PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE DECISION TO AWARD SERCO AUSTRALIA THE CONTRACT FOR THE PROVISION OF NON-CLINICAL SERVICES AT FIONA STANLEY HOSPITAL

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 24 APRIL 2012

SESSION ONE

Members

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

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Hearing commenced at 9.08 am

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

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

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

JOSEPH, MR ANDREW
Acting Director, Budget Strategy and Management, Department of Health, examined:

The CHAIRMAN: Good morning. On behalf of the Public Accounts Committee I thank you for presenting yourself to provide information to our inquiry. The purpose of this hearing is to assist the committee as it gathers evidence for its inquiry into the decision to award Serco Australia a contract for the provision of non-clinical services at Fiona Stanley Hospital. You have already been introduced to members of the committee. The Public Accounts Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it will assist Hansard if you could provide the full title for the record. If during the course of today's hearing you feel that information being requested by the committee breaches commercial confidentiality requirements, please let us know and we will be able to move into closed session if we judge that necessary.

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

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: No.

The CHAIRMAN: Thank you very much. I understand in terms of communication with the staff, Mr Snowball would like to make a bit of an opening statement, which we have to have.

Mr Snowball: Yes, thank you very much. With permission, I will make a brief statement. I want to clear the air and clarify particularly around some allegations made during the committee's

proceedings on 3 April in relation to the engagement of Paxon Consulting Group by WA Health. The hearings obviously looked at the engagement of Paxon to provide advice, testing the benefits associated with contracting out non-clinical support services at Fiona Stanley Hospital. I was disappointed obviously with the allegations of possible irregularities in relation to the engagement of Paxon, as in our view they unfairly tarnished the reputation of WA Health and its contractors. These allegations, in our view, inappropriately sought to discredit the procurement process surrounding the provision of information to inform government decision making in relation to the ordering of the facilities management contract at Fiona Stanley Hospital. WA Health obviously has fully cooperated with the committee appearing many times at hearings and providing almost 2 000 pages of information. No evidence of wrong doing by WA Health has been found to our knowledge in the engagement of Paxon Consulting Group and again in our view the facts clearly demonstrate that WA Health followed government procurement processes in awarding these contracts.

For the public record—we have responded in writing to the committee on those allegations—six contracts were awarded to Paxon that related to the facilities management contract, not nine, as indicated by the committee at the hearing on 3 April. Our selection of the project management services panel itself, which included Paxon, was in line with government processes and was appropriately informed by advice from Building Management and Works. The advice received from Paxon in terms of their contracted information went through a full validation process with the Department of Health and also with the Department of Treasury before being used to inform government decisions. There was no conspiracy to deliver some kind of predetermined outcome. It went through a lot of validation processes in terms of the quality of that advice. In this latter regard I will repeat the advice provided by the Under Treasurer in his letter of 16 November to the committee in which he said —

> Treasury reviewed and validated that the PSC analysis undertaken was consistent with the National and State Guidelines …
>
> Treasury did inform the EERC that it is confident that the assumptions and costings in the model are reasonable and that the contract with Serco represents value for money.

I would like to reiterate that at all times WA Health followed government procurement processes and in the selection not only consulted but also got advice in relation to the facilities contract for Fiona Stanley. The selection of Paxon Consulting to provide this advice reflected their good standing and their well-credentialled firm and sound knowledge of government processes. We have included examples of other contracts they have been awarded in terms of PPP-type arrangements with both the commonwealth government and other state government agencies. So they have considerable, substantial experience in that area of work.

[9.14 am]

In regards to today's hearing, I would also like to note the committee's intent to question us particularly on commercially sensitive material and information, particularly around the construction of the public sector comparator; the identification, valuation, transfer and retention of risk in particular; and the contract specifications and contract management arrangements. So whilst we have provided obviously to the committee all of that information, including the contract, I would ask that if the committee's questions go to a level of detail in relation to those areas and those matters around the commercially sensitive information, it be held in closed session.

The CHAIRMAN: Just on the last point, we have framed our questions to be fairly general, so it may be only if we follow through and bore down into detail that we need to do that, but we will make that judgement as we go along. Obviously, your information to us will be important. We will take on board your information on the confidentiality of the particular information and perhaps change the proceedings to a closed hearing.

Mr Snowball: Thank you.

The CHAIRMAN: Coming back to the matters you took up in terms of perhaps feeling misrepresented or the accusations made which were not well based, we do not want to go back over all of that last evidence, but you have said that there were six and not nine. Perhaps by way of supplementary information, could you provide us with which six you think were and why the other three were not? Rather than go through them now in technical detail, perhaps you could provide that as supplementary information.

Mr Snowball: Yes.

The CHAIRMAN: If there are no other brief comments or questions, we can leave that there. We have certainly got a very broad area to try to cover today. The first area we would like you to look at is some of the pricing mechanisms. Could you please tell us the services that are being procured through Serco via the use of variable payment mechanisms? We have the variable and fixed payment mechanisms. Which ones are actually in the contract via variable payment mechanisms?

Mr Sebbes: There are three services in terms of variable payment, which are catering, sterilisation and waste.

The CHAIRMAN: With respect to these services, would it be fair to say that the volume risk is retained by the state? There is this issue of where the risk is retained by the state, we have been able to pass the risk to Serco. We want to get underneath that a bit if we can. To a non-technical person in this area, it would seem to be that where you have got variable payments, the volume risk is actually retained by the state.

Mr Sebbes: Of the 29 services, 26 are on fixed price. Of these three services, yes, there is a volume risk retained by the state.

The CHAIRMAN: So the state retains that; okay.

Mr Snowball: Of the 29, 26 —

The CHAIRMAN: We will come to those; let us just try to knock them off one at a time. For those three which you have just mentioned in terms of catering, sterilisation and waste, the variable payment is the mechanism in the contract, and therefore in those areas the state retains a fair bit of the risk. For the other services procured through the Serco contract, there is a fixed payment mechanism; is that correct?

Mr Sebbes: Correct.

The CHAIRMAN: Would we say that that is firmly a fixed payment or are there within them a bit of room for variability?

Mr Sebbes: Essentially, they are firmly fixed payments. There are some, though, that are related to other indicators; for example, the property management service is a percentage of the revenue received, so if the revenue goes up, the payment goes up. But we have seen that as a fixed payment service.

The CHAIRMAN: Would it be fair to say, then, for those 26 services that the risk has been transferred to Serco?

Mr Sebbes: Yes.

The CHAIRMAN: Do any of these services that you describe as being subject to a fixed payment mechanism include additional allowances for variable costs—for example, cleaning?

Mr Sebbes: No, not that I am aware of.

The CHAIRMAN: So there are not other parts of the contract which would mean that even though you are putting them down as a fixed-payment mechanism—you mentioned perhaps property management is one area —

Mr Sebbes: That is linked to the revenue generated, so the fixed payment is a fixed percentage of revenue. That is the way it works in that case. Cleaning is just a straight fixed payment, which is indexed over time.

The CHAIRMAN: What about isolation cleaning?

Mr Sebbes: Isolation cleaning? I cannot recall how that works in particular. I would have to go and check.

Mr Snowball: We have got the detail here, so we can provide that information.

The CHAIRMAN: The issue with isolation cleaning is that if isolation cleaning is required, my understanding is that that is an additional cost that the department would have to pay.

[9.20 am]

Mr Sebbes: I would need to check that.

The CHAIRMAN: Perhaps we need to follow that up with supplementary information if we could, please.

In terms of risk in these variable payment areas, the level at which the contract is set would appear to be important. I want to get some understanding of that in terms of—because, you know, the contract assumes a certain level of activity. If it goes above that, the state is going to pay more. So, in terms of if there is more sterilisation to be done, above that. So, I want to try to get what are the expected levels of activity at Fiona Stanley Hospital in these non-clinical services. Could you say: what are the operational capacity limits for the hospital in terms of the provision of inpatient and outpatient services? Do you have this by a whole range of categories—it is not necessarily just one number, but can you give us some understanding of the operational capacity limits at Fiona Stanley Hospital as they impact on non-clinical services?

Mr Sebbes: I do not have the numbers in my head. They are in the paperwork here somewhere. In relation to those three variable services, there are in the contract specified starting point levels, if you like, for that service. Then they are checked via an annual service plan arrangement.

The CHAIRMAN: How would you benchmark that starting point? Is it, like, the hospital running at 75 per cent capacity, 80 per cent capacity?

Mr Sebbes: The hospital ramps up in the first year, but essentially it is running up to about 85 per cent in the second year.

The CHAIRMAN: Could we get a clearer understanding of what those benchmarks are going through first, second, third, fourth year? You cannot give that straight off your head?

Mr Sebbes: There is an assumption in there about the base level and where it starts and how it goes, but, yes, we can give you that information.

The CHAIRMAN: That is what I am asking you. How does that appear now for us in terms of what is that assumption on which the contract is based?

Mr Sebbes: It is in here somewhere, but I just cannot remember the numbers.

The CHAIRMAN: We will have that as supplementary information if you cannot get it now.

Mr Sebbes: If I get a chance, I will have a look. I am not sure which document.

The CHAIRMAN: We can wait a moment, if you like.

Mr Snowball: While he is doing that, the basic premise here is that we look at the hospital's operation and it is predicted throughout the clinical services framework, which basically predicts activities right across the system. We have been using that for about three years now in terms of our budgeting arrangements. It has proven to be very accurate. That would form the basis of our thinking around what are the activity levels that we are expecting at Fiona Stanley Hospital in the

first year and then in the normal full year of operation. The first year we are seeing as basically a year in which you are stepping up services, people are getting used to using Fiona Stanley instead of Royal Perth or Fremantle. But in that second year we are looking at optimum use of that facility. So, you are looking at occupancy of around 85 per cent, which is the normal optimum we aim for, but capacity, obviously, within that to scale up and down. So, in terms of the contract and the clinical services framework, where we are looking at, what is the activity that underpins those fixed-price contracts, those 27 services, and it is based around those activity base predictions for the hospital. As I said, that has been reliable for us up to this point. The risk for those services in terms of activity, therefore, transfers to the service provider—in this case, Serco.

