T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Inquiry into infrastructure projects

Melbourne — 20 September 2016

Members

Mr Joshua Morris — Chair
Mr Khalil Eideh — Deputy Chair
Mr Jeff Bourman
Mr Nazih Elasmar
Mr Bernie Finn
Ms Colleen Hartland
Mr Shaun Leane
Mr Craig Ondarchie

Participating member

Ms Samantha Dunn

Staff

Secretary: Lilian Topic

Witnesses

Associate Professor Alex Cockram, chief executive officer, and
Mr Russell Harrison, executive director, operations, Western Health.

The CHAIR — I will begin by declaring open the Standing Committee on the Economy and Infrastructure public hearing and welcoming all those present here today. Today the committee is hearing evidence in relation to the infrastructure inquiry, and the evidence today is being recorded. This hearing is to inform the third of at least six reports into the infrastructure of projects, and witnesses present may well be invited to attend future hearings as the inquiry continues. All evidence taken today is protected by parliamentary privilege. Therefore you are protected for what you say in here today, but if you go outside and repeat those same things, those comments may not be protected by the same privilege. Thank you, Professor Cockram and Mr Harrison, for coming along and providing evidence to us today. I believe you have got a presentation you might like to take us through, and we might follow it with some questions after that.

Visual presentation.

Assoc. Prof. COCKRAM — Fabulous. I have done a short presentation just to orientate to perhaps the conversation of the day. Thank you very much for the opportunity to come and discuss the west of Melbourne and the important issues around health.

Just to orientate — I am sure people are pretty across a lot of this — the catchment for our health service is over 800 000 and expected to grow very rapidly in the coming years. We serve the western suburbs of Melbourne and obviously in that have two of the fastest growing municipalities in Australia, particularly the Wyndham and Melton corridors. One of the challenges in health in the west of Melbourne is the high rates of diabetes, obesity, cancers, mental health and drug and alcohol problems. A lot of these are factors that are related to high rates of smoking, high rates of obesity, low rates of physical activity, poor nutrition and low health literacy in our region, which means that people are less likely to present early with symptoms or concerns about their health.

The outer west particularly, but across our region, also has challenges around access to health care, so we have low rates of general practitioners in our region, low rates of private providers — such as specialists and those activities — dental services and pharmacies. All that, I guess you can imagine, leads to increasing challenges on the actual public health system.

A high proportion of our population was born overseas. Sixteen per cent prefer to have their health care delivered in a language other than English, and we have 110 languages spoken in the region, which again you can imagine influences how we deliver health care.

Just to talk a little about our health service, I think the first thing I want to say is that we have a very strong relationship with the other health services in our region. We have a group that works together with Western Health, Werribee Mercy and Djerriwarrh Health Services to try and consider the issues across the region, because of course the three health services do work in partnership. In particular in relation to Western Health, our services are delivered through the Footscray, Sunshine, Williamstown and Sunbury hospitals. We have the Hazeldean Transition Care centre in Williamstown, and we also deliver a lot of care in community settings and in patients' homes.

We have got the third-highest number of births of any hospital in the state, with 5300 births delivered at the Sunshine Hospital. That is obviously growing very rapidly, and one of the wonderful things about the west of Melbourne is that we have a lot of young families who are needing both maternity and paediatric services.

Just for the committee's consideration, we are one of the largest delivery organisations, or maternity organisations, that has maternity embedded within a general hospital. That is unusual. It has a lot of benefits to it, though, because we have very rapid access to specialist care, such as cardiology, intensive care units and all the specialty services — imaging and stuff — that go with being actually co-located within a large general hospital. And so therefore the two other maternity hospitals that deliver more babies than us are the standalones, being the Women's and the Mercy.

We have 6500 staff and over 600 volunteers. I guess the thing that we talk about a lot is most of our resources are delivered in frontline care. We see a lot of patients, do a lot of ED presentations and see a lot of people through outpatients. Where we are wanting to focus a lot of our attention at the moment is improving community outreach and stronger research relationships but also importantly working more closely with general practitioners, community health and our other health agencies to look at developing stronger programs around chronic disease, preventative health and increasingly early intervention for our community. So that is bit of a whip-around of Western Health.

What I thought perhaps was of interest today was to start obviously talking about some of the infrastructure components that have happened in recent times. So particularly looking at the Joan Kirner Women's and Children's, this is a relatively up-to-date picture, but we are still working through schematics and design at the moment. Just to say, the process with Joan Kirner has been well consulted with community. We had a local resident meeting just fairly recently, but we have had a number of consultations with our consumers, patient advocates and a whole range of people about how to design and think about what this wonderful new building and women's and children's hospital will be delivering for our community.

The actual building itself is a large building, from basement to level 9. It is well connected back to the existing facility. As I say, the interiors and patient and public areas have been well consulted to ensure that they are welcoming, friendly and appropriate for our community. I have mentioned before that our community is very diverse and has very different considerations in relation to health care and what they expect a healthcare facility to look like. We have also got one of the fastest growing Indigenous communities in Melbourne, so that is another thing that we have been consulting and thinking about in relation to how this facility will feel from a community perspective.

This is the Sunshine site, and just to orientate you, down the bottom of this graphic is Furlong Road. Our site then moves up towards St Albans, if I can describe it — further towards the St Albans shopping centre — and you can see the indicative site of the Joan Kirner Women's and Children's. It is well nestled back into the main building, which means it has ready access through into other parts of the building for both public areas, such as the front entrance and all those sorts of things, and also through to clinical and other specialties.

So just some detail around that: Natalie Suleyman is leading the community consultation committee and is meeting with the community about how the building is coming together and how that is being developed. There has been widespread and comprehensive clinician and staff engagement through this process. Because we are a high-risk, high-value project, we have gone through three of the gateways successfully, and they have been very helpful, as I find the gateways are, in contributing to providing support around managing the issues in relation to any build.

We are near to finalising the exterior facade, although I think that picture that you saw is pretty close to where we are getting to. The design on the interiors as a large block layout has been completed, but what we are currently working through is the specific detail around mock-up rooms — the actual individual spaces — and so we have five prototype areas currently that our staff and consumers are starting to view to make sure that the inpatient room feels right, that the delivery room feels right, that when a nurse walks in they can feel everything is in the right space for them. Alternative pathways and access points during construction are planned and arranged, because we obviously are a going concern and have to keep the site working.

The other major infrastructure consideration for us is thinking about the Footscray site and the future of the Footscray site. We currently have a plan for moving forward. Just to describe where we are up to on that, in the May budget we were successful, with the support of government, in getting additional funding to keep essential works going. It is the south block that is particularly aged, if I can describe it that way, on the Footscray site; 1955 we were built. We have definitely ageing infrastructure that needs significant support at the moment, and so that support from government will keep us going now for the next five years. What we are anticipating is an opportunity to go forward with more detailed planning — and the budget provided for that — to consider how the site is best utilised for the community. That is the most important part here.

The funds that we have already got are addressing things like the infrastructure support funds — building facade, repairs of roof membranes, floors, chillers. These are not super exciting, but they are very important for keeping the infrastructure going. Things like the chillers are very high-cost items. As we put in the new chillers we make sure that they are able to be uplifted and put into any future buildings, so we are considering anything that we can make sure will be able to be utilised in our future. Those essential works are being prioritised in conjunction with the department and based on the advice of detailed plans by engineering experts. That is a bit of an introduction, and I thought I would then leave it open for questions.

The CHAIR — Thank you very much, Professor. I was staggered by the number of babies that are being born each year in your health service. I imagine, with my rudimentary maths, that works out to about 15 babies a day that are being born, and I can only imagine the pressures that might be placing on the health service. It is very exciting for Victoria but at the same time challenging as well. I thought I might just begin with a question in terms of looking into the future. If we were to pick a date of, say, 2025, do you know how many extra beds

are going to be required in your health service to manage that increasing demand looking forward into the future?

Assoc. Prof. COCKRAM — We have gone through detailed service planning over recent years, and that has to be refreshed fairly rapidly because the community of the west has accelerated its growth in a way that people, I think, did not fully anticipate in the past. We have been supported by the department to keep making sure that we are as current and contemporary with our projections as we can be. Currently we are predicting that we need for our health service — this is not for the region; this is for our health service — about an additional 550 beds for 2025. That should then support the community, but it also would anticipate that Werribee Mercy and Djerriwarrh are getting increases in that same time period.

The CHAIR — Where are those 550 additional beds, which is a phenomenal amount of beds, planned to be?

Assoc. Prof. COCKRAM — So 270-plus points of care come online with the Joan Kirner, so that has already been now supported and taken care of. The Joan Kirner not only has the advantage for us of bringing on new maternity beds, but as you can imagine, it means that we can move maternity services out of the existing facility and repurpose the existing facility for other surgical beds and short-stay beds for the emergency department and other aspects like that. It gives us the advantage of not only supporting women's and children's services but also giving us enhancement within the facility, so that is a significant support to that. We have anticipated that some of the additional support would come through the Footscray developments at some point.

The CHAIR — Obviously with the Footscray Hospital, you gave us a bit of an update on that, I am just wondering: at this point in time are there any beds at the Footscray Hospital not being used?

Assoc. Prof. COCKRAM — The south block facility has, as we have mentioned, significant infrastructure problems. It has significant challenges in delivering high-quality care through the existing infrastructure, so we are down to now just over 70 beds existing in the south block. There are closed wards in the south block, but they are not currently fit for patient use, so we have taken those beds out.

The CHAIR — So how many beds might that represent that are not being utilised?

Assoc. Prof. COCKRAM — It is hard to say how many beds, because we would say that the facility is not appropriate to be restocked.

The CHAIR — If it were up to scratch?

Assoc. Prof. COCKRAM — When we had the opportunity of bringing the acute services building fully online over at Sunshine and taking the critical care package, which was a very significant component of the development of Sunshine, we moved 90 beds out of the south block out to the Sunshine facility.

The CHAIR — I was going to ask what the rebuild of the Footscray Hospital looks like, but you had some images there about what it may look like. I am just wondering: do you have an indicative cost of what the rebuild of the Footscray Hospital might cost?

Assoc. Prof. COCKRAM — When we did the original indicative cost we were anticipating how the two sites would be done sequentially. There has now been a break between bringing on the Joan Kirner and the Footscray, and we think we need to go back and rescope the Footscray development. A couple of things, we know, are changing, and one is that Footscray needs a new ED. That has always been part of the plan, so it is the south block and the emergency department. We believe that the emergency department and new ambulatory facilities, which were anticipated, now need to be somewhat redesigned to meet modern standards around chronic disease management, so we think that needs rescoping. I would prefer not to put a figure on that — you can work with the department a little more on that, but I prefer not to put a figure on that — because I think it does need rescoping and some sense of where it is heading. The original figure I think now would need updating.

The CHAIR — Do you know the original figure, just in the ballpark?

Assoc. Prof. COCKRAM — The original figure was around over $300 million, but I think that the figure now would be significantly greater than that.

The CHAIR — In the order of making sure, are we talking double or $450 million or — —

Assoc. Prof. COCKRAM — I would just be guessing.

The CHAIR — Indeed. I note that there was $2 million of planning money in the last budget for the Footscray Hospital. I am wondering: how far will this get you into the planning process of, obviously as you are saying, the changes?

Assoc. Prof. COCKRAM — I think that would be helpful in establishing the actual cost of the configuration on Footscray. The original plan was how we could continue to deliver services in Footscray whilst going through the rebuild. That is very important. The community would need us to continue to deliver care through that facility, so it has to be a staged development, particularly for the emergency department. We would have to build a new one before we could close the old one, so I think an important part of our next step is using that planning money to actually consolidate now what the build on the Footscray site would look like and then what it would cost.

The CHAIR — Do you know what additional planning money is required to get to that point where you will know what the new scope of the project is going to look like, what order of magnitude that might be, just the planning dollars?

Assoc. Prof. COCKRAM — I think that the anticipation following the discussions and stuff we had prior to the budget was that we would anticipate that we would need at least that $2 million to do the planning.

The CHAIR — So should that $2 million be enough to scope it up?

Assoc. Prof. COCKRAM — I am sure people understand that planning can go from a very early business case through to detailed planning through to comprehensive schematics and all the way through to actually getting ready to get a builder to build the building. I do not think it is going to get you through that whole process, but it would certainly get us well underway to know what the best configuration on that site is and what the budget pool would be.

The CHAIR — I note there was the $14.8 million that was in this year's budget for maintenance. I am wondering: how long does that money keep the hospital running for and how much more money might be needed for maintenance next year?

