is the better one?

Ms TEBBUTT: My view, and it goes back to almost, in some ways, what I said right at the beginning, is that these are so complex that actually having people in the same room in the same meetings working together on a daily basis—certainly at this stage of the program, if things were emerging all the time and actually having people together. I think the dual governance is accurate and is required. I think the on-the-ground working was better at Fiona Stanley.

The CHAIR: This project was delivered under a managing contractor model. Can you describe how the managing contractor model differs from other procurement models used for construction projects?

Ms TEBBUTT: I could not.

Mrs WEST: We have not been involved in —

Ms TEBBUTT: Both Tanya and I have worked in health services for a number of years. Our involvement is in the clinical commissioning, not in the building work.

The CHAIR: Did you attend task force meetings?

Ms TEBBUTT: Yes.

Mrs WEST: Yes, there would be two of us attending at every task force meeting—either Trish or I at every single one.

The CHAIR: Any questions?

Mr S.A. MILLMAN: No.

The CHAIR: We might have a closed session, I think.

[The committee took evidence in closed session]