The CHAIRMAN: Thank you, Mr Snowball. That certainly puts very clearly what would be the general understanding of the whole approach. We are trying to get some hard numbers to know what it really means.

Mr Sebbes: I have got the information here now. Would it be better if we table the document?

The CHAIRMAN: If you are happy to. That is considered open information?

Mr Snowball: That was my question. At the beginning, some of this is commercial-in-confidence as you dip down to the detail. The general information, which I provided, is obviously freely available. I am just cautious about providing the level of detail of this information in a public hearing—that is all—without properly considering this particular bit of information and whether that would be an advantage to another provider in another environment into the future. But in terms of the numbers at Fiona Stanley Hospital—that is fine to provide, sorry.

Mr Sebbes: Just to quickly run through it, in terms of patient catering, the morning and afternoon and meal numbers are around 239 194 meals per annum.

The CHAIRMAN: Those are annual numbers?

Mr Sebbes: Annual numbers, yes. Morning, afternoon and evening snacks are in the order of 4 882 per annum. Sterilisation is put around three separate components. One is packs, which is 19 647; bowls, 12 446; and reusable medical devices, 61 875.

The CHAIRMAN: To make sense of these numbers, what do they mean in terms of the capacity of the hospital? That is based at 85 or that is the first year at perhaps a lower number or what?

Mr Sebbes: These are based, from memory, on 85 per cent.

Mr Snowball: Eighty-five per cent occupancy, which is the optimum most major hospitals operate on.

The CHAIRMAN: Given that since you began the planning of what is a very big project the government's policy has changed in respect to Royal Perth Hospital, has that been figured into any change in the level of activity at Fiona Stanley, given that the government has a policy of retaining Royal Perth as a tertiary hospital?

Mr Snowball: In terms of the activity numbers predicted for Fiona Stanley, that accommodates existing activity levels both at Royal Perth and Fremantle as they are described in our clinical services framework. That framework is what we work to and it describes the predicted activity levels, demand from the community, and describes where we would provide that service in terms of bed numbers. It looks at Royal Perth with 410 beds; it looks at Fremantle Hospital and looks at Fiona Stanley Hospital. So, these numbers are based on the activity we are predicting into the future and are planning to deliver at Fiona Stanley Hospital.

The CHAIRMAN: But that did not answer my question. My question is: have you refigured or changed the numbers for the level of the activity at Fiona Stanley Hospital given that the policy has changed with respect to the continuation of Royal Perth Hospital?

Mr Sebbes: If I can go back to comments, I think, at the first hearing. Initially, Fiona Stanley Hospital was planned around 643 beds with a certain service mix. The numbers we have calculated here, whilst they equate to about an 85 occupancy, they are actually based on bed day occupancy rates rather than those things. With a decision to retain Royal Perth Hospital, the original Fiona Stanley Hospital had a stage 1 and a stage 2 and it was going to go to 1 000 beds at stage 2 and there were some services that were not in the stage 1 development. With the decision to retain Royal Perth Hospital, we reconfigured the services. We kept the same size of the facility—643 beds—but we brought into the hospital obstetric services, neonatal services and a mother–baby unit into the mental health service. That still had approximately the same [indistinct] we simply recalculated those numbers and in addition to that, after that point, it was also we got the commonwealth money for the state rehabilitation service. That is factored in there as well.

The CHAIRMAN: The point of the question, if it is not obvious, is that when it came to a pricing mechanism, if you actually have a lower level of service at Fiona Stanley Hospital than what you are anticipating in the contract, then you are paying money for nothing. So that is the concern, because then the risk comes back to you, to the health department.

Mr Snowball: That is why the activity levels pre/post the decision to retain Royal Perth are the same by adding in additional services into Fiona Stanley Hospital to basically accommodate that number of beds.

The CHAIRMAN: In terms of the contract, can you give us some understanding of the basis for the cost escalation over the life of the contract?

Mr Sebbes: Yes. In schedule 7 of the contract—we provided this information—there is a very detailed list of escalators by service line and you will notice that that is broken down into a labour and wages escalator and a public goods and services escalator and it goes through service by service what those rates are.

The CHAIRMAN: I have looked at that and it is certainly quite complex, but what is blacked out in terms of part of it is the starting figure. I am wondering why we cannot have the starting figure.

Mr Snowball: We are happy to provide that number, but in closed session, if that is acceptable to the committee.

The CHAIRMAN: We will go that way if we need to, but I do not understand why a contract that is signed and sealed as being delivered, we cannot have the starting number for the price escalator. That is not going to affect any other contracts, so I do not see what commercial confidentiality is attached to the starting number.

[9:30 am]

Mr Sebbes: It potentially has an impact upon Serco's negotiation position.

Mr Snowball: So this is information, too, that we hold that is important to us in terms of our contract management process.

The CHAIRMAN: We will pass over that and potentially come back to it in closed session. Thank you for that.

The next area that we wanted to look at was a bit more detail on some of the risks involved and we understand from your submission dated 6 February 2012 that the financial analysis completed by Paxon in July 2011—so the July 2011 analysis—was the final public sector comparator and reflected changes once negotiations with the preferred respondent had been completed. Is that correct: what has been stated as the final public sector comparator from July 2011 actually included all the changes that were made in negotiating the final contract with Serco?

Mr Sebbes: So there was the original one in May 2010, which was on a 10-year analysis at that point in time, and then a final one in July 2011, which was on a 20-year analysis, so the numbers

are quite different when you look at them. And included in that, as well as the different time period, were things like the increase in scope for the state rehabilitation centres that would come in; some more detail in terms of asset costing that came through out of the negotiation process; we requested Serco to increase their surety—and that was factored into it; and there was some additional changes in some of the detail around the ICT scope.

The CHAIRMAN: I think you have jumped ahead to my next question. What I was asking about was what we have understood to be the final public sector comparator from July 2011, and what I am trying to get clear is: did that reflect all the changes that took place in negotiations so that it reflects the costs in the final contract?

Mr Sebbes: Yes, it did; there may have be some changes after that that occurred because of the Treasury analysis and the way that we count things, but that did reflect all of —

Mr Snowball: The July 2011 —

Mr Sebbes: — the final position in terms of negotiations.

Mr Snowball: Yes.

The CHAIRMAN: So the public sector comparator results contained in that July 2011 document, which was released in facilities management contract summary—sorry! Were those results the ones that were then released in the facilities management contract summary of February this year? I mean, this has gone through so many different stages. We are just trying to tie down where things were at the stage we understand them. So the question I am asking you is: were the public sector comparator results—the July 2011 document, which we have just clarified some things about—actually incorporated into the summary of the FM contract released in February this year?

Mr Joseph: My understanding is that they were.

The CHAIRMAN: It was. Thank you. So it is not other bits that we do not understand.

Mr Joseph: Yes.

The CHAIRMAN: Thank you.

You may wish to refer to page 30 of the financial analysis document—I have it here in front of me—because the question goes to it. It is again back to information about services subject to variable prices and it notes that volume risk was not transferred to Serco for those services, and those services were catering, sterilisation and waste, which we have already come to. Is that right? Is that what it mentioned?

Mr Sebbes: Yes.

The CHAIRMAN: So was the risk-adjusted public sector comparator, which appears later in the final analysis document, which was released to the public in February as we said, calculated on the basis of three or more than three services being subject to variable price mechanisms?

Mr Joseph: My understanding is that it was just those three services.

The CHAIRMAN: Just those three?

Mr Joseph: Those three services.

The CHAIRMAN: And you are saying that in the final contract only three services are subject to variable price mechanisms.

Mr Snowball: Yes; with the exception of the additional one that was mentioned at the earlier stage based on the differences. So there is three in terms of activity; that is, volumes. There is the one that is related to revenue. They are the only adjustments in terms of volume.

The CHAIRMAN: But in the contract—this is a public document isn't it?—which Serco has released parts of, they say that there are seven. They say that there are the ones that you have mentioned, which is catering, sterilisation and waste management—is that right?

Mr Snowball: Yes.

The CHAIRMAN: Whereas they have said external transport services, helpdesk, human resource management and managed equipment services are all variable services. So unless they have put up on their website a different version of the contract and not the final contract they are saying that there are seven.

Mr Sebbes: That is not —

Mr Snowball: Not our contract.

Mr Sebbes: — my understanding.

Mr Snowball: Of the contract.

Mr Sebbes: I mean, they all have potentials for other things but that is not the way that we have evaluated it.

Mr Snowball: So when we are talking about the variable contract, variable services—services in which the risk is caught by the state, not by Serco, it is those three that we have outlined plus the services that relate to revenue adjustments.

The CHAIRMAN: I understand what you are saying. The problem seems to come down as to whether what Serco has put up on their website is not the actual contract because what they have there on variable services payment—they list all seven, and that is—you know, you can see from that, that purports to be, and I assume is, a copy of the contract. Unless it is a different, earlier version.

Mr Snowball: We can clarify it. I do not know the source of that document; accepting that it is on their website. But we will check that.

Ms R. SAFFIOTI: The seven items include, for example, an item for external transport service payment. I suspect that that would be a variable because it would be based on volume and not fixed. I am just reading from page 48 of the contract where it identifies seven different variable service payments and there is one categorised as external transport service payment. So would you envisage that that would be something that would be variable given that it would be based on volume and not fixed on —

Mr Sebbes: My understanding of the contract of the external transport is there is a fixed arrangement of a certain amount of service to be available to us and therefore it is a fixed cost.

Ms R. SAFFIOTI: So it is a fixed price.

Mr Sebbes: Yes. And I think the one in that list that you mentioned—human resource management—I think in that there is a cap. During the pre-operations period there is a role for Serco to support us in getting operational and there is, I think, from memory, a cap in there that if we were to exceed—and that is our choice whether we exceed it or not—we could have to pay more. But it is a fixed price on that cap. So they act as our recruitment agent, if you like, in many cases.

Ms R. SAFFIOTI: So for example if your employee numbers went over a certain level, is that —

Mr Sebbes: No; we have in the contract a level of support that Serco need to give us to recruit staff. They are effectively acting as our recruitment agent, if you like, in many cases. We control who goes into that and if we go above a certain level, Serco has reserved the right to come back to us and ask for more money. But we can do it ourselves. We do not have to pay that money.