Assoc. Prof. COCKRAM — The maintenance money has anticipated that it would support the organisation over the next five years for substantive infrastructure.

The CHAIR — So that $14.8 million is for the next five years.

Assoc. Prof. COCKRAM — Yes. The challenge around substantive infrastructure is that there is preventative infrastructure, which is what the engineers have been working with us on, and that is anticipating where you are going to get failure points. In a very old building — 1955, still running on steam in a large component of it — there can be failure points that we cannot anticipate, and therefore how that money is deployed during those five years will be a bit dependent on both getting going on the preventative work but also obviously using what we need to if there are urgent, critical aspects that we have to just fix. One of the things is, like the chillers, you can spend very different amounts of money depending on how much we need to invest in that at that point in time. I think $14.8 million is a substantial amount of money. The preventative works will protect us to a large degree, but there are also, I think, going to be unanticipated works — and they are unanticipated, so we cannot fully predict that.

Ms HARTLAND — I live not far from the hospital, and as I am an accident-prone person I have used the emergency room on a number of occasions. Staff are fabulous, but the room itself is in just a really, I think, physically diabolical state. Could you walk us through what would actually be needed to rebuild the emergency room and roughly — I know you are saying the rescoping would make it difficult to pin it down — what you think it would cost? I think there is a third question: how much longer can the hospital survive with that emergency room or how much longer can the emergency room survive in its present condition?

Assoc. Prof. COCKRAM — Like is often discussed in the public domain, emergency department presentations are increasing, and they are particularly increasing across the west of Melbourne. The Footscray

ED is a very busy place, and it is anticipated it will continue to grow. Therefore it is still working within very old infrastructure that is very fixed in its space. There are not any obvious easy fixes to the Footscray ED. We know that if we benchmarked ourselves against the college of emergency medicine or various other ways in which you could do that, we are vastly under-cubicle-sized, if I could describe it that way, in relation to what you would anticipate for the amount of people currently turning up in that ED, let alone any future growth.

The other thing that we know is that the ED cubicles themselves — and, Colleen, you are right, you have sat in a few of them — are built for a different era. An example would be that if someone has a cardiac arrest in one of our ED cubicles, they cannot get the equipment in next to that patient — they have got fixed walls — and the patient has to be wheeled out into the central corridor and the resuscitation has to start in that setting. We do have obviously resuscitation cubicles that are all there, available when they are, that people get moved into, but the facility is not a modern environment that is geared to the modern equipment and modern practice, and we know that.

The care there is outstanding, and as you say, the staff are remarkable — remarkable every day. I think that the care in our facility is terrific, but the facility is a challenge to our staff. Anyone would say it would be ideal to start rebuilding the Footscray ED. The anticipated cost when we originally did the costings — but this is now a number of years ago, and that is what I am trying to be honest with the committee about — was well over $60 million if we wanted to rebuild the ED up to a modern facility and include things like short-stay units and appropriate other facilities that now go around a modern ED. I think, Russell, the new ED was anticipated to have more resuscitation rooms.

Mr HARRISON — We are going to go to 65 cubicles. We have currently got 36. We were going to go from three resuscitation bays to six, and that would start to get a horizon out at 25 years and beyond in terms of the likely growth and what the facility needed to be. We would go up to 24 short-stay beds, which is equivalent to what other new EDs have built for that kind of model of care. It is a pretty tested model around Victoria and around metro, but that is the kind of size and scale of change that we would get. And as Colleen has said about the cubicles, you are not really supposed to be able to do that from the bed and touch the walls. It does make health and safety, and lifting and getting equipment into the rooms challenging.

Ms HARTLAND — If Western Health had been able to do the combined rebuild of Footscray and Sunshine, can you talk about the economics of that?

Assoc. Prof. COCKRAM — When you are trying to rebuild on a site, one of the issues is always how you continue to deliver care whilst you are doing your rebuild. So there are issues around decanting, really, of being able to place your current clinical areas somewhere else while you refit and demolish or whatever you need to do.

In relation to the emergency department, actually it is relatively straightforward from a site perspective. The first stage would require us to have demolished education areas that could be repurposed and replaced in another part of the facility and allow us to pretty much rebuild — it would not be a greenfield — in a relatively easy space while we kept going with our emergency department.

Where the challenge comes is when we need to in the current plan — and again I think part of what the process of planning might do is look to see if this is still the best way forward — bring down the south block whilst still delivering care at that hospital facility. One of the aspects of that was being able to use the decant out to Sunshine, if I could describe it that way, so not actually reduce our capacity to deliver care for the community of western Melbourne, and therefore be able to make that reduction at Footscray as an interim and then bring new care back online at Footscray.

As we get more and more growth out at Sunshine, our capacity to use any unutilised facility is diminishing, if I could put it that way. We are needing every space we have got at Sunshine and increasingly needing every space we have got it Sunshine, and even when we move patients into the Joan Kirner building, it is likely that that backfill capacity, if I could describe it, which is terrific for the community, will get utilised pretty much straightaway. That repurposed surgical ward will be needed to manage the waitlist at that point of time. So that is why the economics change as you get a delay, because we had anticipated not needing to build, if I could describe it, a decant facility. I am not sure how that projection now starts to work.

That is the economics. It is about what you do with existing points of care. So the ED is relatively straightforward. We are not particularly concerned about how that would work. The issue for us is actually when the south block comes down and how we would be able to manage.

Ms HARTLAND — Can you tell me what the average age of a hospital is, because Footscray is 1955?

Assoc. Prof. COCKRAM — Given the substantial part of Footscray is the 1955 facility, I think we are now one of the oldest facilities in the state. I am sure other health services have components of older buildings, but as a substantive part of our facility, I think we are one of the oldest.

Mr LEANE — Thanks for your evidence today. Just recapping on your presentation, regarding the Joan Kirner women's and children's, I just want to talk about funding. My understanding is that was $200 million, and then there was $44 million to Sunshine, and I might ask you to expand on what that capital works funding in Sunshine means, and I accept along with you and other committee members who have already spoken that $17 million to Footscray is not the end of all the woes there, as we all do, but there is $17 million there. When you add up the 244 and the 17, I would understand that there would be some miscellaneous capital works projects through the network. I do not know if you want to expand on that, but there might be some smaller capital works projects going on at different locations. So that takes us well over $270 million of capital works spend in Western Health. What does that compare to in the recent past? Has there been that amount of money spent on capital works in the previous four years or the previous eight years? Is that a hard question to ask?

Assoc. Prof. COCKRAM — It is probably a hard question for me to answer; I have been at Western for the last four years. We have been well supported across the last couple of governments in relation to the Sunshine campus. The acute services building was funded by previous governments — I cannot tell you which previous governments — and that was a new inpatient facility at Western. Then in the last government we were supported with the ICU coronary care package, which was an important part of bringing the Sunshine facility up to being a full acute health service, and then over the last couple of years we have been well supported with both the Joan Kirner funding and then, more recently, with the additional funding works at Sunshine, as you have described.

Just coming back to Footscray, I agree about the $17 million. What that does do is it allows us to keep going for a bit longer, but I think we all understand it is a bit longer. Also, I think that with the planning money it means that we can get on and plan the right facility for that community. I think that is a real opportunity at this stage to move forward on that.

Your other question was in relation to the additional package we got in last year's budget in relation to Sunshine. As you can imagine when you bring on a new hospital, which is a substantive new building, there were a number of additional things we needed to ensure that were appropriately scaled to support that new building — loading docks, food services, and the refurbishment, as I have described, of some of the existing facilities so that we can actually not only bring on new women's and children's facilities but bring on new acute-care facilities, which is very important. It also provided some support around additional support to the emergency department, which is growing at a rapid rate. So with all of that, that is what the additional package was able to provide — additional support across the rest of the facility to not only support the new building but also to give us some additional acute-care capacity.

Mr LEANE — So are there any smaller capital works projects going on in the network?

Assoc. Prof. COCKRAM — The only additional funded capital — well, it is capital — is that we have been supported with, part support to, the EMR, the electronic medical record.

Mr LEANE — Can I touch on — —

Assoc. Prof. COCKRAM — Yes, I could describe that to you. One of the big things for us is that car parking at Sunshine is an absolute challenge. So we are just working with DTF and have had an initial positive response back to receive the loan for the new multideck car park.

Mr LEANE — Fantastic.

Assoc. Prof. COCKRAM — That is fantastic as well. That is another component that is very supportive.

Mr LEANE — Yes, I think car parking at every hospital is a challenge.

Assoc. Prof. COCKRAM — Yes, because that is us working with DTF around that loan, but it is a great opportunity and it will make a huge difference. We anticipate that we will have the car park completed at the same time as the Joan Kirner. So you can imagine, the Joan Kirner has a lot more staff but also a lot more patients, and so that will support the facility significantly at that point in time.

Mr LEANE — Can I ask: what are the extra staff numbers that you would need for the Joan Kirner?

Assoc. Prof. COCKRAM — When we first did the figures we said about 1000 for both the Footscray and Sunshine developments; I think we are still sticking with that at this point.

Mr LEANE — A thousand?

Assoc. Prof. COCKRAM — Yes.

Mr LEANE — Fantastic. Can I go back: you mentioned the previous government supported the ICU — I cannot remember the middle word you said?

Assoc. Prof. COCKRAM — Coronary care.

Mr LEANE — Yes, package. Was there a money amount of that?

Assoc. Prof. COCKRAM — Over 25 million.

Mr LEANE — I can appreciate you saying that government support is good. But I suppose when it comes to capital works, what is the best way for a government to support a health network? I can come and say I support you — right?; which means nothing — but if I was in your seat I would say, 'Show me the money'.

Assoc. Prof. COCKRAM — Yes.

Mr LEANE — Yes. Okay, thank you.

Assoc. Prof. COCKRAM — I mean, one of the challenges in the west of Melbourne is that it is significant growth, and so just keeping up with that is a real challenge, and we know that. I know I am not here to talk about the north, but I do always feel really conscious that when I talk about the west I could be sitting here running a health service in the north of Melbourne and it would be the same challenges. The high growth corridors are very significant at the moment.

Mr LEANE — Yes; thank you.

The CHAIR — I just want to ask a question that arose from the car park there. I note that you said there is a loan with DTF that you are arranging. I know the cost of car parking at hospitals has been in the news of late. What sorts of arrangements have you got to try to recoup that cost? Are you trying to keep the car parking fees low? What is the methodology behind that?

Assoc. Prof. COCKRAM — So we do keep the car parking fees low in the west of Melbourne, and we think that is a part of supporting our community. We obviously also support people with concessional requirements, and anyone who has any hardship or need also is supported — with chronic disease, who are in and out a lot. So we have a whole range of considerations for our community around car parking fees. I absolutely understand that people would prefer not to pay any fees on site; however, it does cost us to run the car parks and it does cost us to maintain those facilities. But we are very conscious of our community.

The CHAIR — Indeed, very good. There was talk earlier this year that the Williamstown Hospital emergency department could close due to funding changes. Was that ever really going to happen?

Assoc. Prof. COCKRAM — I will talk a little about Williamstown. So Williamstown is obviously our oldest facility and is a facility where investment over recent years has meant it has a very strong surgical and rehab component to it. So we have four very modern theatres working down there which provide elective surgery support to a large number of our patients, and then they can go straight through to the wards and straight through to their rehab. So you can imagine quite a lot of orthopaedics is done in that facility.

Also there is a large dialysis centre, and it has an emergency department. The emergency department has limited hours, because the nature of the facility that exists at Williamstown means that you would not want to have acutely unwell people there arriving at midnight — the radiology, the pathology support services and those things. It is a small hospital, so it is a safety issue for us about how that ED runs. But it provides enormous support for the community with a whole range of emergency presentations during extended daylight hours, seven days a week.

The issue for us that was flagged was not a state-based issue but was a commonwealth-based issue. If the commonwealth had continued to look at activity-based funding in relation to emergency departments and moved forward on some of those funding changes, it was going to make it more difficult to run a facility such as the Williamstown ED. That is where the conversation started.

The CHAIR — Just to get to the pointy end of that question though, was it ever going to close? I mean, it was mooted by the government that it may close. Was that ever on the cards?

Assoc. Prof. COCKRAM — If some of those agreements had been put in place and moved forward, I think it would have been up for further discussion.

The CHAIR — You spoke about changes to federal government funding and the methodology by which it was calculated. I am wondering, did you lose any funding as a result of the federal government changes? They may have been concern that there may have been a loss of funding, but was there any funding lost as a result of those changes?

Assoc. Prof. COCKRAM — So over recent years the state has continued to support us with growth funding, and we have continued to receive more funding from the government year on year to support the growth of our community. A number of years ago there was a discussion about state and commonwealth funding agreements. From our perspective, we wait until the state and the commonwealth sort that out, and then we move forward on what the consequence of that agreement is. We were advised by the state at that point in time to be ready to make some changes to our delivery of care, but that was still being discussed between the state and commonwealth.

The CHAIR — So the information that you received about the changes to funding that may occur from the federal government came to you from the state government? Is that what you are saying?

Assoc. Prof. COCKRAM — Yes, but it happened under both the previous government and under this government. There have been two cycles of commonwealth government discussions that we were notified by in two different rounds, so this has happened twice in my time at Western Health — under both the previous government and under the current government — that the state-commonwealth discussions had meant there may be cuts in the state-funded public facilities. But as I say, as the CEO of an active, running, busy health service we prepare for anything our government requires of us, but we wait to be told if we are actually going to have to enact them, because obviously we would not want to disturb or change our community's access to care unless we were told it was absolutely necessary.

The CHAIR — Certainly. What I was really hoping to drill down to was whether or not you lost any funding in the 15–16 financial year due to changes in the way the federal government calculated their health funding? I would be happy if you might be able to take that question on notice and just provide a response to that. It is quite a specific question, but I would be pleased if you might be able to do that.

Assoc. Prof. COCKRAM — Okay, we will take that on notice.

The CHAIR — That would be great, thank you.

Ms HARTLAND — I just had one more about the car park at Sunshine, and having been out there for various meetings I know exactly what you are talking about. The 401 bus that goes from North Melbourne and then circles around all of the hospitals, is that something that the hospital has looked at with Public Transport Victoria or the bus association?

Assoc. Prof. COCKRAM — I have not had an opportunity to talk about the Sunshine health, wellbeing and education precinct activity that is going on around the Sunshine site. We have a council that is led by local government — so the Brimbank council leads it and chairs — but involves all the leaders of the health services.

But also we have representatives from transport and planning and a range of people there to advise around the Sunshine precinct broadly — education providers, the universities, both University of Melbourne and Victoria University, are also participating.

What that group has been able to consider is how that whole precinct is planned, which does include transport. Due to the level crossing changes and a range of things around that, we will be able to be benefited by the fact that the Ginifer train station is moving closer back to Furlong Road. That means that the access from a public transport point of view to the facility is just so much better. It is fantastic. We are looking at how Furlong Road — that access between the new Ginifer train station and Furlong Road — is going to be made more accessible and pedestrianised, if I could describe it that way; not the actual road but how the footpaths and stuff work. We are working on how the intersections are working around the precinct with the RTA and stuff at the moment.

I think we are very lucky that local government, health, education, planning and transport are all coming together to actually see that precinct as a whole and provide support to how it works as an entire precinct from all those aspects. So it is actually, I would say, very exciting what is happening around public transport and other things. Bike paths are being put in, a whole range of things are happening around that precinct.

Ms HARTLAND — How much closer is Ginifer going to come to the hospital?

Assoc. Prof. COCKRAM — It comes now to the absolute intersection of Furlong Road, and so it is less than 500 metres.

Ms HARTLAND — So especially for staff who are working day shift, that should take a lot of pressure off the car park.

Assoc. Prof. COCKRAM — Yes. It is fantastic.

The CHAIR — At that point I will thank you very much Associate Professor Cockram and Mr Harrison for your attendance here today and providing evidence for our committee. In the coming days you will receive a copy of the transcript of today's evidence for proofreading and that transcript will ultimately be made available on the committee's website, but once again thank you very much for your attendance today.

Assoc. Prof. COCKRAM — Thank you very much.

Witnesses withdrew.

T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Inquiry into infrastructure projects

Melbourne — 20 September 2016

Members

Mr Joshua Morris — Chair
Mr Khalil Eideh — Deputy Chair
Mr Jeff Bourman
Mr Nazih Elasmar
Mr Bernie Finn
Ms Colleen Hartland
Mr Shaun Leane
Mr Craig Ondarchie

Participating member

Ms Samantha Dunn

Staff

Secretary: Lilian Topic

Witnesses

Mr Lance Wallace, Deputy Secretary, Corporate Services, and

Ms Leanne Price, Director, Infrastructure Planning and Delivery, Department of Health and Human Services.

The CHAIR — I will begin by declaring reopen the Standing Committee on the Economy and Infrastructure public hearing, and I welcome all those present this morning. I will just explain that today we are hearing evidence in relation to our infrastructure inquiry and the evidence today is being recorded. This hearing is to inform the third of at least six reports into infrastructure projects, and witnesses present may well be invited to attend future hearings as the inquiry continues. All evidence taken today is being recorded and is protected by parliamentary privilege. Therefore you are protected for what you say in here today, but if you go out and say those same things, those comments may not be protected by this same privilege. Thank you very much, Mr Wallace and Ms Price, for coming along to present to us. I believe you have a presentation. Then we might move into some questions after that. Over to your good selves.

Visual presentation.

Mr WALLACE — Thank you. I might start. Thank you for the invitation. I should mention that I am Deputy Secretary responsible for Corporate Services. Unfortunately, at reasonably short notice for the inquiry, the Deputy Secretary responsible for Infrastructure and the Secretary were unable to attend today, but you have me and you have Leanne, who is our Director of Infrastructure Planning and Delivery.

The CHAIR — Great. Thank you.

Mr WALLACE — I was just going to make a couple of brief introductory comments about the whole infrastructure program. If I turn to the first slide, it is really just an introductory slide. It just indicates, I think, as we know, our health assets are some of the most highly used assets that we have in the state system. They are 24-hour-a-day, 7-day-a-week, high-intensity usage. The major components of the health infrastructure are the health services, hospital buildings, but also residential aged care, community health centres and some ambulance assets involved there. As the slide indicates, there is about 3.3 million square metres of floor space, which is considerable. The replacement costs of assets are about $21 billion. The book value is a reasonable amount lower than that, but that is what the replacement costs are.

Regarding challenges and opportunities, every issue has both. For us probably the major challenge in health that people are aware of is demand pressures on the health system, so not only population growth but obviously the ageing of the population, meaning that we have significant demand running at 3 per cent or more per annum. Also the good news is that people are living longer lives and they are living longer, healthier lives, but they are obviously living a long time with one or more complex conditions.

Models of care are changing, so there has been a trend for a very long period of time of moving away from overnight stays to same-day treatments, as improved treatments are able to be done on a same-day basis. Also, changes in technology are providing options for us, whether it be telehealth or in-home options, with improved technology and clinical practice.

Also, one of our challenges and issues is obviously asset condition and configuration. We have some older facilities that were built many years ago. We maintain them in pretty good condition because of health, quality and safety issues, but some of the fabric is tired and it does not have an indefinite life. Some of the models that health services built in the 1950s, 1960s and 1970s with different models of care sometimes are not best practice for current models of care.

I will just move through to funding. The committee may be aware of the broad way that health funding works, but just in a couple of sentences, services are primarily funded to health services on an activity cost basis, a per-procedure basis. Under our national funding system, that per-procedure basis does not include a capital price component, so the price paid for an appendectomy or a knee operation includes all recurrent costs but does not include capital costs. That is a national decision, and it applies through the national health reform agreement across all states.

Infrastructure funding does not run through the pricing process; it runs through a separate process, and that is fairly much a bidding process to government as part of the state budget process. So the vast majority of funding is coming that way. Health services sometimes will have local revenues, whether they be donations, whether they be other funds from commercial activities they undertake that they can contribute to capital. Sometimes Federal Government makes direct capital contributions to health services and the primary funding comes through the state budget process.

The department is undertaking a major systems design and planning process at the moment. If you go to the department's website, there is good material there. That is aimed at preparing a new statewide design and service infrastructure plan for the health system, and the aim is to deliver that plan by July next year. So there is a reasonably strong engagement process. Discussion papers are up on our website in relationship to the development of that plan. There are local forums being run to engage people, and there are a series of pivotal questions that are being asked about what the priorities should be in the consideration of infrastructure and trying to engage as broad a group of stakeholders in the community as possible in that discussion. The plan will take a 20-year horizon and have an initial five-year focus.

As I move through, the department works in partnership with health services on infrastructure delivery. That involves us creating steering committees, sometimes called project control groups, with health services and bringing some central expertise to bear from the department as well as local infrastructure planning. It is very important that the steering committees have good clinical engagement in design initiatives. The department itself tends to engage initial consultants — engineers, project managers, architects — because we are a repeat customer. So an individual health service may do a major project every now and then, but because we are a repeat customer with those consulting firms, they need to give us good service or else when we move to the next health service, they will not get the next job. We find that a pretty efficient way of working in cooperation with the health services.

Generally the department is the contracting party for very large projects. Health services quite often are the contracting party for smaller projects. We use a common standard procurement and contract management process, so there are common documents through the system to make sure we get consistency.

Whilst there are a number of slides in this pack and a lot of diagrams at the back, I am nearly finished through here. This slide just indicates to you something that you are probably aware of, but it just puts a little bit more detail into that, and that is the fairly long lead times in major capital developments. If you do not think ahead and you do not have a pipeline of projects, then you will not be able to meet service needs, because it does take a while to actually move through all of the planning stage and through to delivery stage.

This slide really just highlights the fact that we have a very large program of works. If you go to the state budget papers in the assets section, you will see a total of more than three billion projects which are currently in train across multiple years. The series of following slides then really just details some of the projects that are recently completed or nearing completion and some in train. Because infrastructure is prone to very good graphics, we have put a couple of graphics in for a series of the projects that are currently underway.

So that was just a very quick tour at a high level through some of the issues to give you a bit of an idea of the scale, the challenges, funding and delivery issues.

The CHAIR — Fabulous. Thank you very much for that. I am sure the committee members and I will have plenty of questions for you, which we might lead into at this juncture. I did note that the VCCC project was one of those that was listed and that you had some very nice diagrams of and the like. I am just interested in the bed numbers at the VCCC at this point. I understand that the website says that there are 160 overnight inpatient beds presently at the VCCC, 96 of which, I believe, are at the Peter Mac and 32 of which are at the Royal Melbourne. I am just wondering where the other 32 inpatient beds might be.

Ms PRICE — I might have to take that question on notice. I think the numbers do actually add up in terms of what is on the Royal Melbourne site, because you would be aware that the main facilities — what we call the south facility on the southern side of Grattan Street — was primarily the Peter Mac relocation, plus some additional capacity, and then there was the extension to the Royal Melbourne on the northern side of Grattan Street, and that involved a number of wards with additional capacity in that area. I would need to probably just confirm the numbers that you are looking at.

The CHAIR — That would be great, if you could. That would be fabulous.

Mr WALLACE — We obviously have a detailed listing of the bed numbers in front of us, so it is just whether there is a reconciliation issue to your question. I certainly could rattle through what we think the bed numbers are, if that helps, but I am very happy — —

The CHAIR — I am happy for you to take the question on notice. There may be some of these questions that you may need to take on notice, and if that is needed, that will be fine. I was wondering again about the VCCC, talking about the 13th floor and just asking about the rent payments on that particular floor. I understand that the department had previously outlined rental costs of about $723 000, but I understand that this is only for about half of the space. So I am wondering: is the state government paying the rent, or is Peter Mac, as the committee of management for the VCCC? Who is currently responsible for the payment of that rent on that floor?

Ms PRICE — The state actually has the lease of that area, and the state is actually funding the component that the state had taken up earlier and is currently funding, and we have recently run an EOI for other tenants to come onto that site, and they will be expected to take up their lease payments once they are in occupation.

The CHAIR — From what I understand, the $723 000 is for rental of in the order of magnitude of about half of the space on that 13th floor. What is the total cost of the rent of the 13th floor?

Ms PRICE — Again I would probably have to take that one on notice. It is a level of detail — —

The CHAIR — Not a worry at all; that will be fine. You just said that there is an EOI process being run for who it is that is going to utilise that 13th floor of the VCCC.

Ms PRICE — That is correct.

The CHAIR — As part of that process is the state government intending on making any contribution to the fit-out of the 13th floor, or is that dependent on who it is that takes up the rent on that floor or the like? What is the process going to be from here?

Ms PRICE — Yes, the state will be contributing to the fit-out of those areas, but the tenants will be paying their annual rental and outgoings in that area.