Mr Snowball: So what may be the issue here is that the ones that we have described as being variable are in respect to volumes of patient use and activity of our hospital. I can only second guess on these, but it seems that we have described them as fixed because we have a cap in terms of fixed price for a fixed level of service delivery, including, for example, the recruitment. So we determine what level of activity is in fact contracted to Serco—not based on, simply, activity numbers that might be going through our hospital. So it is support services that support us. The helpdesk would be an example of that as well because there are certain volumes that we have effectively purchased the service of from Serco. But we determine the level of use of those particular support services.

The CHAIRMAN: Obviously it is hard for us to understand this, but given the complexity of the contract there may be an explanation which, you know, we will find totally reasonable. I am explaining that we need that and that you will have to come back with further information.

Mr Snowball: And we are happy to do that. So, we can go to each of those, what the contract is from a state side, and where is the risk of activity. Because if we make a conscious decision that we want to use more of that particular service, then that is our decision to make; it is not simply applied to the vagaries of how many patients happen to turn up to our ED, for example.

[9.40 am]

The CHAIRMAN: If I could turn to ICT. The ICT projects are generally considered to carry significant risks and the history of ICT delivery, both here and clearly from what we are aware of in the UK, has created major problems with very poor outcomes in terms of contracts. I think we are all aware of that. In the contracts signed with Serco, has the state transferred all risk associated with late or over-budget deliveries of the ICT components?

Mr Sebbes: From the delivery from Serco?

The CHAIRMAN: Yes.

Mr Sebbes: Yes and we have got some mechanisms in there to deal with the, shall we say, uncertainties of large ICT projects.

The CHAIRMAN: What has this transfer risk been valued at?

Mr Sebbes: Off the top of my head I cannot tell you.

The CHAIRMAN: Could we have that number, please?

Mr Snowball: Again, if I could ask—that level of detail—we might answer that in closed session.

The CHAIRMAN: Can you give it as a rough percentage of the total ICT value of the contract? Just within four or five per cent will do, just in terms of you doing the numbers in your head.

Mr Snowball: Less than five per cent.

The CHAIRMAN: Less than five per cent. So in an area which has a history of being problematic with cost overruns and failure to deliver—we only have to look at our shared services in Western Australia; it is not just Health—you are saying that the risk cost that you are transferring to Serco in a major IT contract is under five per cent?

Mr Snowball: That is what we valued; that is what the risk has been valued at, yes.

The CHAIRMAN: Can I have some explanation, because to me that does not stack up?

Mr Sebbes: Is it worth explaining how the ICT payments work in principle?

The CHAIRMAN: Yes, please.

Mr Sebbes: The calculation of these is in accordance with the guidelines. The ICT component is essentially a fixed-price component, but understanding that the nature of ICT is there will be some unexpected events that will occur in the process. We have a fixed payment, plus what we call a risk

pool for that money, and those two payments together cap out the payment on the ICT payment. The fixed payment they get; there are some mechanisms for drawing down on the risk pool —

Mr Snowball: Only when they deliver.

Mr Sebbes: Yes, and they have to be agreed what they are; there are some rules in the contract about that. But then that is capped, so ultimately there is a cap on the ICT component.

Mr Snowball: This relates to if there is any delay in delivery of that ICT component, basically that is identifying—that is the level of risk that the model has valued slippage in terms of an ICT contract.

The CHAIRMAN: Again, assuming you do not want to give numbers —

Mr Snowball: No.

The CHAIRMAN: — as has just been suggested, there are two components with this risk pool. What percentage of the overall cost is the risk pool, again, just in general?

Mr Sebbes: In broad terms it would be in the order of 15 per cent.

The CHAIRMAN: Fifteen per cent is the risk pool, thank you.

Which company provided the valuations for this work?

Mr Sebbes: The valuations for this work on the ICT component, the primary company was a company called ITNewcom.

The CHAIRMAN: Was that a separate contract or were they subcontracted under Serco to do that work?

Mr Sebbes: A separate contract is my understanding; certainly not under Serco. They were working for us.

The CHAIRMAN: If I could now move to something again in our discussions in the UK, was the issue that you might have that in the contract, that you transferred risk, but how do you maintain it then? Could you explain the operation of the surety provisions in the contract so that the risk which you are assuming in the contract has been transferred actually is transferred and does not fall back on Health and the state, which is a very common issue, particularly in the UK where the risk has been transferred back?

Mr Sebbes: The state has the right to draw down on the securities surety provisions under a number of circumstances. All the common ones, if you like, that you would have under legal contracts such as insolvency and other things to pay out money, but also for any non-performance under the contract. So, the state has two ways of recovering non-performance abatements, if you like, one is the surety, which would be the sort of hard-edged thing; the other one is we can actually deduct money from future payments, so we can actually take money out of future payments and just net off the amount to get —

The CHAIRMAN: Is there a cap on what you can take out of future payments; and, if so, what is that cap?

Mr Sebbes: One hundred per cent.

Mr Snowball: All of it.

Mr Sebbes: Yes; all of it.

The CHAIRMAN: You can take the full amount of the payment?

Mr Sebbes: Yes; we can take the full amount of that. The whole performance regime here puts 100 per cent of the payment to Serco at risk.

The CHAIRMAN: Coming back to that surety, again, for confidentiality you may not want to talk about the specific examples in this contract, but what is your view in terms of the relative strength or importance of using bank surety, bank bonds or insurance bonds as that surety?

Mr Sebbes: We took Treasury advice onto the split, if you like, between the bank guarantees and insurance bonds that Serco put up for proposal. We negotiated up; Serco had the surety level lower than what wanted, so we negotiated that up to the level we required, and then Serco came back with a proposal for a split of that. We took that past Treasury and they agreed to that split.

The CHAIRMAN: So this is the split between insurance bonds and bank bonds?

Mr Sebbes: Yes; it is roughly a one-third–two-thirds split, I think from memory, between the two.

The CHAIRMAN: So basically you were guided by Treasury on that, even though Infrastructure Australia's recommendation might be somewhat different from where you landed?

Mr Sebbes: That is possibly true, yes.

The CHAIRMAN: There was an example with major hospitals in the UK where insurance bonds were worthless because the insurance company in the US went belly up in the global financial crisis, and so you have moved to a situation where you have a fairly large amount of insurance bonds as opposed to bank bonds.

Mr Sebbes: And as I said, we got Treasury advice on that; it was not without assistance.

The CHAIRMAN: Has Serco met the pre-operational milestones which were set for 31 October 2011 and then for 31 December 2011?

Mr Sebbes: That is milestone 1 and 2, is it? Yes.

The CHAIRMAN: So they have both been met?

Mr Sebbes: Yes; and 2A.

The CHAIRMAN: We are still looking at that issue of managing risk through the contract. I would like to get some understanding of the size or professional make-up of the health department's contract management team which you will be setting up or have started to set up to manage the contract with Serco. It is not primarily the transition, but the ongoing management of the contract.

Mr Snowball: Sorry, who is on it? Do you mean, the officers that are involved?

The CHAIRMAN: The resources which Health has to commit, so something of the quantity and the type for Health to actually manage the Serco contract.

Mr Sebbes: And you want to talk in your ongoing contract period?

The CHAIRMAN: Yes, because I notice there are a whole lot of issues in the transitions, but when you actually have it up and running, the commitment of resources, the type professional make-up of your team to manage the Serco contract.

Mr Sebbes: We have allowed in our forward planning for that of approximately $2.5 million per annum as a starting point for that contract management costs going forward.

The CHAIRMAN: That has been the figure for some time now; you have not upped that as you have gone through the process?

Mr Sebbes: No.

The CHAIRMAN: That is a very small percentage of the overall contract.

Mr Sebbes: In raw dollar terms it is just over one per cent, I think.

The CHAIRMAN: Talking to hospital administrators in the UK, they suggested about three per cent that they thought was required to be able to effectively manage these sorts of contracts.

Mr Sebbes: That would surprise me, considering the UK guidelines suggest a maximum of two per cent.

The CHAIRMAN: This was the manager of one of the trusts for major hospitals in London.

Mr Snowball: I mean, we drew, as you have done in terms of the visit, on their experience and obviously using their guidelines of two per cent, set our position in terms of the contract management process. Bear in mind also that we have several phases in this, so there is a transition phase, which it is managing the contract in respect to that, particularly around some of the developmental areas, like ICT for example. So whilst there is a dedicated contract management team in terms of the contracting with Serco, we also have other contract management roles in terms of ensuring, for example, under the ICT area, that we are equally delivering what needs to be delivered on the health side to match. So, while Brad is talking about $2.5 million, that is purely for the contract management of the contract as it currently stands, so the milestones assessment, the reward payments et cetera.

The CHAIRMAN: If I could move on to some questions on the public sector comparator. Was Paxon Group responsible for calculating most of the raw cost services used in the public sector comparator?

Mr Joseph: Yes, that is my understanding; they were.

[9.50 am]

The CHAIRMAN: Because if we look to examples like the work that is being done for the Midland health campus, we can see from just on the public record that you have got a major company looking at the financial advice and then you have got a range of companies who are doing the raw costs, if I can put it, which feed into that. What you are saying here is, in terms of this particular contract at Fiona Stanley, it was the Paxon Group that calculated. We have already said that IT was done out to a special contract, but most of those raw costs were actually done by Paxon.

Mr Snowball: Yes, but they were costs that were actually assessed by our own facilities. Part of Paxon's role was to collect that information. When you say "calculating the raw costs", actually it was the raw costs in terms of the hospitals that we used as benchmarks to arrive at that cost. So, it was not like, "Paxon, just go away and work out the raw costs on your own"; it was actually those costs to a large extent were calculated within the system. We already know what our cost profiles and structures are. It was about bringing it together in a form that you could then apply it as a public sector comparator.

The CHAIRMAN: The point that I was sort of covering was really more the structure you have adopted, because it is not a common structure in terms of the ones that I have looked at. It was just the way you structured the work to be done.