The CHAIR — Any idea of what the size of the cost of the fit-out of the 13th floor might be in terms of the state's contribution?

Ms PRICE — I think the detailed design is still being worked through and the actual fit-out details, and that will give the actual final cost.

The CHAIR — In terms of the likely inhabitants of that 13th floor, what type of a tenant is the government looking at in terms of who is involved in the EOI process and the like?

Ms PRICE — The government has actually recently announced who the tenants will actually be. It is primarily the Ian Potter Centre for New Cancer Treatments, which is providing a home for the Peter Mac-led immunotherapy research program and the Australian Genome Research Facility, the cooperative research centre for cancer therapeutics and the Innovative Clinical Trials Centre.

The CHAIR — Are those tenants of the 13th floor going to be paying the entire rent of that floor, or is the state going to be making some contribution to the rent of that floor?

Ms PRICE — As I indicated before, the tenants will be expected to pick up their rental.

The CHAIR — Yes, I am just wondering if there is any gap or anything like that that the state is going to be picking up at this point.

Ms PRICE — No.

The CHAIR — Very good. Just one more on the VCCC. I am just wondering: did the VCCC take a loan out from the state government for the car park?

Ms PRICE — Yes, that is correct.

The CHAIR — They did?

Ms PRICE — Yes, they did.

The CHAIR — Do you know what the amount of that loan is?

Ms PRICE — Sorry, I should correct that. It was Peter Mac that actually took the loan out.

The CHAIR — Peter Mac, was it, not the VCCC? Yes, okay.

Ms PRICE — That is a fairly standard way of funding car park developments across the health system, particularly major car park developments, and I know just prior to this session you were talking to the Western Health CEO about their car park development. There is generally a revenue stream that comes off the car parking, which can over a period of time pay off the capital, depending on the mix of the costs of car parking. There is a differential mix usually between staff and visitors, and short-term and longer term or frequent visitors. There is a differing mix of those payment structures, but there is a revenue stream that can pay off the capital. Depending on the size of the car park and the cost of it and that revenue stream, the loan arrangements can be anything from a couple of years up to 20 years, but it is standard process that the health service bears the cost of that. It also means they get the revenue stream beyond the term of that car park. So particularly in our PPP arrangements the state has retained that revenue stream and provided it through to the health service.

The CHAIR — Do you know what the size of that loan was that the state government — —

Ms PRICE — Off the top of my head, I do not have that exact figure, but again I can certainly provide that to you.

The CHAIR — Take that on notice, yes; that would be fabulous. I do have a few other questions, but in the interests of allowing other committee members to ask some questions I might ask Ms Hartland if she might like to continue.

Ms HARTLAND — I have got a few. In your presentation you talked about how some hospitals have become tired and they need work. Well, we heard evidence from Western Health this morning in regard to Footscray, and it is actually beyond tired. It is not just a cosmetic problem, especially in the south block that has buckled floors and has toilets that can no longer be used. As I said before, the staff are amazing, but the actual physical layout of the emergency room is just no longer fit for purpose.

So I just wanted to ask: in terms of the service and infrastructure plan for the Victorian health system, how would a hospital like Footscray be dealt with under that plan? Because it feels, to me, a lot like planning — and this is a very political statement, and you do not have to respond — is based on how marginal the seat is that you live in rather than what the actual need is. Could you talk to me about how a hospital like Footscray would be treated under the service and infrastructure plan?

Ms PRICE — So the statewide plan is fundamentally looking at the range of services we deliver — public health services — across the state, how we deliver them, where we deliver them from and what we need to provide for communities into the future. It is looking at the best mix between services delivered at individual sites and the relationships between the health services. For example, our major regional health services play a very significant role in their partnerships with some of the smaller health services within their various regional areas, so it is quite important to get that right from a system perspective.

The statewide plan is being supported by a range of area-based plans, which are looking very much at the geographic profile of specific areas, particularly the outer growth corridors, whether it is the outer west, the outer north or the south-east. It is also looking at some of the growth areas, for example, around the inner Melbourne area, with some of the infill developments that are occurring.

The other set of plans that are supporting the overall statewide plan relate to clinical streams — what is the best way of delivering cardiac care, for example — and that has already been published. Other plans that are in place or that are being developed and are going through consultation processes include a statewide mental health plan that is underpinning it, there is a statewide maternity plan that is also being developed and there are a number of others that are being worked through. They will all feed into having a system-wide perspective.

Obviously that will then start to identify where the needs are. Where do we have gaps in the system? Where do we have potentially some capacity? Where do we need to strengthen resourcing or clinical capacity? It will be a little bit clearer about the role that each health service plays in relation to each other. That will then help to support the understanding of the infrastructure or the assets — that includes ICT and medical equipment as

well — required to support the delivery of those services. That will feed into a longer term, 20-year vision with a 5-year priority of understanding some of the priority investments that we are going to need to know.

Then we will need to be working with the individual health services in developing those up to a greater degree. For example, when it comes to Footscray — and we have been working with Western Health for a number of years in relation to their needs — we will have a clearer picture on exactly what is required, what sorts of services, what kind of volume of services and what the best mix of services is, particularly between their campuses but also in relation to their nearby neighbours, whether it is Melbourne Health, Werribee Mercy or Djerriwarrh. That will all feed into the mix and go into that planning cycle.

It is a very long way of saying that there is a fairly detailed process to make sure we are actually looking at the right range of services on any particular site before we feed then into looking at the capital development to support them. If I can use by example, again, Western and particularly Footscray, around a decade ago the growth patterns in the west perhaps supported planning that looked like the build-up of Sunshine Hospital as the more acute campus and that Footscray over time would become more subacute and ambulatory based. That was only about a decade ago. That led to a range of investments over the last decade that have been primarily focused on the Sunshine site.

The growth in the west has been unprecedented; I think we are all aware of that. It has been enormous. You heard earlier today some of the challenges that Western Health are experiencing in catering for that. That growth is all the way out to the outer west, all the way out through the Melton area, but it is also in the inner west as well, and that has changed the profile. Recent planning that we have done over the last few years with Western Health has clearly indicated we need to maintain hospital facilities across two campuses to cater for both the inner west and the outer west.

Through that process we are now currently working through in more detail a further review of that service profile, and that is linked back again into the statewide plan, to understand what those services actually are and the volume. The volumes being experienced, for example, through the Footscray emergency department are higher than previously predicted. We need to make sure, if we are building for the future — and hopefully it will not be another 50 or 60 years before further works would be done on a site — that the buildings we do build will last us into the future.

Ms HARTLAND — I do not know that Footscray can last another 50 years.

Ms PRICE — Absolutely.

Ms HARTLAND — I doubt that it can last another five. I appreciate all that information, but I suppose I am, some people would say, fixated about Footscray, but it has been allowed to deteriorate physically. The staff are great, but the building is just terrible. If we had a major accident in the western suburbs — we have had a number of really bad industrial accidents over the year — and that became the first hospital to receive, I do not know that that emergency room could cope with it, just the physical layout.

I suppose what I am really looking to understand also is: why has it been allowed? I understand what you are saying about a decade ago and the whole growth patterns, because I have lived in the area a long time and I do understand that, but at the same time the hospital has been allowed to physically deteriorate, and that I do not understand. It is not just the emergency ward; it is the south block. I suppose what I am looking for is information about how long it is going to take to actually do the planning, to put something in place and for the funding to become available. Even though Western Health have said that they have got the $17 million to keep them going, if there was a major problem, that is really I think the tip of the iceberg with that building.

Mr WALLACE — I could probably just add to what Leanne was saying previously. One of the pivotal decisions is — and there are no easy answers to this — when a health service requires some fabric improvement, to what extent do you improve it? Do you spend a small amount of money just to do some make-good work on it, or do you actually consider a more significant reconfiguration of that health service because of the changes, as Leanne indicated, in your service planning and other issues?

I think in the west in particular, as Leanne has indicated, there have been some real policy discussions going on. I think that the growth in the west has been unprecedented. Governments of the day have been looking at the

growth and looking at the configuration of the sites and trying to actually make sure when we invest a very large amount of funds there that it is appropriate for the long-term future of the whole of the Western Health.

I think the point that you are making is a very valid one. Western Health is one of the sites that does have very poor fabric at the present time, and action is required. I think you will recognise in the last budget that immediate action has been taken to address the most immediate concerns. There is a very sophisticated planning process going on at the moment that I think will inform, and I would imagine that this is going to be a site that the department, from the department's perspective, will keep raising as a site that needs further work. I am sure, without second-guessing government at any time, that there will be very active consideration of what the next steps are. The fact that there has been $17 million put in immediately and further funds put into Sunshine during this budget is an indication that the government understands this issue and needs to deal with it. From the department's perspective, we will be raising this as a priority.

Ms HARTLAND — I have heard that said a number of times over the last decade, and the emergency room is still in a state. Having had to use it a few times, it is in a terrible state, and I do not understand why people in the western suburbs should have to put up with that emergency room. It would not happen elsewhere, but somehow it is all right for us.

I have got a couple of other questions. In terms of Monash Children's Hospital — I have had this information second-hand, so it could be completely wrong — one is around the emergency room. Will there be an emergency room at Monash Children's Hospital?

Ms PRICE — Monash Children's Hospital is being built — in fact it is almost completed, as you are possibly aware — alongside the existing Monash Medical Centre. Monash Medical Centre has an emergency department. It already provides paediatric services through Monash Children's as an entity. The emergency department at Clayton already provides for those services. That will continue. The Monash Children's Hospital, which is effectively a wing on the main hospital, does not have a dedicated children's emergency department. Instead they will actually be fed through the main emergency department. That was actually a clear operational decision by Monash Health, who runs the service, as the best way of providing the emergency services to all people coming into that facility.

Ms HARTLAND — That sounds totally fine. I do not know that people out in the community understand that, because I have had several people ringing me about this in the last week, believing that there will be no paediatric emergency service.

Ms PRICE — There are definitely services, yes; there is just not a separate dedicated paediatric — —

Ms HARTLAND — It would probably be good to clarify that with the community, because I have had five or six calls in the last year.

Ms PRICE — It is a good point.

Ms HARTLAND — And you know what happens once rumours get started; they just snowball.

Ms PRICE — To give an indication of how closely they are linked, as part of the hospital we are currently installing a helipad on its roof. That is part of the children's hospital. That helipad will link via lifts straight down to the emergency department, and that services anyone being airlifted into the hospital.

Mr LEANE — Thank you so much for presenting to our infrastructure inquiry and for actually giving us what I think is quite a good news story when it comes to health capital works when you take into account the Joan Kirner hospital, the Casey Hospital expansion, the Werribee Mercy expansion, the Goulburn Valley Health Shepparton project — $168.5 million — the infrastructure fund, the Victorian Heart Hospital and the Angliss Hospital extension, which I know a bit about, being based out east. I wanted to ask you about another project in the east, the Maroondah breast cancer centre, which I understand is around the $10 million mark at this point, and also one that I do not know a lot about, the Broadmeadows surgery centre. But what I wanted to touch on first is that you have mentioned that $3 billion figure. I know that is sort of forecast at the moment. I am an ex-tradie. I hope I am not a future tradie, but there is always that possibility. Is it a hard question to ask whether there is any forecast of how many construction jobs are going to be created with this amount of capital injection into the health system?

Ms PRICE — On a rough rule of thumb we work on how many jobs are forecast. Obviously they are then tested when we actually go out to tendering, but on a $3 billion-plus program we are talking probably in the region of about 10 000 construction-related jobs.

Mr LEANE — I understand that in the recent projects that have been tendered — and some of them have commenced — there is an onus on a ratio of apprentices being trained in that construction sector. Is that correct?

Ms PRICE — That is a new policy that is just coming in, and of course we are implementing that on all of our projects. I have not got the figures for that immediately at hand. For our significant projects we meet all of the local content requirements, so for our major projects we typically look at about 80 to 85 per cent local content.

Mr LEANE — Local content as far as what sort of — —

Ms PRICE — Materials, basically, and that goes to local manufacturing.

Mr LEANE — That is similar to the level crossing removal program, which I have been involved with, where I do not think everyone comprehends how many off-site jobs are created. That is where the procurement, 85 per cent, will come into play.

Can I get back to the Maroondah Breast Cancer Centre. Could you give an update on the progress of that project, where it is at and what it is about?

Ms PRICE — Yes, sure. This is about bringing together the breast cancer services out in the far east, the outer east, of metropolitan Melbourne. It was a government commitment, and it has been funded. It is a $10 million project. We have been working through the detailed design phase with Eastern Health, looking at where it would go on the Maroondah Hospital site and how it would interrelate with the surrounding services and the streets. We are progressing through detailed design at the moment, and we are hoping to go to tender within about the next month.

Mr LEANE — That will incorporate the services that are currently being delivered by Breast Care Victoria; is that right?

Ms PRICE — Yes. Some of those services are currently being delivered in, effectively, modified houses across the road in Grey Street. They will come into the new centre, and we have planned for the future so there is the capacity to expand that facility into the future as well, should those broader cancer services come in, but the focus on this particular project is around the breast cancer services.

Mr LEANE — The services actually support a very big geographical area for women. That is my understanding as well. It is in Maroondah, but it does cover quite a wide area.

Ms PRICE — Maroondah is the main hospital that is servicing most of the Yarra Ranges. Eastern Health also operates Healesville hospital, which is an important part of the health system, but Maroondah is really the major acute facility that is servicing all of those outer eastern suburbs right up into the hills.

Mr LEANE — As I said, I know a bit about that, working with, as we were discussing off the record before, Alan Lilly, who was a fantastic CEO. I can say that now he has gone, but I am sure that MPs of every political persuasion would agree with me. I am sure a fantastic CEO is about to take his position.

Regarding the Broadmeadows surgery centre, which I know nothing about, could you give us an update on what that is and its progress?

Ms PRICE — At Broadmeadows we are looking to expand their surgery capacity — Broadmeadows is operated by Northern Health — as a way of helping to manage some of the demand. Just as we have been talking about demand in the west, the demand in the north is probably equal, if not greater. It is massive when we are seeing the growth all the way heading up both the Hume corridor and also the Plenty Road corridor. One of the area-based plans we are currently doing under the statewide plan is an outer northern growth corridor plan. We are working on that in conjunction with the local health providers, the local community health and the local councils because they are all very concerned and well aware of that kind of growth.

Northern Hospital, if you look at its catchment area, sits on the very southern edge of that catchment. For the new suburbs that are coming in sort of a 20 to 30-year period you are looking at growth that could be the size of two cities of Bendigo coming into the future. It is huge. So we need to actually look at what the health services are, but there are a lot of issues currently. We have done some expansion at Northern Health, but they are under a fair bit of demand pressure as well. They are looking at expanding the surgery capacity at Broadmeadows, which will help take some of the load off Northern Health, so it is a bit about the balance of services between the two. The project, from memory, is about $17.3 million. It is about an expansion of theatres and some of the recovery areas supporting that area.

Mr LEANE — Fantastic. If you do not mind, I will join in the fixation on the 13th floor of the VCCC. My understanding is that that level is unsuitable for patients because of the way they would be delivered to that particular storey.

Ms PRICE — It was in the original design that was presented back by the project company when they bid for it. It was designed as a research floor. It is sitting on top of a stack of research floors. It is quite separate from any other clinical floor. So one of the problems with any kind of configuration, if it was used for clinical space, is it is quite some distance from any other clinical services, which is problematic should there be adverse issues that arise with patients. Plus, the lift design was primarily as a goods lift — so, not designed for patient transport. There are some fundamental design problems if you were to use that floor for anything other than the research-type processes that it is now going to be used for.

Mr LEANE — Because that goods lift is shared by other research facilities, what sort of research would they be doing on those other levels, as patients may have to share that lift if there were patients on the 13th level?

Ms PRICE — It could include such things like rubbish removal obviously, but it is also things like animal transport and a range of other sorts of things in the back-of-house-type lift arrangements not designed for public use or for patient use.

Mr LEANE — So when you say 'animal transport' — as in research animals, as in rats. Is that — —

Ms PRICE — Small rodents are the main research.

Mr LEANE — Small rodents, yes. So I apologise to rats — small rodents. And obviously with those small rodents, all sorts of tests they are doing on them produce waste. That waste would be taken away.

Ms PRICE — Through the same lift. As I said, it is a goods lift, so it is those back-of-house services.

Mr LEANE — Yes, so even to the point where some of that waste, because of the tests being on the particular small rodents, could be radioactive animal waste. Is that — —

Ms PRICE — I cannot really go into the detail of that.

Mr LEANE — You cannot say, but it could be.

Ms PRICE — Yes.

Mr LEANE — Okay. I have got one more question. In last year's federal budget, is it true that there was no funding for capital investment towards the Victorian health services?

Ms PRICE — I think that is correct. Traditionally, as Lance indicated before, most of the capital funding for state facilities comes through the state budget. A number of years ago the commonwealth had what was effectively the first round of a major funding stream, which was the Health and Hospitals Fund. It was a 5 billion fund nationally, of which Victoria got a share. The Victorian Comprehensive Cancer Centre was one of the main recipients of funding from that facility. There were some minor funding streams to do with national partnership agreements following that, but they have all ceased at this point in time. We are coming to the tail end of the delivery of the last of the projects that received any sorts of funding under those streams.

The CHAIR — I just did want to clarify one point that I asked about before, and that is the fit-out of the 13th floor of the VCCC. I believe you said before there would be some state contribution to that, and the other

costs of that fit-out, I am assuming, would then fall to the Ian Potter centre and the international cancer research centre and the like. Is that where the cost of the fit-out of that floor would go to?

Ms PRICE — I do not have the breakdown of either the detailed costing or where the funding contributions will be coming from. But, yes, the state will be contributing to that fit-out cost.

The CHAIR — Sorry, yes. So the state will, but for the other costs of the fit-out, obviously there is a contribution from the state, but I am assuming the tenants of that floor would be making a contribution to what is — —

Ms PRICE — Unfortunately I do not have the detail of that, but we are happy to come back to you and take that one on notice.

The CHAIR — That would be great. Thank you. I was hoping to move on to the Victorian Heart Hospital, and I believe there has been $150 million committed to this project to this point. I am just wondering if you might be able to detail how much of this has been spent and what it has been spent on.

Ms PRICE — At this stage we are in planning processes, and they will take some time. I have not got the exact number of how much we have actually spent, but we have engaged architects, engineers and cost consultants. They have been working with us to work through the detail of the early stages of this planning. It is a necessary part of the planning, just as you have heard earlier around some of our other health facilities that we are actually planning. So we are using that. I can take it on notice and look at the exact cost.

The CHAIR — That would be great.

Ms PRICE — But it would be well below the $2 million mark at this stage.

The CHAIR — Great. In terms of the overall cost of the project in terms of the build for the heart hospital, what sort of number are we talking about there for the overall build of the heart hospital?

Ms PRICE — I do not have that number yet, because that is precisely why we have got the architects and the engineers and the quantity surveyors working away on it at the moment. There will be a range of costs as we look at a number of different options for how that might be delivered in terms of physical form, and once we have those we will bring those back to government and advise them on what the costs to deliver the project actually are.

The CHAIR — So from my understanding, this work has been going for over a year now in terms of determining the cost of the project. Is there some number, an estimate, of some magnitude that you might be able to give the committee in terms of what the expected cost of this project is in terms of an envelope between this and this?

Ms PRICE — For a brand-new hospital that is on a greenfield site, that has got 195 beds, an emergency department with 20-odd cubicles and a range of research facilities and that will have all the site establishment costs for bringing services onto the site — that sort of scale of standalone hospital — whilst I do not have the exact costs for this one, you could look at comparative sorts of locations. The Monash Children's that we were talking about earlier at 230 beds was in the order of 250 million, and that was tapping into a lot of the services that were already on the Monash Health Clayton site. So it is fair to say we will be talking in the hundreds of millions.

The CHAIR — Hundreds of millions but, I mean, less than 500 million?

Ms PRICE — I do not have that detail or figure yet until we have actually got the quantity surveyor costs coming back. I would anticipate it to be less than 500 million, yes.

The CHAIR — Yes. We are talking ballpark figures here of course, but you are saying in the vicinity of more than 250 and less than 500.

Ms PRICE — Yes.

The CHAIR — Do you have a specific location on the Monash campus site as to where the state is purchasing the land for the hospital?

Ms PRICE — The planning work that we are currently doing is very closely aligned with Monash University; they are heavily involved in all the processes. They have nominated an indicative site at the moment, and that is what we are testing through the planning work that we are doing. The area that they have nominated is over on the eastern side of their site, and that is not particularly surprising because that is currently vacant land — vacant in terms of it does not have buildings on it; it does have playing fields. We are talking over towards the Blackburn Road site and probably close to the alignment of the synchrotron across the road, so in that general area, which again will facilitate the research components of the new facility.

The CHAIR — Have the purchasing arrangements of that land been arranged to this point? Do you know what the status of the land is going to be?

Ms PRICE — We are still in discussion about what that might look like. It may not be purchasing, it might be a lease arrangement. There are many different ways we can actually manage tenure and access to sites, and we are still working through that with Monash University.

The CHAIR — Do you have any commitments for funding for the project from project partners to this point?

Ms PRICE — I am not aware of any at this point.

The CHAIR — Do you know if any potential project partners have been approached to this point?

Ms PRICE — As I said, at the moment we are working through what the options are. The university is obviously a key partner, and we have been reasonably clear that there would be expectations that partners would contribute. It might be in kind, it might be through land, it might be through capital contributions, but we would also be looking for broader partners within the facility as well.

The CHAIR — So there are no formal partners at this point?

Ms PRICE — No.

The CHAIR — Do you know when the start date for the building of the project might be? Have you got some forward projections about when it may be that ground may be broken?

Ms PRICE — Again that is premature now while we are still working through the actuals. We are effectively developing the detailed business case for government. That will have some indicative time lines for the delivery of a new build, and that will give greater detail around when and how something might be started, again depending on funding contributions coming from others.

The CHAIR — But at this point you cannot nail down a date to begin with that?

Ms PRICE — No.

Mr LEANE — Can I actually expand on the Casey Hospital expansion, where that is at, progress, what will it deliver for that community once it is finished?

Ms PRICE — Casey Hospital is again in a major growth area, this time to the south-east, so there is a major population boom happening down that corridor as well. If you drive out along those freeways, you see the development going everywhere. Casey was developed more or less as a community-based hospital about 10 to 15 years ago. It has greatly exceeded its expectations over that time. This is a pretty substantial expansion of the facility. It is in the region of about a 35 per cent area increase that is being funded.

The original project was developed through a Partnerships Victoria policy, so through a PPP; in fact it was our first under the Partnerships Victoria policy way of doing things. We have an incumbent operator on that site, and that comes with a whole range of contractual obligations about how we manage the facilities as such. The health services themselves are actually delivered by Monash Health.

We are in a process of working through with the incumbent operator about how we might do a very major modification to their contract effectively. That will impact on the facility's maintenance side of things, and they are contracted to meet various service provisions. We have recently agreed a process agreement with them, which is kind of the rules of the game of how we are actually going to move into this next phase, and we are then working through with them what the proposals might look like — how we are giving them the technical standards of what we are actually requiring for the delivery.

We are being supported very strongly throughout that process by our colleagues at the Department of Treasury and Finance, who have had that expertise in the PPP field, and they are currently also advising another major modification to an existing PPP contract through the Exhibition Centre, so we are able to tap into that quite readily.

The actual services: there will be increased bed numbers, we are reconfiguring theatres, we are reconfiguring a lot of the support areas that go within that. I do not have the exact bed numbers in front of me, but it is quite a substantial expansion of services. At the same time St John of God, who have a facility across the road, are also building and expanding their services as a recognition of the needs out into the south-east area. Monash Health and St John of God have good partnerships around how they can deliver a lot of their services. Many of their clinicians may work across both facilities, so again that is being worked through in terms of exactly how those services are best met and who provides what sorts of services.

Mr LEANE — I know in recent years that hospitals have really taken into account environmental design. An example that I know of in Box Hill Hospital is there is actually a trigenerator in the basement that creates electricity from gas. The steam that comes off that generator gets used to heat and also cool the building, and it is a very energy-efficient way to produce that. There is also, I understand, designs in making it energy efficient and so forth. Can you expand on that?

Ms PRICE — Yes, sure. It is a very important thing for us — our environmental sustainability policy. It is something we have been promoting for a number of years. Hospitals are intense assets; they operate pretty much 24/7. The acute parts of them are major drainers. It is the biggest public sector user of energy, and water to some extent as well, so they are major resource-intensive facilities.