Mr Sebbes: Perhaps if I can comment on that, because Paxon did a lot of the work, but they did not do all of the work. I have just mentioned ITNewcom in terms of the ICT component, but there were other groups that provided information into this. So there is Colliers International, Ralph Beattie Bosworth —

The CHAIRMAN: What did Colliers International cover?

Mr Sebbes: Property advice. Ralph Beattie Bosworth, who are quantity surveyors in the market, a well-known company. Appian Group, who were providing technical advice in some of the areas. Royal Perth Hospital biomedical engineering was providing some technical advice into some of the nurse clinical service information. And MBM PL, which is not to be confused with the MBM in the Brookfield Multiplex group, as specialist facilities management advisers.

The CHAIRMAN: So can you say a little bit more about what the MPM work was?

Mr Sebbes: MBM it is. MBM are a company that have been providing advice in major PPP contracts around Australia for a number of years now. They were sourced primarily because they had good commercial knowledge of the market and what is achievable and what the rates are and those sort of things that we should be chasing.

The CHAIRMAN: They were looking at raw costs. Which areas of contracts?

Mr Sebbes: They were looking more at the performance requirements. The performance requirements drive some of your cost calculations, so we actually had to understand what performance level we were aiming for, what that means in the market and then the cost of that.

The CHAIRMAN: Coming back to some of the things that Mr Snowball was already commenting on, the sources and assumptions document describes a range of consultation with the Department of Health staff, which provided Paxon with a baseline understanding of how services are currently delivered in existing hospitals and their costs. I would like to get some idea of the timing of those consultations, when they put together that information from the reference project, which I presume is what we are talking about in that sources and assumptions document.

Mr Sebbes: The reference document you are talking about is the preliminary financial analysis. Is that the same?

The CHAIRMAN: I am talking about the sources and assumptions document. It describes the range of consultations with the Department of Health staff that was undertaken by Paxon as the baseline. This came to us on Friday, so our staff have been very busy. That was May 2011. What I am trying to find out is the actual time taken, the dates roughly when they entered into that consultation with the Department of Health to get the information that was critical to developing the public sector comparator.

Mr Sebbes: Notwithstanding some comments we had at the last presentation about preliminary work that was done around our business case, they commenced this work, from my recollection, at the time we got approval to go to the market. That is when they worked that through, and then they worked that through so it was ready to be included in the public sector comparator that needed to be completed by May 2011.

The CHAIRMAN: So you went to market in—what was the date?

Mr Sebbes: I am not clear whether that was when we went to the EOI market or we went to the RFS market. I just cannot remember the timing of that. One was February 2010, the other one was October the year before.

The CHAIRMAN: So this was after you had the request for submissions.

Mr Sebbes: Sorry?

The CHAIRMAN: That is when you made your request for submissions to your shortlisted three.

Mr Sebbes: After the decision was made to go down that path, not necessarily after they were released.

The CHAIRMAN: So, you are talking about the cabinet decision in November 2009?

Mr Sebbes: Yes. That would be my recollection, yes.

The CHAIRMAN: How was this actually conducted with Paxon getting this information through Health. Did you have a unit in Health which put them in touch with the various people in charge of your pricing centres? I mean, how did it actually work?

Mr Sebbes: There are a number of aspects to that. They met with senior people at Sir Charles Gairdner Hospital as an example as part of that—the heads of department around the cost centres, so they took the cost centre information that Health had. They met with various individuals about that and what would change—we went through this before—if you had the new hospital

environment and those sorts of things, so to take the benefit of the new hospital environment into account. There was also some consultation with people in south metro, just general consultation there. There was some clinical activity and other cost information provided by the Department of Health into that. Later on, we had an asset list from Serco that we used as a basis for that. There was some salary information and the like from the Department of Health. They also took a lot of information from the health corporate network information base.

The CHAIRMAN: This was approximately over a six-month period, was it, or over a four-month period?

Mr Sebbes: I would have thought it would have taken about four months to collect this data and then inform the final processes.

The CHAIRMAN: Coming back to something you said a moment ago, how did Paxon account for the anticipated efficiencies to be derived from the new hospital when working off data from Sir Charles Gairdner and Royal Perth?

Mr Sebbes: Part of that process was to interview the heads of departments at Sir Charles Gairdner, explain to them how the new hospital worked at Fiona Stanley and ask them what things would you do to improve your services if you had that environment, and adjust the services that way.

The CHAIRMAN: So did that come out to be generally a percentage across different sectors?

Mr Sebbes: I cannot recall the detail of that.

Mr Joseph: They interviewed the service managers and asked a question, if you were to develop their service from scratch, the claims database, how would you do things differently to get the benefit of this service redesign? So in that way incorporating —

Mr Snowball: What this process attempts to do is go, "Here's a current cost of a facility"—for example, Sir Charles Gairdner Hospital. Then over the top of that, you go, "Well, they're operating in an old hospital environment. Are there structural efficiencies that you could actually deliver out of that and make adjustments then to that base assessment of cost that you would get from Charlie's or other facilities?" and double-check that against the department's own information, the discussion with the managers and so on about what efficiencies would you be able to deliver if you had a different working environment to operate the services in. That is the validation, if you like; if the public sector was to provide this service in this facility in this new environment, what would it cost us?

The CHAIRMAN: The point of my question is: what number comes out of that? Do you have an overall number or a number for different services to say, "Look, the service for cleaning in an old hospital compared to a new hospital, we've looked at the two, and we say there is practically no difference; we don't do anything. But when it comes to the orderly and moving patients around, the new structure is going to give us a five per cent saving over Sir Charles Gairdner." They must have come out with some numbers, because at the end of the day you ended up with numbers. So what I want is some of the numbers that show what efficiencies were there simply because you had a brand-new hospital which had been thought through and well planned. How much would that reduce the cost of various services over what it currently costs in Royal Perth or Sir Charles Gairdner?

[10.00 am]

Mr Snowball: In terms of the provision of the public sector comparator, we are able to do that basically service by service, which we are prepared and able to do, but we would ask that we could do that in camera. That is a very kind of low-level detailed bit of information which, on a service by service, would be an advantage to other potential contractors in the future.

Ms R. SAFFIOTI: This relates to the efficiencies, as in the different human resource management structures, in the new hospital. Were there any assumptions in the public sector comparator based on cheaper wage costs per employee in any area?

Mr Sebbes: No.

Mr Snowball: Do you mean from the public sector point of view—that we would drop the salaries for workers? Is that the question?

Ms R. SAFFIOTI: Yes.

Mr Snowball: No.

Mr Sebbes: There might have been some change in mix of staff, which would have different salary rates, but they are all based on the current conditions in the public sector.

Ms R. SAFFIOTI: Yes, the current conditions. But what I am talking about is average salaries for particular workers. For example, at the new hospital you might have level 1s and 2s doing jobs that level 3s and 4s are doing in Charlie's and Royal Perth.

Mr Snowball: Yes, and that is the work that was undertaken that we have just talked about.

Mr Sebbes: To my knowledge, the costs of the other hospitals were not adjusted down to create a new starting point, if you like, of what we have built up over the first years, if that is what your question is.

Ms R. SAFFIOTI: We might need to follow that up later.

The CHAIRMAN: If members are happy to move on, we have some questions on information and communications technology. I would like to get some understanding of the role of the ICT service contingency payment. We did talk earlier about how you have a risk area.

Mr Sebbes: That is exactly the same payment as I have described as the risk.

The CHAIRMAN: So it is also a sort of contingency payment?

Mr Sebbes: Sorry. It is just my language. It is the same.

The CHAIRMAN: So when you put the straight-up contract cost, plus the contingency payment, you are saying that is capped?

Mr Sebbes: Yes. That caps out the total payment that we have to make to Serco for ICT development.

The CHAIRMAN: So in what circumstances would a payment be made to Serco from that contingency? You touched on it earlier; perhaps you can elaborate on that.

Mr Sebbes: There are some broad criteria in there. There are two areas, and one of them is very broad. In essence, it is any cost in the development of the ICT that could not have been foreseen.

The CHAIRMAN: As we know, there are always unforeseen costs in ICT development.

Mr Sebbes: Which is exactly why we have capped it. The other component is there is a list of assumptions, if you like—"assumptions" is the wrong word; there is a list of potential drawdowns as well, which is part of our current contract management process. It includes things like Serco have said they have not included in their cost the email servicing solution for the health department; so potentially, if we wanted that, that would be a drawdown on that. We have gone back and said we do not want that; we already have our own email system. So there is a list of items like that. That is not anticipated to have a significant drawdown on the ICT contingency plan. It would be the unforeseen things that happen.

The CHAIRMAN: You have said that you already have your own email system. How does that integrate with the ICT system that Serco and BT will be developing?

Mr Sebbes: Only in the normal way that emails interact with each other across all networks. We are not asking Serco to provide us with an email system—we already have one—but they had put that as an exclusion in their risk.

The CHAIRMAN: So why was the ICT service specification not developed to the same level of detail as the other service specification that you provided to the shortlisted bidders during February and May 2010?

Mr Sebbes: We simply did not have enough knowledge of what sort of solution we wanted at that point in time.

The CHAIRMAN: So when was the full, completely developed ICT service specification actually completed so that it could be provided to the company?

Mr Sebbes: In March 2010, we issued out the ICT service scope document, which the bidders put proposals against. We evaluated those proposals and then we went into negotiations around our view of their proposal versus our scope.

The CHAIRMAN: So they had those full service specifications by March 2010?

Mr Sebbes: The ICT scope document was issued in March 2010, yes.

The CHAIRMAN: I know there were documents issued. What I want to know is when the full one was issued, because once you change your service specifications, you are in a new ballgame in terms of costs.

Mr Sebbes: We have provided you with a list of all the amendments that went out. I do not know if there are any additional ones in ICT. On 23 March, we issued the ICT service scope document.

The CHAIRMAN: Were there variations to that scope document after that or was that the full and final?

Mr Sebbes: There were three amendments after that. I am not sure what they are. On 26 March, 31 March and 6 May there were three further amendments that went out to the proponents, but I am not sure if they were ICT or not. It does not say.