A large part of our stock is actually probably greater than 10 years old, so for us, while all of our new facilities aim to meet greenhouse standards, whether they are 5-star or higher, to some extent it is relatively easy when you are building a new facility to incorporate newer technologies into that, whether it is embodied energy in the building materials themselves or how the facilities are actually going to use power and water and produce waste. It is harder for us when we are talking about our existing facilities, and that may be facilities that are 50 or 60 years old, but it may also be facilities that are only 10 or 20 years old that have not got the same sorts of inherent things built into them.

A lot of our policy processes at the moment are that we have been looking at what kinds of improvements we can make in the existing stock as well as what we do in the longer term in the newer stock. Again bear in mind that anything we build today will still be around at least for 30 years and the change that we have seen in the climate and with energy costs just in the last decade or so — if you can imagine that exponentially, so we do have to do a fair bit of forecasting. We look at a range of different measures. We build in a proportion of our capital budgets for implementing those measures in the facilities. We have certain aspects that we just expect as standard, and then we have the sorts of stretch targets about how we might build some of those things into it.

It also goes to the facilities themselves that will be better outcomes by building some of these things in. By that I mean that there is a lot of research going on around the world at the moment about the impact on the people in the facilities of the design of them, and whether they have access to fresh air, whether they have access to removed pollutants in materials, whether the design enables natural daylight — those sorts of things all feed into that process. Some research from overseas is showing that can actually reduce the time people spend as patients in hospitals, and we are trying to build those into some of our facilities.

Mr LEANE — On top of that — and you mentioned water there, which twigged my understanding, anyway, around Angliss — hospitals are now talking to the community about when a project gets done, if there is anything that the community could be in partnership with or party to or add some sort of added advantage to. My understanding at the Angliss is that the water tanks — this is a new project — that will be catching the

rainwater will be accessible to firetrucks to be able to fill up at that point as well. You might want to take that one on notice.

Ms PRICE — That is probably a level of detail, but I would certainly commend Eastern Health.

Mr LEANE — That was my understanding, and it is an excellent idea. I think it goes to the community consultation program that you take now. We had a discussion offline before about how fantastic it is that medical staff have a great input into the end product of what a hospital ward or a hospital will look like, because they are the ones who work in it every day, but also you have extended it out to speak to the greater community, your neighbours, other stakeholders; is that correct? I know the Joan Kirner hospital is an example of that. Could you expand on that?

Mr WALLACE — I was going to probably just add one thing to the conversation and that was the stats that I have in front of me. In the last decade health services have reduced water usage by some 800 million litres — very, very substantial. In 15–16 we also reduced energy usage in that particular year. Energy usage over the decade has still gone up very modestly, but what you need to do is divide energy use per patient, because the volume of patients treated is very significantly higher, and when you look at energy usage per patient there are also very significant gains that have been made over that period. That is just reinforcing Leanne's points. It is something that the department treats seriously, and I agree with the comments made that it is something that the community and staff are also interested in working in cooperation with the department to achieve the sorts of outcomes that are being achieved.

Ms PRICE — Just leading onto the consultation part of your question, because that is a nice lead back into that, we get some great ideas coming from some of the staff for some of our environmental sustainability initiatives. There are usually strong communities at each of the health services who are usually quite committed in terms of how they either produce waste or can reduce energy usage, those sorts of things. Also the consultation goes right throughout the design of new facilities. When we are looking at a new facility the health service has the expertise about how they actually run the services. My team and I, we can bring a lot of expertise about building design and construction, but they really know what their business is and how they run it. We do that at all of our facilities. Our capital programs and our facility designs are done in very close consultation with the health services. There is strong user group involvement right throughout, which is that clinicians, who are actually going to be using the facility, will be involved in detailed working groups around particular areas of the new facility that need to be developed up.

We also look at working with the community members who might be coming in to experience those facilities. One great example is, say, the Monash Children's, where Monash Health actually engaged with mothers with young children who would actually be coming in to use the facilities. So rather than just from the clinician point of view, they also took into account the end-user type of view. All public health services in Victoria clearly recognise their role in the local community and how they interact and provide services, and they all have, in varying forms, community engagement panels or similar sorts of things where they actually engage with the community on a regular basis through different forums. It is not just about physical construction or infrastructure, but it is also about how they deliver their services. We tap into a lot of that because they know their communities and they would work with them.

We heard before that the local member is involved with the Joan Kirner development. We have also got a community engagement panel going on with the new Goulburn Valley hospital that is led by the local member, Suzanna Sheed. That is a very active contribution in understanding what is important to the community when we are building these sorts of assets and how they experience them as well.

Mr LEANE — With the Joan Kirner hospital, the previous submission from Western Health is that 16 per cent of people in that geographical area prefer to use a language other than English, so that is something that I imagine you have really put your mind to — about how to engage and get input from those communities.

Ms PRICE — The buildings need to be legible, if I can use that sort of term — if it is not too architecture-speak. They need to be intuitive. People need to be able to find their ways around them. So in modern hospital design we do not use just pure signage with very technical labels of clinical areas because that does not mean very much to the people that are coming in for the first time or even for the second or third time. It means quite a lot to the hospital clinicians because they understand that medical technology. For most of our hospital designs now they try and make it a little bit easier to find your way through a building. The signage that

is in there is more accessible in terms of how they actually describe the areas. They also try to orientate it — so, for example, elements in the Royal Children's Hospital, when that was designed, each floor had a different colour scheme that effectively went from the ground up to the sky as it went through each level. It echoed walking up through trees and then the sky. That gave a bit of intuitive wayfinding to being able to find your way around.

Being able to orientate yourself to a central area is quite important as well. Having open windows at the end of long corridors rather than just closed space so you start to feel where you are orientated in the building is quite important. We have quite large atriums in a lot of our services in new hospitals, which is again a way of helping people to orientate themselves, because if you can see back into that, you can always understand where you are moving around the building rather than just being in enclosed corridors.

Mr LEANE — I have one last question on what we just discussed. How did you achieve the reduction in energy use? Are there any simple examples of what was done to do that?

Ms PRICE — There are a lot of perhaps easier ways of updating older buildings, and that might be through energy-efficient lighting, for example. It is what we term the low-hanging fruit. We have done a lot of those smaller improvements. It might be through introducing changed habits of the users as well. We know in our homes you have to turn the lights off when you are leaving rooms. That sounds a bit silly, but it is an element of it. So we look at changing some of the usage patterns. We look at putting in relatively easy to install energy-efficient fittings. We might look at dual flushing in cisterns — those sorts of things. They are simple measures, but when you multiply them many times over a large building, they can have a real impact.

The CHAIR — I was hoping to ask about the Casey Hospital that Mr Leane was asking some questions about earlier. At this point in terms of the planning of the hospital, it is still talking to partners and working up exactly what that is going to look like. Would it be fair to say that is where the planning process is at this point?

Ms PRICE — So with our single partner, which is the incumbent project company, we have an agreement about how we are managing the next phases of the project. We are negotiating with a single party, if you like. That has to be managed quite carefully so that the state is getting the value out of the outcomes. It is not a competitive tender when you have an incumbent, but we have agreed those rules of engagement. We have released the first proposal requirements to them, so they are now working through, and they will come back to us with a proposal for how they will respond to the needs of the hospital.

The CHAIR — So effectively the ball is in their court at this point, and you are waiting for their response to come back.

Ms PRICE — Yes. They will be responsible for the design as well as the construction of the extension. We have worked through it to have a bit of a reference design so we understand how it can be achieved, but the actual design, just as it is in any PPP, will be their response.

Mr WALLACE — Just to emphasise the point that Leanne is making, obviously when you consider a procurement if you procure from a single person because of the efficiencies that brings, you need to make sure that you get an appropriate price. So these reference works using quantity surveyors to actually give you a very good view about what a reasonable price would be are very important to the negotiations.

The CHAIR — This next one you might need to take on notice. I am just wondering, of the $106 million that has been committed for the project, how much of this has been spent and what has it been spent on?

Ms PRICE — I would definitely have to take that one on notice, but we can certainly provide that to you.

The CHAIR — That would be great. I am also interested in the project's building start time as well as completion time. Do you have dates and time frames for when the start of the project and the conclusion of the project are expected?

Ms PRICE — The actual start of construction will obviously be once we have concluded the negotiations with the incumbent, but I believe we are looking at probably around mid to late next year for the actual starting of the construction. The end date we are expecting to be late 2019, which is consistent with the original budgets papers when it was actually funded.

The CHAIR — Regarding the Moorabbin hospital and the medical imaging, $16.2 million was allocated in 2015 to expand the Moorabbin hospital with the addition of an MRI and a CT machine, as well as 11 new outpatients specialist consulting suites. The Auditor-General's report *Managing and Reporting on the Performance and Cost of Capital Projects* of May 2016 said the project was red flagged for being over six months late. I am wondering why this project is running so late.

Ms PRICE — There was a fair bit of detailed design that we needed to work through. We have now let the construction contracts and the contractor has started on the site. So the project is now moving forward on a revised time line, but we needed to do the detailed planning in an appropriate way up-front.

The CHAIR — So it was the detailed planning that really pushed the project back.

Mr WALLACE — I would just make the point as well that the AG looked at 60 — there were 30 projects with two dimensions — on time and on budget — and there was one red flagged out of those 60 projects.

The CHAIR — Which was that one. And the completion date for that particular project?

Ms PRICE — I would probably need to come back to you on the detail. I do not have it off the top of my head. Sorry.

The CHAIR — Certainly. That will be fine. Thank you very much. I have a final question just on the National Proton Beam Therapy Centre. I am just wondering did the $2 million in the 15–16 budget finish the business case, and if not, how long until it will be finished?

Ms PRICE — We are working through the detailed business case right now. The $2 million was partly used for initial review of what proton beam therapy actually is. There was a task force formed last year that gave a report back to the minister about the scale and breadth of this new technology. It is breaking technology. There is no similar facility in Australia, certainly, and very few in the South-East Asia-Pacific area. We were looking at the technology that is in both North America and in Europe at the moment. That is partly what that went towards. You might also note that in this year's budget there was a government commitment to a further $50 million towards developing the new national proton beam therapy centre but with a very clear footnote in the budget papers that that was subject to the detailed planning and development, and that is what we are currently working through with a range of partners in the area — Peter Mac and the VCCC, as well as the Royal Children's Hospital. There is a preference for it to be located in the Parkville area, but we are testing various sites in that area at the moment.

The CHAIR — Fabulous. You must have been reading my questions because you followed that right through. The location, you were saying, Parkville, preferably; and in terms of the cost, $50 million has been provided in the 2016–17 budget. Do you have any idea of what the estimated total cost might be for the build of the national proton beam therapy centre?

Ms PRICE — That is probably a much broader question even than the discussion we were having earlier. A lot of that depends on the scale of the sorts of services that are going to be provided within that facility — whether it is a two-bunk facility or four-bunk facility, for example, changes things enormously. My technical people are telling me the technology has changed dramatically already, just in 12 months, so that now we are talking a 360-degree spin of the scanning equipment around the patient, and that requires a bigger housing, if you like, for the facility, which will impact on the capital cost. We are exploring those because, as I said, it is totally new technology, moving very, very rapidly, but it is incredibly exciting to understand how this could be used and how it might develop over time in the treatment of cancers.

The CHAIR — Great. Are there other states that are also trying to get this centre?

Ms PRICE — Certainly there have been recent press articles in relation to South Australia, which are also exploring options. I am not exactly sure where they are up to in their exploration either, but I believe they also had a level of committed funding held in contingency. But there were some, as I said, press releases just recently that I saw, so I am not sure if they are continuing their development and exploring that themselves.

The CHAIR — Okay. Obviously with other states looking to possibly get this centre, what is it that would make Victoria best placed to be developing such technologies?

Ms PRICE — I think the key thing is probably building on the incredibly strong presence that Victoria has in medical research around the nation. We currently — I do not have the figures, but I am well aware — receive the majority of the research grants, for example. Victoria is a major player. We also have a massive strength in the Parkville region, with the number of researchers, clinical bodies and training facilities that we have in that precinct — and it really does operate as a precinct. We have got a cluster of major specialist hospitals in that area. We have been talking about the Victorian Comprehensive Cancer Centre, which is obviously a major player, but we have also got the Royal Melbourne Hospital and the Royal Women's Hospital and the Royal Children's Hospital all closely aligned. We have a number of research entities: the Walter and Eliza Hall institute and the Peter Doherty institute. We have the University of Melbourne, which is a strong partner in all these relationships and in all those facilities. So in bringing all that together we have a significant opportunity to leverage all of that, without doing the pitch, but maybe this is the pitch we should use to the commonwealth and to others about the strength that we can actually deliver in that space. But that is what we are hoping to demonstrate through the business case that we are currently developing.

The CHAIR — Great; wonderful. Any final questions from the committee? If not, at this juncture I thank you, Ms Price and Mr Wallace, for your attendance today.

Ms PRICE — Thank you.

Mr WALLACE — Thank you.

The CHAIR — You will receive a copy of the transcript of today's evidence for proofreading in coming days. That will ultimately make its way onto the committee's website. Once again, thank you very much for your attendance and evidence today.

Witnesses withdrew.

T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Inquiry into infrastructure projects

Melbourne — 20 September 2016

Members

Mr Joshua Morris — Chair
Mr Khalil Eideh — Deputy Chair
Mr Jeff Bourman
Mr Nazih Elasmar
Mr Bernie Finn
Ms Colleen Hartland
Mr Shaun Leane
Mr Craig Ondarchie

Participating member

Ms Samantha Dunn

Staff

Secretary: Lilian Topic

Witness

Professor Jim Bishop, executive director, Victorian Comprehensive Cancer Centre.

The CHAIR — I reopen our Standing Committee on the Economy and Infrastructure public hearing and thank Professor Bishop for agreeing to come along and provide testimony to our committee today. The committee is hearing evidence in relation to our infrastructure inquiry and the evidence today is being recorded. This hearing is to inform the third of at least six reports into our infrastructure projects inquiry, and witnesses present may well be invited to attend future hearings as the inquiry continues. All evidence taken today is protected by parliamentary privilege. Therefore you are protected for what you say in here today, but if you go outside and repeat those same things, those comments may not be protected by this same privilege. Once again, Professor Bishop, thank you very much for coming along today. At this juncture I might hand over to yourself if you might have some introductory comments you might like to make of some description, and then we will move into some questions from the committee.

Prof. BISHOP — Thanks very much, Chair. Thanks for the opportunity to talk to you about this infrastructure project. The Victorian Comprehensive Cancer Centre program was really from my perspective put into shape with the 2009 business case for its development, and the vision of the Victorian Comprehensive Cancer Centre was to really provide a world-standard cancer centre based on integration of research, teaching and clinical care, and then pursue excellence as a flagship program for Victoria. It is based on the model of the US national comprehensive cancer centre program, which does that integration of research, the types of research as well as research with clinical care and education. So it has not been invented solely from the beginning; it is based on successful models over the last 45 years in the United States. They have grown their comprehensive cancer centre program, there is approximately 62 of those across the United States. They are world-leading centres for care, but that program has also been copied in France, the UK, in other Western countries and in Asia.

The introduction of this is that the project really from an infrastructure perspective is developed into two parts. So there is the building-construction element, which is the building project, and this was managed by the Department of Health and Human Services under the project management office. Then the builder obviously was part of a private-public partnership consortium, which is the Plenary Health company.

In the building as it is set up now the major occupant or the major tenant, if you like, of the private-public partnership is the Victorian government, and the chief tenant is the Peter MacCallum Cancer Centre, and, because they occupy most of the space, they are the operators of the building. So just in terms of the questions that you might have, there are some questions in there for which I will not have your answers, and I can refer you to who does have the answers.

But I represent the second part of the project, which is to set up a collaborative joint venture company, which is called the Victorian Comprehensive Cancer Centre Limited, and that is to promote collaboration between the partners, the collaboration to establish the function of the program, which is this comprehensive cancer centre program I have described for you. What I represent is essentially 10 members. There are 10 members of the joint venture, so obviously the Peter MacCallum is one of the members, but there is also Melbourne Health — the Royal Melbourne Hospital — the University of Melbourne, the Royal Women's Hospital, Walter and Eliza Hall Institute for Medical Research, the Royal Children's Hospital, Western Health, St Vincent's Hospital, Austin Health and the Murdoch Children's Research Institute.

It has been quite deliberate to develop this network of expert cancer groups configured broadly around the University of Melbourne-affiliated hospitals, and the reason is so it also links very strongly to the opportunity that is there with the medical health research centre which is around that program. So we have good collaborative relationships with our Monash colleagues, but it is essentially as it stands at the moment around those University of Melbourne hospitals as a joint venture.

So there are three joint venture members in the building — Peter MacCallum, Melbourne Health and the University of Melbourne — and obviously the joint venture office, which is what I look after, also sits within the building but does not run the building. This joint venture under the 2009 business case was essentially developed to do three major things — that is, to reduce the burden of cancer, to develop a centre of excellence in cancer and to increase cancer research income for Victoria — and they are obviously important given the position of this state in terms of its medical research expertise.

This obviously has been set up since 2009, the joint venture company, and what we have been able to do is over the last few years develop new methodology around translational research methodology. We have set up tumour streams which go right across the partnership, which essentially focus on the research and the education — so,

remember, we are not running clinical services through the joint venture company. We have attracted new research leaders. We have 12 new professorial posts as a result of our work and we have 7 fellowships, so that is 19 high-quality researchers that we have brought to the program since it started.

We have been able to harmonise clinical trials right across the program, including out to the Austin Hospital, and that now brings in or is responsible for about 80 per cent of all cancer patients going onto clinical trials in Victoria coming through this group, so it is a very strong clinical trials program. We have been able to audit the research, look at its quality and benchmark it against international measures, and we sit very well. We produce something like 40 per cent of all the research publications that sit within the top 1 per cent of cancer publications coming out of this country. So they are a very successful group on that measure.

They bring in a lot of money as well. The total income for the group as a whole is around $110 million per annum, of which about 12 per cent is in clinical trials, and that includes a mixture of both government funding, which is the majority — that is, from NHMRC and other government funding sources for research — but also philanthropy and industry funding. So that is something to grow; that is what we have to grow. We have grown it up from about $75 million up to about $110 million, so we are doing our work in trying to bring more research dollars to Victoria, but there is more to be done there and I think we all want to do more.

We have developed a number of new research platforms, including expanding genomics. We have established clinical proteomics. We have started work on health services research, which is an area I think of great interest to make our health system more efficient, and we have developed a new primary care and screening research program which we think is important for outreach into the community. There are about 1400 researchers involved in the program as a whole, and we think it is a very large footprint in broad terms compared to, say, New South Wales. This program sits between four and six times bigger in terms of its research capability then any one program in New South Wales and therefore it is a very important asset, I think, for Victoria.

What we want to do, now that the building project is complete and the partnership is, I think, further consolidated by all this work, is to take advantage of all the infrastructure that is built to make it a catalyst — a platform, if you like, a translational or research platform — where we can do even more than what we did when we were all in bits and pieces all over the place before we came together in the new building, which has been occupied since the middle of the year.

So that is the sort of brief introduction of what I am about. So what I am not: I am not the builder, I am not a public servant, I have not been directing the project through the government and I am obviously not the operator of the building. So that might help you in terms of questions that I can help you with compared to what you may need to get answers from others about some of the other things you may be interested in.

The CHAIR — Great; fabulous. Thank you very much, Professor. You obviously spoke about your responsibilities there. A lot of it was about bringing the partners in the group together. Are there other roles that you play other than bringing those partners together?

Prof. BISHOP — Yes, well, I think our job is to essentially look for new income. So, again, we have been supported as part of the project development by the successive governments through the last period of time with our core grant, and that core grant over the last seven years or so amounts to about $8 million, which is quite substantial. We have generated an additional $40 million by going out after new research grants, doing it jointly and getting philanthropic chairs. We have now two philanthropic chairs, both worth $5 million or so each, and we have also developed some philanthropic fellowships, which is getting fundraising money or generous donors providing the money.

The CHAIR — Did you say it was $8 million over seven years that has been provided to you by government?

Prof. BISHOP — Yes, that is about right.

The CHAIR — Do you have forward projections of what government is going to give you?

Prof. BISHOP — Government is going to continue the core grant for us and I believe that we are also in the process of negotiating a research development grant, which I think will allow us to essentially build much more quickly the infrastructure that will be shared infrastructure where all the partners will benefit and therefore all

their researchers will be more successful. So we anticipate being able to receive an additional research development fund, which will help us further grow the enterprise.

The CHAIR — So, just to clarify, that $8 million over seven years has been from the state government?

Prof. BISHOP — Yes.

The CHAIR — And that has been your core grant?

Prof. BISHOP — That is it.

The CHAIR — But you are looking forward to a research and development grant?

Prof. BISHOP — Yes, we are in discussion. We anticipate being able to get both the core grant that we have been used to and then also get an additional research development grant. Because we have been able to do a fair bit with what we have got they think, and I think hopefully we will do that shortly, that we should be able to do more, and we agree. I should note that the core grant is funded half by the Victorian government and the 10 partners then match that. So the 10 partners have got their own commitment to the project as well, and that has been the case from the beginning. So each of these hospitals and institutions which are not flush with cash often have nevertheless put some of their funds into the joint venture, which I think we are very grateful for, and it shows that they see value in what we are doing.

The CHAIR — Great. Could you provide to the committee — obviously you may need to take this on notice — an exact amount of funding that the government has provided you with for maybe the 2015–16 financial year?

Prof. BISHOP — Yes, I will take that on notice.

The CHAIR — That would be fabulous, if you could; that would be great. With that funding you develop facilities for research and the like? That is where that funding goes?

Prof. BISHOP — Yes. So what we have done essentially — and I will take it on notice in giving you detail, but just in broad terms — our plan is to build research infrastructure that they can then all share. So we build it once but we make it highly collaborative so that they do not have to build their own essentially, and it also can be cutting edge because building allows us to put research platforms in place, so there are scientific platforms there around genomics, the animal facilities, the microscopy facilities and others. Clinical proteomics is a joint approach, for which we also have some of the equipment housed at the Bio21 Institute as well as within the building. So that money is being spent essentially to grow the shared infrastructure, the functional infrastructure.

The CHAIR — And the funding the government provides to you, are there KPIs that the government has set that you need to deliver upon? How does that accountability work?

Prof. BISHOP — Yes. The 2009 business case had a number of KPIs associated with it, and we are still reporting on those and have been throughout. In addition, as we have renegotiated this, there will be additional KPIs on what we are going forward with, which is not completed yet, so we are in the middle of that.

The CHAIR — So that is in the negotiation phase at the moment?

Prof. BISHOP — It is, but we feel confident that we are at the end rather than the beginning of that process. That will have a whole series of KPIs around it that we are very keen to make sure that we meet.

The CHAIR — In terms of the building itself — you are obviously not responsible for the build — in terms of ongoing maintenance and the like, what is the VCCC responsible for in the building?

Prof. BISHOP — We are a tenant within the building. Honeywell is the maintenance company, which has been in association with the Plenary Health set-up for the project. We sit there as a tenant doing the functional work; we do not deal with the running of the building. The building from our perspective is both well built and well managed.

The CHAIR — I was hoping just to ask you about the 13th floor of the VCCC. I am just wondering what is currently on the 13th floor?

PROF. BISHOP — The 13th floor had a little bit of building done initially because it was originally meant to be a research lab up there, and then work stopped while, I think, various governments made decisions in relation to what should be there. In July the Minister for Health made an announcement that there was going to be a development there which will include an immunotherapies laboratory and the opportunity to bring together some of the Cancer Therapeutics CRC from Bundoora, some of that program, into the building. They are the group that develops new therapeutics — new cancer drugs — and they are very well connected into industry and into UK technology and other places. They have got a number of successful agents that they are getting licensing or royalties from. The VCCC is a member of the CRC, as are most of our partners, so again it is rather like a joint venture.

The other thing that the minister announced was, firstly, that there would be a coordination centre for clinical trials, and that is certainly something we welcome. Then, finally, the commercial space there on the northern part of the 13th floor will be occupied, the minister announced, by the Australian Genome Research Facility, and I believe there is another tenant.

Again from the VCCC perspective, we proposed what should go into what I call the southern area of that floor, which is the research lab, the cancer therapeutics expertise to come into the building and the clinical trial coordination. That is essentially the area that we have been associated with, so I do not have all the details of the other parts of the set-up of that floor.

The CHAIR — We have sort of been piecing it together with other witnesses today too, so that is — —

PROF. BISHOP — What is that?

The CHAIR — We have sort of been piecing together a view of the 13th floor from other witnesses today.

PROF. BISHOP — Yes, so you are getting a view.

The CHAIR — Yes.