The CHAIRMAN: I need to get clear here whether we are talking about the scope document or the service specifications. The scope document I understand is about five pages. The service specification is a much bigger document.

Mr Snowball: That is right. The first one, the actual scope document, was the 23 March document. There were three amendments. We know that one of them was the ICT one. We have not got exactly which one. The three dates were 26 March, 31 March and 6 May. So we will just clarify which of those related to the ICT.

The CHAIRMAN: Coming back then to the actual ICT service specifications, when were they finalised?

Mr Sebbes: Absolutely finalised?

The CHAIRMAN: Yes.

Mr Sebbes: During the contract negotiations.

Mr Snowball: We put our specifications out. Obviously when we got the proposals coming back, we then considered the proposals in the light of those service specifications that we had developed. So at that stage you make decisions around the extent to which you want to contract the ICT development. So basically what Brad is describing is that while we have the specifications up-front for the providers, we get the bids come through, and ultimately we decide the extent to which we contract the ICT, and that becomes the final specification in terms of supporting the contract.

The CHAIRMAN: I think we can say that through that process, your actual contract cost for ICT blew out by a very large amount, or increased—perhaps "blew out" colours it—by a substantial amount.

Mr Snowball: In terms of the ICT, it is actually the decision about the extent to which you contract that with the provider, and the extent to which you provide it within broader Health. So when you say an increased cost, it is actually the same cost; it is where you have that cost borne, whether it is more appropriate to have it borne through the support service provider, or whether it is appropriate to have it borne through, in our case, the health department of WA.

The CHAIRMAN: So what are some examples of components of the ICT work that you may have started out wanting to do by direct contract through Health and you ended up bundling into the Serco contract?

Mr Snowball: We will just get the ICT services list and give you some examples.

Mr Sebbes: It is, unfortunately, a document of about this size! In the areas where we looked at risk, if that is your question, for ICT, we looked at a number of options, where the state could deliver a service, or we could get Serco to deliver a service. Essentially, the main service we got Serco to deliver was the scheduling and billing system for the hospital. That was a decision to take that out of the state's pool of work and put that into Serco's pool of work. That might not sound like much, but that is an extremely complex piece of ICT because it incorporates all of the bookable spaces, people and items in the hospital, so it is every meeting room, every machine, every doctor required to attend the outpatient clinic, every theatre list, every piece of mobile equipment, as an example. So, it is a very complex piece of ICT. I use that as an example. That is probably the major example I could use.

[10.10 am]

Mr Snowball: If I can just go through it, because there is a whole range of stuff under the ICT umbrella here, so that there is a good understanding of what that involves. The ICT arrangements form, the actual platforms and systems themselves that operate, basically allow connection of various parts of the hospital in terms of the provision of a service. So that might be as far as scheduling is concerned so you are able to flow through into your bed management system so you know how many patients are coming through in terms of your theatres, which flows on. So you have got to actually have your system capable of communicating right across the hospital.

The CHAIRMAN: So are you saying you started out going to have that booking system done directly to Health and then you rolled it in, or are you just giving that as an example?

Mr Snowball: I am giving that as an example of the range of things that we considered under this agreement. So we included things like the clinical services themselves, the hospital operation—the patient admin, the scheduling, those sorts of things, patient entertainment system, patient food services—so we made decisions about is there something we would provide in terms of the broader health strategy and then implementing in Fiona Stanley, or is it fundamental to the way we want to see Fiona Stanley operate as a contemporary ICT facility? And that is why you are seeing in quite a few of those areas we are actually saying, "Let's do Fiona Stanley as the contemporary tertiary hospital that we want to see in place." Notwithstanding that, we still have to connect with the wider system. So in patient administration, for example, we want a common system across WA Health so that it is appropriate that WA Health actually builds, delivers and procures the patient administration system so that every hospital has the same process and can communicate. So the job here as part of the contract with Serco is to make sure any systems that we are contracting them to provide are capable of connecting, linking and communicating with our wider patient administration system. So then a patient who —

The CHAIRMAN: I understand all that. We have a situation here, if I can just come back to a higher level, where we have a lot of very competent people working in Health. You tied up a

contract with Serco, which is a major international company and which has very professional people as well. They are used to doing these deals; the health department is not. What I am keen to get is an understanding of the process so that we know that you did maintain some competitive tension to get a good deal. Serco knows how to make money; that is what they are about. They know how to set up contracts so that they are the winner. Through this process I am trying to get some assurance that the health department has had a bit of a win and has not ended up in a situation where you are not getting value for money. Now, you have given these specifications to Serco; you have changed them through the project. I think at the time that you had given them to them, they were the preferred bidder, so that basically they could be seen to have you over a barrel.

Mr Snowball: No, no. The specifications that were provided —

The CHAIRMAN: The final specifications were provided on what date? What date, and by that date do we not have a situation where you had already selected Serco as the preferred bidder?

Mr Sebbes: No. As I said, the scope went out while we were in there —

The CHAIRMAN: Not the scope. I am talking about the ICT service specifications where they knew exactly what was involved, and that if you change it when you go with the preferred bidder, they have the upper hand in the negotiations of the contract.

Mr Sebbes: We need to provide you with that date because it is not clear on that document. But you also need to understand, from a value-for-money point of view, that was the key role that ITNewcom played in this, and they are an expert group in ICT programs within PPP-type projects, and particularly within health PPP-type projects; actively involved in all of the major health developments in Australia in this exact field; and they were providing us with benchmark information to make sure that we understood what our costs were and should have been.

Mr Snowball: So, while we might be seen as bunnies in terms of the contract negotiations —

The CHAIRMAN: I want the assurances that you are not. I am not saying that you are, but I want the numbers and assurances so that you are not the bunnies. That is what I want to know.

Mr Snowball: What I am trying to describe is that we brought in the hired guns that basically gave us that knowledge and ability to make sure that we were not bunnies in this process. And I think that is entirely appropriate for us to make sure that we are protecting the interests of the taxpayer to get value for money in terms of this ICT service.

The CHAIRMAN: So when you had these companies give you advice with respect to the ICT component of the contract, which was going to be cheaper—the public sector comparator cost or the Serco cost for ICT?

Mr Sebbes: Look, I do not have that information in my head.

Mr Snowball: But we can provide that. Again, it is a line-by-line thing. It is the same as the conversation we had about the total service of a hospital. In ICT it is about a whole range of service decisions and whether you go as a package with these services. If you do it line by line you will get a different outcome. If you look at a package you will get a different outcome. And that is what we are seeking to do. It is to get the optimum package that was a better value product than what we could deliver as a public service.

Mr Sebbes: And then as part of that process, we retained the licences back to us so that we can roll out those systems across Health. And bear in mind —

The CHAIRMAN: That is, licences within licences? Perhaps we can come back to that.

Mr Sebbes: Yes.

The CHAIRMAN: But, Mr Snowball, what you are saying I do not have any problem with. The issue is that if we are to know that we really do have a good deal and value for money, we need the

level of detail and the numbers. For instance, I just asked you with respect to the ICT component whether the Serco bid or the public sector comparator came in as the lower cost.

Mr Snowball: And we are happy to provide that information, but again as part of the commercial-in-confidence conversations. So, you have got that. We are told that you have that information. That was provided —

The CHAIRMAN: Without giving the numbers, the way I am reading it is that the public sector comparator would have cost you slightly less than going to Serco.

Mr Snowball: If we could talk that through in closed session so that we can go through and explain that in some detail. And we suspect you are using, in doing that number, the raw number rather than the risk-adjusted number, which is what we will go through in camera.

The CHAIRMAN: Sure. Can I ask: which organisation, whether it be BT or Serco, is going to procure the software licences and hardware on behalf of the department?

Mr Sebbes: We have no direct relationship with BT. We have a relationship with Serco and Serco subcontracts to BT. So it is Serco that provides us with the licences, the guarantees, the security— all of that. They have presumably reciprocal arrangements in the background with BT, but we are directly contracting with Serco.

The CHAIRMAN: But I understand the nature of the contract is you sort of have the ability perhaps to vet some of these decisions in terms of major contracts, but Serco would have to come to you. What you are saying, I assume, is you cannot deal directly with BT; you deal with Serco.

Mr Sebbes: Yes.

The CHAIRMAN: Serco will come to you and say that we are contracting this major element with BT, and then you have some ability to influence that.

Mr Sebbes: Clearly if we do not believe what they are coming to us with will work, we have the ability to intervene, yes.

Mr Snowball: But Serco carries the risk for the performance of its subcontractors in our contract with them. So if they do not hit our milestone in terms of the ICT, then it is Serco that is putting itself at risk in terms of its financial make-up.

The CHAIRMAN: And is it assumed that the platform will be a Cisco system? Not yet? What is the major software platform going to be, or has that not been determined? I assume at this late stage it is determined.

Mr Sebbes: It is whatever the Health platform is.

Mr Snowball: Yes, it is consistent with the health platform.

The CHAIRMAN: So it has to be the same platform?

Mr Snowball: It either has to be the same platform or capable of talking to our system. But in terms of the detail, in fact one of the milestones is to finalise that arrangement in terms of the platforms. But I am aware that that decision has been made. I just do not have that with us.

Mr Sebbes: You mentioned the service scope was a document of only a few pages. We also issued a document of technical specifications within our current ICT, which from memory is a 150-page document.

The CHAIRMAN: That is the document that we are talking about, which we have got a copy of?

Mr Sebbes: Yes.

The CHAIRMAN: So, let us come to the patient administration system, which you are developing yourselves. Can we have an update as to where that is at, because clearly that has to integrate with the BT–Serco system?

Mr Snowball: That is right. In terms of the wider health delivery of the webPAS we are about to go into a pilot of it at Fremantle Hospital. So all of the testing of the product, the software, the training and so on has all been conducted. So we are actually at the task of implementing it across our public hospitals starting with Fremantle.

[10.20 am]

The CHAIRMAN: So you are aware that we have an Auditor General's report on this, which shows a whole lot of problems with your old system and that it was getting to the stage at which it was not maintainable. Can you please give us some new information about the new patient administration system? Who has developed it, when did it start and when will it be finished?

Mr Snowball: In terms of the technical specifications, we can provide that at the close of the session, but in terms of the readiness of us with webPAS, we have a completed product. The product is an iSOFT product. WebPAS is used in other states and systems. We made some changes to webPAS because it has got to be capable of talking to our other clinical systems, including mental health and the like. All that work has been done. In fact, it needs to communicate with 25 different systems —

The CHAIRMAN: I understand that. All I am trying to understand is where the system is in its development because it is crucial —

Mr Snowball: Its development is completed. We have done all the testing of the systems. We have gone into a process of implementing it live, syncing it with our own current system through—what is the system?—TOPAS. Fremantle will be the first site for us to test that, and it is due to go live in about two or three weeks.

The CHAIRMAN: Who was the contractor doing that work for Health?

Mr Snowball: In terms of webPAS?

The CHAIRMAN: Yes.

Mr Snowball: We have our own contractors employed.

The CHAIRMAN: Who was the contractor?

Mr Snowball: A whole range of individuals. When you say "contractor", it is not a particular company; it is a whole series of companies that we have contracted to supply different elements of the webPAS service. As a project, it is led and run by Health Information Network.

The CHAIRMAN: I understood that. You did not have a major contractor doing that work for Health?

Mr Snowball: No. We had software suppliers, and iSOFT is a key component of those. We ensured that their product was capable of talking, as I said, to our other clinical systems. I am talking to you off the top of my head with that lot. I can give the committee the description of exactly where we are at and the chronology of events and all the companies that are involved, because there are a whole series of them and I would not be able to name all of them.

The CHAIRMAN: I just thought there would be a major contractor. If there is not, we will move on. I understand that the issue with the patient administration system is that it is actually crucial to the functioning of Fiona Stanley Hospital.

Mr Snowball: And all hospitals in the future.

The CHAIRMAN: No; I am talking about Fiona Stanley Hospital. Fiona Stanley Hospital could not start up if you did not have this system operational.

Mr Snowball: Yes, it could. We have existing systems. If for whatever reason the system is incapable —

The CHAIRMAN: No, that is not the question. The question is: can Fiona Stanley Hospital open without a patient administration system?

Mr Snowball: No, it cannot, but —

The CHAIRMAN: Okay, so you have a system. The point I am coming to is that it has to integrate with the software platform that Serco will provide.

Mr Snowball: There are two products. You have to have a patient administration system. We currently have TOPAS as our patient administration system and we are developing webPAS as our new patient administration system. Fiona Stanley Hospital can operate with either of those two systems, but you have to have a patient administration system.

The CHAIRMAN: And that system has to integrate with the Serco BT system; is that correct?

Mr Snowball: Correct. The other way around—the Serco system must be capable of interacting with the WA Health patient administration system.

The CHAIRMAN: I understand that. The question I am coming to is: what contractual arrangements or what documentation do you have for that integration so that the two systems actually gel together?

Mr Snowball: They are part of our milestones in terms of our contract. We have milestones in terms of the development of the Serco components so that they are synced and coordinated with the developments of the wider webPAS and state Health ICT systems.

The CHAIRMAN: I understand that is how it works. My question is: what contractual arrangements do you have between Health, iSOFT or your particular service providers and Serco, because if they run into a problem, Serco can place all the blame back on you and say it was your iSOFT or your webPAS that created the problem, not them. In order to handle that complex integration of the two systems, my understanding from talking to IT people is that you would have a detailed contractual arrangement to know how you share the risks by integrating the two systems. Can you provide us with a copy of that? Is it in the major contract, is it a separate document, or is it a document that is still being worked up?

Mr Sebbes: It is incorporated into the contract. The principle of that is that Serco need to match up with whatever system we provide on the day. If, for example, webPAS did not get up and we had to continue to use our TOPAS system, Serco would have to match up to that. That is the contractual arrangement that is in there.

The CHAIRMAN: So what you are saying is that you will be able to shift the risk totally to Serco with them having to match to your patient administration system.

Mr Sebbes: Yes.

The CHAIRMAN: So they cannot come back in any way and lay blame on any dysfunction as being within your system and not theirs?

Mr Sebbes: I am sure that they will try, but my view is that no, they cannot.

The CHAIRMAN: Okay. Thank you.

Mr J.M. FRANCIS: Can I ask you to clarify that very last statement? You said, "I am sure they will try."

Mr Sebbes: I am sure that there will be a problem with any organisation that is struggling to get their own ICT up because we are not developing ours at the same rate. There is no doubt about that. Serco will, I am sure, ask whether they could get some relief under the contract for that arrangement. That is exactly why we created the contingency amounts so that there is some money to draw down to create that position for them, but the way that the contract is structured, they need to match up to whatever system we provide on the day.

Mr Snowball: It is a very clear obligation, for the very reason that has been described by the experience in the UK and other places, which is that this is an area of risk. The contract development is very tight in terms of the contractual obligations under the main contract. There is a big body of work going on behind that, which is around the technical specifications of the relevant systems. One of the milestones is to deliver those specifications by a certain date so that we are then comfortable that both systems are coordinated in terms of their delivery at Fiona Stanley.

Mr J.M. FRANCIS: Clearly, there is a dialogue obviously between the government and Serco. Serco obviously knows what the requirements are on the current system and so they can develop whatever they need to do to make it 100 per cent compatible anyway, so there should not be any surprises.

Mr Snowball: That is why we have designed the contract in the way it is designed, which is to provide that absolute certainty for the contractor and Health.

The CHAIRMAN: If we could turn to the fittings, furnishings and equipment, when was the decision made to require Serco to provide fittings, furnishings and equipment—or FFE, as you have called it—for Fiona Stanley Hospital?

Mr Sebbes: The FFE was always in the arrangement in the original RFS release, from memory. The decision was made as part of the decision of government as to the scope of this project. It was approved by the government back in November 2009, or thereabouts. Does that —

The CHAIRMAN: You have answered that, thank you. If that is the case, good. What other mechanisms do you have in the contract to ensure the quality standards in the procurement of the FFE?

Mr Sebbes: In the contact there is a list of all the FFE. It is some 22 000 or 23 000 items.

The CHAIRMAN: I am referring more to the quality, as opposed to what it has to cover.

Mr Sebbes: That specifies what the list is. We have indicative prices in that whole list and then there are performance standards. The FFE, as against the medical equipment service, is in the estate service contract. There are a whole range of performance requirements in there that Serco need to meet, and a lot of that is around availability. The equipment needs to be there and it needs to work. If it fails, it is Serco's problem to make sure that it works. That could be to either fix it or replace it or whatever. That, in principle, is how the contract works.

The CHAIRMAN: Does the contract have a replacement cycle for various elements of the FFE, or does it just maintain to a quality?

Mr Sebbes: It is maintained to a quality. All the equipment in the hospital has a life cycle component to it.

The CHAIRMAN: Is there a life cycle for beds to be replaced after so many years?

Mr Sebbes: From memory, yes. I think that is on this list.

The CHAIRMAN: So for all the major components, there would be—for most at least—a life cycle?

Mr Sebbes: Yes. We have contracted to a minimum of one life cycle for all of the equipment.

[10.30 am]

The CHAIRMAN: I come to some of the costings. This popped up in the midyear review. The midyear review showed that you have shifted from the state buying it, so it was a capital asset and it was only in the midyear review, which was last December, that it was taken out. It surprises me then it took so long for Treasury to catch up. It was a decision right from the start that you were going to contract it out and Treasury made the change only after 30 June last year, because it

popped up in the midyear review. So they then took out the asset of some $161.2 million, if I have this correct, which was there as capital or the FFE.

Mr Salvage: I can make a comment about the timing of the reflection of that in the midyear review. That simply reflects the timing of the cabinet decision to endorse the FM contract arrangement with Serco. It was the first opportunity subsequent to that decision to make the adjustment through the budget process.

The CHAIRMAN: Thank you. Having reduced the capital spend, it then moves to being recurrent as part of your contract. Just confirming that the costs for the FFE are an integral part of the Serco contract; they do not sit aside do they?

Mr Sebbes: They are paid for via the leasing arrangement we have.

The CHAIRMAN: That is not the question. The question is: are the costs for the furnishings and fittings just assumed or contained in your overall contract cost; they do not sit outside?

Mr Sebbes: Yes.

Mr Snowball: For that list.

The CHAIRMAN: Again, the midyear review gave the figures through to 2014–15, which is standard practice, and in that year the cost will be $71.8 million, slightly higher than the year before, but that is the start-up year. What happens in the years following that? Does it go down; does it stay at $71.8 million or does it go up? Is it inflated?

Mr Sebbes: I cannot remember the picture of the graph, but in one of the documents we provide there is actually a graphical representation as to how that will change over time.

The CHAIRMAN: In general principle does it stay about the same level or is it reduced?

Mr Sebbes: I think, from memory, it goes up and then it comes down?

The CHAIRMAN: If we were to go through the out years, is it likely to be in the order of $70 million a year?

Mr Sebbes: No; I do not think it is that high; I think it comes down quite a bit in the out years.

Mr Snowball: In the way it is structured, it will be a large initial cost but as Brad said, the contract is for the first lifecycle so the various bits of equipment have various lifecycles to them. Then you start to get into a different pattern of annual lease costs based on that lifecycle. We do have those projection figures; in fact, they were in there. Hopefully, we can find them. Maybe not. Can we take that on notice?

Mr Sebbes: I can make a general comment on that. This process smooths out the annual capital purchasing cycle of hospitals, if you like. Typically, hospitals are all over the place. One year they buy a whole pile of expensive equipment because they can get the budget and the next year they cannot because someone else has got the budget—those sorts of variations. This smooths that out over time.

The CHAIRMAN: It does not only smooth it out; it also shifts it off your capital spend does it not, because it is now part of your contract so it will be taken as recurrent?

Mr Sebbes: It is a recurrent cost, yes. It is still a cost, but it is recurrent cost?

The CHAIRMAN: With respect to the way the finances were set up prior to entering the contract with Serco, you then had a capital budget of $161.2 million for your furnishings and fittings. Was there anything built into your 10-year projections for the budget to have replacement and maintenance?

Mr Sebbes: My recollection is that that was costed into our recurrent costs as depreciation.

The CHAIRMAN: Do you have a question?

Ms R. SAFFIOTI: No; but if we can get the further years' costs it would be good.

The CHAIRMAN: Are you able to find those or do we have to come back to them?

Mr Joseph: Supplementary response.

The CHAIRMAN: We come to benchmarking and value testing. Can you provide an example of how a benchmark process will be undertaken against any one of the eligible services?

Mr Sebbes: The benchmarking process is primarily set up around the five-year point—five years after operations commence. It is an opportunity to go back and check that the improvement cycle we have built into the contract is actually working. That is sort of the primary driver for it. There is a process described in the contract, which I will not go through in detail, about appointing experts and that sort of stuff to conduct benchmarking exercises and there is some process about the outcomes of that. I will go to the outcomes, which I think is probably the most important component. The way the contract works is predominantly on the fixed price services. The variable prices are a little bit different in this; they actually go through the market-testing exercise, not to benchmarking. The way the prices work is that as a starting point there is an escalation factor. It looks fairly like a straight line. Through the benchmarking exercise we can get market information and say, "The world is changing now to deliver these services; the performance indicators have changed and the pricing should change." The pricing is capped, so the pricing changes on that are capped to whatever that line is, so they have to be kept at or below that line. If for some reason it drops below the line, it could go up to the line but not beyond it, which are your normal inflationary factors.

The CHAIRMAN: In seeking reaffirmation of that, are you saying the benchmarking process cannot take it above that line of escalation?

Mr Sebbes: That is correct, yes.

Mr Snowball: So you have got certainty.

Mr Sebbes: That would require us to voluntarily offer a variation to Serco.

The CHAIRMAN: Is there a mechanism for resolving disputes about that benchmarking?

Mr Sebbes: There is a general mechanism in the contract for resolving disputes that goes through —

The CHAIRMAN: Not one specific for benchmarking?

Mr Sebbes: No.

The CHAIRMAN: I take it from what you are saying Mr Sebbes that you feel that you actually have a clear cap on that benchmarking.

Mr Sebbes: Yes. In addition, we can also, at our own request at least once a year, ask Serco to benchmark any of their services. Where we have a concern, if the markets change and then it can be value-added, we can actually ask for that individual service to be benchmarked, but not more than once a year.

The CHAIRMAN: I come to variations. How are fees structured should the department seek to vary a contract? A classic example in the UK was that the birth rate went up in an area, and they said, "Okay, we're going to actually remodel these wards and turn them into maternity wards", and because you were in a contract, the contract was able to charge an arm and a leg to make those variations. If in five or ten years' time you have a different demand level at the hospital and you need to make significant changes in one part of it, what is the method by which you would have to negotiate the variation to the contract for that?

Mr Sebbes: A very high percentage of this contract is on fixed price—a very high percentage—and there is no opportunity for Serco to come back and ask for more money based on service changes of

the type you just described. In the event that we make a major expansion of the hospital, that would come back to the variation process, but that would be negotiated at the time. Within the parameters of the physical constraints of the hospital, Serco would provide the services within those arrangements other than for the variable price services.

Ms R. SAFFIOTI: It is based on beds not what those beds are servicing.

Mr Sebbes: It says that Serco takes all the volume risk on those services.

Ms R. SAFFIOTI: So for the mix within the hospital there is no change?

Mr Sebbes: Changing the mix of services from cardiothoracic surgery to obstetrics still has the same number of patients, the same number of meals. The services to Serco do not vary that much.

The CHAIRMAN: We know that medical technology advances very quickly, so we are not talking about a shift from whether it is an orthopaedic person in the bed or a maternity case in the bed. It might be that you suddenly have a huge shift and 40 per cent of your inpatients become day patients, which would mean a major change. How does the contract allow you to make those changes and not end up paying more than you need through the fee structure?

Mr Sebbes: First of all, they are fixed price services, so if the volume is going up, Serco takes the risk. If it changes in that regard and we believe we are losing with that, we can exercise that individual benchmarking exercise I just mentioned.

Mr Snowball: We can do that every year —

Mr Sebbes: Once a year per service —

Mr Snowball: A change in magnitude would occur outside that sort of time frame.

The CHAIRMAN: How does the contract manage the development and medical technology; so when there is new equipment, how is that built into the contract?

Mr Sebbes: This goes to the MES service now. The way these services are looked at—there are reasonably well-accepted industry bands around technology, typically into five bands from old technologies through to leading research technology in a series of bands. The replacement cycle of the equipment under that is to fit in the same band. A 16-slice CT scanner of five years ago would be in band 4 on this and now the equivalent one is a 128-slice CT scanner in the same band, so that has to be replaced like to like within the band.

[10.40 am]

The CHAIRMAN: When you were negotiating the MES, where did you pitch the level of the technology?

Mr Sebbes: Generally, being a new tertiary hospital, we pitched it at about level 4 of that band.

The CHAIRMAN: How many levels are there altogether?

Mr Sebbes: Five generally. It is a little bit more complex than that in some areas, but there are generally five levels. The highest level is the absolutely leading-edge research—almost untried equipment—that is being used in various things. The next level below that is the leading-edge, high-end, hospital-performing standards, and that is where it is pitched at.

The CHAIRMAN: How do you cope with unforeseen changes in medical technology? Again, I give you another example in the UK. There was a big push to improve cleanliness and to reduce infection rates, and they introduced the handwash gel, which is now common in our hospitals. It was not in the contract, so simply placing the gel dispensers on the walls of each ward was charged at a ridiculous price because the contractor had the upper hand. How does your contract enable you, if some totally new aspect of technology comes in, to deal through the Serco contract with the implementation of a new process or new equipment at that level?

Mr Sebbes: Serco is contracted to the outcomes, not to the inputs. That is fundamental to the contract. That is the first starting point of that discussion. I cannot give an example of exactly how it would work in the scenario you have described, but that is the primary driver of the contract.

The CHAIRMAN: Again, with the managed equipment services, which you touched on, how is the procurement of major medical equipment currently managed in your major hospitals in Western Australia? Does each hospital look after its own? Do you do it centrally? Do you have preferred providers?

Mr Salvage: If you look to our *Budget Statements*, you will see a line that refers to the medical equipment replacement program. Its current value in 2012–13 will be about $40 million. There is a centrally managed process whereby area health services put up lists of new equipment that they want specific to hospital sites and a collective process across WA Health for the distribution of that $40 million per annum.

The CHAIRMAN: So does that mean Health is able to, through economies of scale, drive fairly good deals with the suppliers?

Mr Salvage: It was one of the rationales for centralising the equipment replacement program; correct.

The CHAIRMAN: What is the estimated saving for the state in having Serco manage the MES service rather than have the state directly contract with an MES provider or providers?

Mr Sebbes: I just go to the principle of that question. To control the costs, we have actually priced our price list. We have actually put in the best estimates we can get off current achievable market prices, so there is pricing control and then budgetary control built into the process. I will just use one of the examples we used when we looked at the MES. We looked at some hospitals in the UK. They were getting performance rates of availability of equipment way above what we currently get in Australia. For example, Leicester hospital was getting 99.5 per cent availability of major imaging equipment, whereas typically the standard in Australia is around about 93 or 92 per cent. We have contracted up to those higher levels, so what we have is less down time, more efficient use of the equipment and those sorts of things. There is actually a significant operational component to this, as well as the capital component.

The CHAIRMAN: The operational aspect may cost more, but it is worth paying more.

Mr Sebbes: It should not cost more.

The CHAIRMAN: In the example in the UK, I was led to believe that it was costing a lot more, but doctors were happy because they had good equipment that was well maintained and replaced. They like the efficiency side of it and the improved quality, but there was a general recognition that they were paying more for it. I am accepting that you are getting a good deal in terms of the quality and the up time, you are hoping, but what about the cost?

Mr Snowball: The key bit is that this list of equipment, which we have under the contract arrangement, is priced at the broader volume. We are not paying more for the equipment per se. The added benefit, though, as in Brad's advice in terms of the UK experience, has been that we have that equipment more readily available to our clinicians, who are getting better value from the equipment in terms of its life in the hospital. Yes, the risk is carried by Serco in respect to the down time of that equipment. From our perspective, we are getting a comparable price but a better arrangement in terms of equipment availability.

The CHAIRMAN: The market sounding documents, which you have shared with us—you have agreed to make part of it public—actually had a number of your participants, which obviously I will not name, saying that you achieve better value for money by direct purchase of your medical equipment rather than actually contracting it out to someone regardless of who had the contract. There are obviously views in the marketplace which differ from the decision you have taken.

Mr Sebbes: Can I comment on our expert interpretation of that? That was perceived to be the suppliers not wanting to take the risk of managing a major equipment supply, which is the case here. We have stepped back. That was a way of them mitigating their risk going forward, and that was not a risk that we were prepared to take back.

The CHAIRMAN: Going to service specifications, can you please outline for us the process involved in developing the service specifications, including information about the companies contracted to assist in the process?

Mr Sebbes: The service specifications were developed in consultation with a number of companies. The prime company there was MBM PL, which I mentioned before, in terms of extracting the information from other PPPs in Australia and around the world. There was legal input into that, so there was quite a bit of legal overview and commercial overview of that. We had a further review of that after we had developed our first service specifications, which we had completed by Ernst and Young as part of that process.

The CHAIRMAN: What were the bases for the service specifications dated April 2010; that is, what were the benchmarks used to establish the requirements in April 2010?

Mr Sebbes: They were a combination of current best practice that we could find around the world, with some added comments of our own, if you like, where the existing services in other projects did not quite match.

The CHAIRMAN: Obviously, those service specifications changed. Would you characterise the changes made to the service specifications during the contract negotiations with Serco as having a material impact upon the quality of the services to be provided?

Mr Sebbes: My view is that generally where the service specifications changed, it was to our advantage.

The CHAIRMAN: So there was a bit of give and take.

Mr Sebbes: There is always a little bit of give and take, but I have actually got a set of track changes here of the service specifications from the time that we went to the market to the time that we finished contract negotiations. When you go through that generally, what you find is that most of the changes to the service specifications are very technical things like tidying up definitions and linking the definitions back to the contract and making sure they are all consistent and those sorts of things. Where we have changed a specification, it has generally been either to clarify—the avoidance of doubt–type question—or to improve our position.

The CHAIRMAN: Can you give us an example of where you feel, through that negotiation, you actually made up ground and you actually ended up being able to achieve something better, perhaps on the basis that you had made ground somewhere else?

Mr Sebbes: We were just talking under the MES about the performance regimes in there. We had included some. The bidders did not come in at the levels we had expected, so, through the negotiations, we went back through and raised them back up to where our expectations were. For example, where we have got four CT scanners, we have got a very high level there. I have already mentioned the percentage. I do not think it is that thing. That is a 99 per cent up-time standard for that equipment.

The CHAIRMAN: Can we have some examples of perhaps where you had to give ground or lost a bit of ground in terms of some of those specifications?

Mr Sebbes: I do not actually have any off the top of my head.

The CHAIRMAN: Would cleaning times be one of them, where you had to allow greater time for cleaning?

[10.50 am]

Mr Sebbes: What I have done, I had been expecting quite a few questions on that, so I have actually printed the track changes version of the document so you can go through each specification and see what has changed, and then we can take questions specifically on anything you want to look at.

The CHAIRMAN: Can you make that available to us; and, if so, does it need to remain closed?

Mr Sebbes: I can table that.

The CHAIRMAN: Does it need to remain closed?

Mr Sebbes: I think it should.

Mr Snowball: There is only one copy, unfortunately.

The CHAIRMAN: That is all right. If you can leave that with us.

Ms R. SAFFIOTI: On what basis were the decisions made? For example, if there were changes in times in relation to cleaning or other issues, on what basis were those changes made?

Mr Sebbes: There was some discussion about—so, if you are talking about response times in the contract?

Ms R. SAFFIOTI: Yes.

Mr Sebbes: There was some discussion around, for example, the response times we had in the contract. Serco was saying we could not physically get someone from the central hospital to attend on the site in the time you have asked us to. Some of that when we analysed it, was real. We cannot expect somebody to respond in five minutes if the quickest time you can possibly do it is 10. So there are those sorts of changes.

Ms R. SAFFIOTI: But when you initially set up the standards or the required standards, how come—were you wrong in initially —

Mr Sebbes: Essentially, yes, we just picked up standards from other projects and some of those projects were physically much smaller than ours, so some of these errors, if you like, crept in to the specifications.

Mr Snowball: But it is reasonable to characterise this that the vast majority of these are about clarification—removing any uncertainty as to what a particular definition related to. So, that was really by and large the changes, as well formatting changes and the like. In terms of the issues of real substance, most of these, as I think Brad has described, is about ensuring and clarifying the management of that risk for the state. So, in other words, wherever you can be sure that it is really clear that this risk is held by the contractor, not by the state, that is the sort of clarification you have got in the specifications. In terms of the cleaning one, there is a whole range of things. For example, where we talked about the risk category, we talked about location. You might say it is for day services. That has now been clarified to say day procedures, day surgery, day care—every aspect of the services is just made more detailed by the changes that have been made in terms of the specification.

The CHAIRMAN: Also in documents you have shown us in terms of the time to actually complete cleaning when it is non-urgent, you have allowed much more time in a number of categories.

Mr Sebbes: Yes, but we have not loosened down the urgent and emergency categories. That is just about being a bit flexible about what is a sensible request, if you like.

Mr Snowball: It is also no lower level of service that we have in terms of our other public hospitals. It is not a reduction in response time. In fact, across the board there has been an increase in terms of response times.

Mr Sebbes: We have 100 per cent control over what defines the categories of patients. It is not defined by the definitions; it is defined by the senior staff there at the time. So, a senior nurse, for example, can say it is an emergency and Serco need to be acting in emergency time.

The CHAIRMAN: Your KPI on failures with cleaning, you went from allowing six instances in three months to 30 instances in three months. That is certainly was a bit of a lowering of standard, I would have thought.

Mr Sebbes: On the non-urgent ones?

Mr Snowball: Not against other public hospitals. Part of this is about where this is pitched. Obviously, we have tried to be fair about it. So, we looked at pitching it in terms of what is the minimum standard we are expecting in our public hospitals, but then a lot of these are actually lifting those standards. Whilst we may have that as a generally accepted level across our hospitals, we would like to see that tightened and improved in terms of this contract.

Mr Sebbes: Some of our standards, we set the bar extremely high in the contract documents as well, expecting to be pushed pack. Some of those things—I will not go into the details—if you calculate them out, they did not need to have many failures to lose all of the service contracts.

Ms R. SAFFIOTI: They were pushed back after Serco won the contract.

Mr Sebbes: They were pushed back during the contract submission and completed in the contract negotiations. To my knowledge, there was nothing that arose just in the contract negotiations. These were in their response.

Mr Snowball: But the key message is that there is no reduction in terms of the service standards we expect from Serco as we expect from any of our other public hospitals and in the main it is actually a lifting of those standards.

[The committee took evidence in closed session]

[11.17 am]

Ms R. SAFFIOTI: In relation to the state budget and the move from Royal Perth to Fiona Stanley, as I understand, Royal Perth is going to continue operating at its current level.

Mr Snowball: No.

Ms R. SAFFIOTI: How many beds is it going to drop?

Mr Snowball: It goes to 410 under our clinical services framework. It is all public information so there is information out there that says what Royal Perth's numbers will look like post Fiona Stanley being established and what Fremantle Hospital in particular will look like once Fiona Stanley is built and operating. So, those numbers add up. We did not, obviously, bring those numbers with us, but the bed numbers for Royal Perth will go to 410 and Fremantle is —

Mr Sebbes: Fremantle is 330 or something like that.

Mr Snowball: If you want that on notice, we can give it to you on notice, but basically the reductions are to recognise the level of activity. Once Fiona Stanley is established, what we are doing is the level of predicted activity does not change; it is about where you provide the service. That is why the comment earlier was with the retention of Royal Perth, it meant you do not need as many beds at Fiona Stanley, so what we have done is bring other services into Fiona Stanley that we wanted to bring to Fiona Stanley but was not the capacity to do it. So, part of that is a total reconfiguration of service delivery and service profiles at each of our major hospitals to accommodate, basically, the growth that we have seen in demand from our community.

Ms R. SAFFIOTI: So you are comfortable with the current forward estimates in the health budget in that it reflects existing plans for all activity and not increased.

[11.20 am]

Mr Snowball: That is right; we have moved to a system now in the last two years of activity-based funding. What that means is that we predict the activity growth in the system and government says whether it wants to decide to respond that activity growth as well as that cost growth. Now we have certainty around, as our services grow, as demand grows, then so too does the state government contribution to health. It is based around benchmark prices for activities, so there is a certainty from government about value for money in terms of the activity at a level of quality and for us there is certainty is that we can plan our services against our own known understood growth in demand from our community.

Ms R. SAFFIOTI: So just to clarify, Royal Perth is going to drop. What is it currently at?

Mr Sebbes: Excluding Shenton Park, it is around about 680 beds now.

Ms R. SAFFIOTI: So 680 to 410 in about 2014?

Mr Snowball: That is right. The other side of this is, because we have now good solid predictors of activity going forward in terms of population growth and ageing and so on, we are also able to align our infrastructure plan with that, our workforce plan. All of the things that go alongside that projection can be planned and organised from the health system perspective. We have now accommodated obviously Fiona Stanley, Midland and the new kids' will be another one as well, but also across the country with hospitals at Albany and Busselton and Kalgoorlie and so on. It is major investment in infrastructure which is going to give us the capacity to meet the demand and needs going forward in terms of health from our community.

The CHAIRMAN: I have some very quick questions, if I can. The "webpos"—how do you spell that?

Mr Snowball: It is webPAS, which is the patient administration system.

The CHAIRMAN: Thank you on that one. The remote-controlled vehicles that are going to be part of it—is that still progressing, or are there issues that perhaps you have to do it a bit differently?

Mr Sebbes: No, the automatic guided vehicles are still progressing. Serco, from memory, is currently intending to get its suppliers in place right at the moment.

Mr Snowball: But that is all backroom stuff. You will not see a robot in the corridors.

The CHAIRMAN: It was not designed for it, but they have been able to accommodate that.

Mr Snowball: They have.

The CHAIRMAN: The last one is: there has been a bit of disquiet in terms of the contract through BT in terms of local jobs, because on its website it promised that will create 71 local jobs, because the BT statement it put out. Has it given any undertaken to Health that there would be jobs here, or is that something you have not been involved in?

Mr Sebbes: Not from BT I have not heard anything, but Serco has certainly been making some quite strong commitments about how local jobs are part of this process. In fact it ran an industry participation workshop at CCI last Wednesday going right through that in some detail.

The CHAIRMAN: Obviously, most of the jobs for your facilities management, of course they are going to be local people, they are low level. But it is at the higher level perhaps that, where you are bringing in expertise. Was the commitment made there, or just overall?

Mr Sebbes: Even at the technical level, when you get into the higher jobs, particularly around the clinical equipment and the maintenance of that and that sort of stuff, the performance criteria we have got effectively means they have to have people on the ground in Perth to provide those services. They cannot fly somebody in from Sydney and meet their performance requirements.

The CHAIRMAN: Thank you very much. I just have some closing statements. Before I go to that, as I say, I really appreciate the amount of time you have given. Hopefully we will not need to get

you back and use up your valuable time, but we certainly will be in that position if you can respond and if there are one or two things that we ask our staff to contact you to tie up loose ends, then it means we can get on to finalising the report and, again, not take up your very valuable time, which we are most appreciative of. I thank you for your evidence to the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include supplementary submissions for the committee's consideration when you return your corrected transcripts of evidence. There are a number of specific issues where you have undertaken to provide that supplementary information.

Mr Snowball: Thank you.

Hearing concluded at 11.23 am