PROF. BISHOP — I would have to say that we put the proposal to government that that is what should go on that southern area. We, being the VCCC board, had put a proposal to government that they should consider an immunotherapy lab, which is the hottest topic in cancer research right now; and that there should be opportunity to expand the clinical trials opportunity, because that is more dollars but it is also better, high-quality treatments that are going to be changing practice — and we think that is what the VCCC is all about. Then we also feel that having the business expertise and the experience of the CRC on cancer therapeutics in the middle of the large research program is terribly important, because they are a group that successfully has developed new therapeutics.

The final point the minister announced — I am just sticking with the minister's announcement, because that is the world that we know — is that the overall new therapy areas will be branded as the Ian Potter Centre for New Cancer Treatments. That is important because they are a major donor for the project as a whole. I think that is apt recognition of all the support they have given, so that is a branding that we would also support. I think from the point of view of the science side, if I can put it like that — we are apolitical, obviously — that is a good result for cancer. We think all of those things are exciting possibilities.

The CHAIR — Do you know when those elements of the 13th floor are going to be operational, when they are going to be up and running?

Prof. BISHOP — No, I do not. I do not have enough information. The people who are doing this — the project team within the department of health — are responsible for the design, construction and completion of that, so they would have the timetable to give it to you more accurately. I have got a broad idea, but I am not responsible for the delivery of that area.

The CHAIR — No, indeed; that is right. We have had a chat to the department and they have taken those questions on notice as well. I have got a couple more here, but I might, in the interests of ensuring everybody has a chance to contribute, hand over to you, Ms Hartland, if you want to ask a couple of questions.

Ms HARTLAND — I think what is happening in the facility just sounds so exciting and to hear about what is happening on the 13th floor is really interesting. As I understand it, there has been a lot of controversy about

what was supposed to go there and what is going there, and I am just trying to get this all straight in my mind. So the proposal for it to be a research area is what the proposal always was?

Prof. BISHOP — My understanding — and remember, I have to say that this occurred before I came on — is the proposal was to build a research lab there. As the building got downsized a little during the project because Ludwig pulled out, for example — you remember that — and because of the way the project was being developed, that research lab was never built. You would have to check the timing, but I think following that other proposals were put forward. That is obviously an area of controversy, but really the opportunity to say what should be there came to us following the controversy, so we said what we thought would make sense. We were not involved in the controversy, but we were rather putting up a proposal of what would be a good use of it, given everything else that we now had not seen developed with the project.

Ms HARTLAND — But in the original business case in 2009 that was the original purpose for that floor?

Prof. BISHOP — That southern pod was meant to be a lab and the northern part of it was meant to be for commercial purposes, and that is the way it has actually turned out in the end.

Ms HARTLAND — So 2009 was the Brumby government, and then it was a change of government. So with that business case that has gone through those four years of a Liberal-Nationals government it was always that same proposal that the southern part of the 13th floor would be for research?

Prof. BISHOP — I am not the best person to tell you what went on with the government submissions in relation to the 13th floor. I would have to say, though, that under the previous Labor government, the Liberal-National party government and now the Labor Party again, the support for this project has been pretty solidly bipartisan. I really cannot fault it. I can say anything; I am not a public servant.

Ms HARTLAND — That is right, yes.

Prof. BISHOP — I would have to say that really we got very good support from government no matter what persuasion, and through those years where we were dealing with the Liberal-National party they were very helpful and helped us with the project as we developed up. So there were ups and downs, and you can look at the controversy as you wish, but from our point of view what we needed to do was not around the 13th floor; it was around a consistent view that we must get this thing built and signed off when it was needed under the arrangements — that the vision, if you like, that I put before you was maintained, and it was. So I think it is very much a Victorian piece of infrastructure, and I congratulate all the political people that have been involved with this. It has been fantastic.

It is very unusual. I am old enough to say this, but really it has been a dream of 40 years that we can develop a cancer centre of such depth and breadth to actually make a difference. The other states are looking at this and saying, 'Well, you know, they got it together finally'. It is not easy — all the things that you have to think about — but I have to say it is a marvellous piece of infrastructure for Victoria and puts Victoria right ahead because of the fact that we can push people together and they must come up with the solutions that the patients really expect them to come up with.

Ms HARTLAND — That is an interesting way to put it, and I think that whole Parkville precinct having so many high-quality medical and research facilities in the one spot is really quite inspiring.

Prof. BISHOP — I used to be the chief cancer officer for New South Wales, so I know how the cancer program is configured there. It is very fragmented. They are also very good — they have great programs — but the trick for Victoria is called co-location. I do not think we should de-emphasise the importance of pushing people together and expecting them to collaborate and actually answer the big questions. That is not just for cancer; it is actually for everything. The Monash hub, the Melbourne hub, the new work around Monash Medical Centre et cetera — I think they are all things that work. It is a great idea, and other states cannot do this very well. Obviously South Australia is attempting to do this through their North Terrace development.

Ms HARTLAND — When it is all open I would love to come and visit. I think it will be fantastic.

Prof. BISHOP — Certainly. It is very much a public building, and it is a piece of infrastructure for all of us — and I think quite an iconic piece, frankly.

Mr LEANE — Thanks very much, Professor, for helping the committee today, and congratulations to you on what is just amazing. I know you call it infrastructure, but it is more than that. I think you have probably answered the questions that I was going to ask you. I might rephrase it. So what does it mean for Victoria? You have had a long history in research in this area yourself, so I think you would probably be in a good space to tell us what it actually means for Victoria as far as this sort of research?

Prof. BISHOP — I mentioned the comprehensive cancer centre model at the beginning, the US style. When you put population health research, laboratory research and clinical research together with a strong teaching program — and there are 1200 people in training at any one time in this group — it is a winning combination, and no-one else in the country has this. It provides an edge that we have in terms of attracting dollars, but, perhaps more importantly, attracting the best people who really are going to make a difference.

Those people we have attracted through our Leaders in Cancer program, which we have cobbled together during the formative set-up period, are people who would not be here if it was not for this infrastructure, this program. Certainly we were able to attract our most recent person, Professor Sean Grimmond. He set up the genomics program in Scotland, and was originally from the University of Queensland. He came here because of the facility and what that offered to him and the networking that we had.

We will see this time and time again. We will be a magnet for the best researchers, and that is the difference. We have now got an edge, but can we take advantage of it in terms of making sure that people are fully collaborative, that we are using these shared bits of infrastructure and not buying a whole lot of duplicate equipment and duplicate activities. It is still human nature, it is still change management, it is still getting people to work together, which is what we have been doing, but that is not easy. Nevertheless the dynamic is working in our favour because of the great amount of support we have had from the Parliament and the governments as they have come through to do this. It really is the right idea.

Mr LEANE — Yes. I think you have probably crystal-balled the other question I was going to ask you. You mentioned research leaders and fellowships. I assume they have come from all around the world?

Prof. BISHOP — Yes. For example, of our PhD students, which are our future, around 40 or 43 per cent are from overseas. We take our best local people, our best from Sydney et cetera, but we are really attracting a group of people now — from China, UK, US, western Europe, everywhere — that want to come here, and we have got to make that happen at all levels, including the postdocs, the PhDs as well as the clinicians and the professors.

Of the ones that we have attracted, the 12 professorial positions, a lot of them are international, and you will see more and more of this. We have got to be the place people come to in this country if they want to do research, but, not only that, one of the world places that they would think of coming to. Melbourne will sell itself, because it is a beautiful place to be. I think the research is now at a level where we are attracting people who are heavy hitters, if you like, in the Northern Hemisphere.

Mr LEANE — You mentioned 1200 people in training?

Prof. BISHOP — About 1200 anyway.

Mr LEANE — Can I ask what professions they are being trained in?

Prof. BISHOP — To give you an example, 360 of those are PhD students who are enrolled at the University of Melbourne doing cancer work. These are the future leaders. These are the people that will make the difference in 10 years time.

Also we are training surgical oncologists, we are training radiotherapists, we are training radiation oncologists, medical oncologists, haematologists and cancer nurses. We are training allied health staff, we are training social workers — we are training everybody. We want to make this a place where you can actually come to know everything you need to know about cancer for your particular discipline, and not only that, but you will get linked across to all the other disciplines just by the fact that we have pushed things together. If you are coming as a physiotherapist interested in cancer problems, you will be talking to the best cancer nurses, the best oncologists, the best surgeons as part of the environment.

There is a very large program there of cancer imaging. That is really cutting edge; it is to do with new radiopharmaceuticals that are PET products. These are world-beating opportunities, and linked through various grants across to the University of Melbourne brain centre, which has a lot of imaging as well, you will see that the co-location will start to work for itself. We do not have to invent the co-location opportunities, because people bump into each other and then start talking and doing things. That is the opportunity.

Mr LEANE — I am just trying to imagine the nature of the building. You have got the ground level, which is the foyer. Is there parking underneath?

Prof. BISHOP — Seven hundred cars and 400 bikes.

Mr LEANE — That is underneath. You have parking, ground level foyer, then patient services for so many levels — —

Prof. BISHOP — Up to six. Seven is the mixing floor, so that is education. That is where the medical staff offices are, it is where the nursing education is, it is where the lecture theatres are and it is where the tearooms are. This is the mixing floor. It is also a public floor, so the public is up at that level. Above that is mainly laboratory and dry research, not just laboratory research. It has people on computers doing population health work as well as people in labs doing genomics research et cetera.

Mr LEANE — This is probably a hard question, but what is the capacity? How many researchers can be in that?

Prof. BISHOP — Well, the 1400 figure is really for the whole of the VCCC. It might even be a little bit bigger than that with the Austin and ONJ coming on board with us, but essentially there are about 1200 researchers in the building. A lot of the researchers are also on the clinical floors, remember, because they are doing clinical trials there. They are taking samples from patients, sampling their tumours for genomics and other things. The whole program — not just the building, but the whole program — should be driven by evidence, the new evidence, research and putting research into practice as quickly as we possibly can to get the benefit straightaway rather than waiting 10 or 15 years for the research to filter down into the clinical practice. We want it immediately there. That is the opportunity.

Mr LEANE — Just one last question, and then I think I am finished. You said level 7 is a public level — —

Prof. BISHOP — It is also an educational floor.

Mr LEANE — It is an education and public level, and then above that is research, so if someone just walked in off the street, there would be some sort of barrier, given the nature of research, to them ending up on level 8 or somewhere like that where there is some serious research going on.

Prof. BISHOP — Yes, the builders have thought about this. They have got the public lifts going up to level 7. The research lifts go up to level 12.

Mr LEANE — Thank you very much. Congratulations again. It is fantastic.

Ms HARTLAND — I just wanted to talk a little bit about population health. You were saying that there will be work done in that area. I live in Footscray and am concerned about diesel emissions and environmental health. I have worked a lot with firefighters around the range of cancers they get because of their work. Is the kind of work you are doing also in that environmental and industrial cancer?

Prof. BISHOP — The way we have done this is that we have linked our aspirations in population health directly to the University of Melbourne school of population and global health. So if you immediately bring in a whole lot of researchers who were not thinking particularly about cancer — some of them were — we can then involve them. We are developing within the VCCC building a node which relates directly to the school of population and global health, so we have all of the university's expertise bought as a node to us. That has been the principle. We have a CRE, a centre of research excellence, in bowel cancer screening, run by Professor Jenkins, who is part of the population school but actually sits physically within the VCCC building. We have a professor of primary care, who I mentioned, who is doing a lot of population health work and sits within the VCCC building that links and is directly at home within the school of general practice within the

university. The idea is to actually break down the institutional barriers by putting the people together that need to be put together.

You mentioned diesel fumes and other things like that. It is a great area for research and an area of importance. I have previously been chair of the scientific committee of IARC (International Agency for Research in Cancer) that did the monograph on diesel fumes, so I know a fair bit about that. A group spontaneously formed in the VCCC family, if I can say that, which wanted to think about air pollution and diesel fumes, so they bought the respiratory physicians, the lung cancer doctors and the population health people together in a workshop symposium, which I was very happy to open for them, and they are starting to work together on issues like that. That just happened because they wanted to think about it. The ability to take an issue and start to think about how we can bring the research together and how we can deal with it came spontaneously from the staff that were interested in what the research was telling them.

The good thing about the program is that you can get the people actually having to deal with the consequences, the lung cancer doctor and nurse, also directly talking to the scientist, who is directly talking to the person who knows a lot about carcinogenesis. That is what I mean by having a research project that goes across rather than just one silo. We are all in silos in various ways, and we aim to try to work across them.

Ms HARTLAND — Is that group then talking to the community? Having lived there for a long time, it is very difficult to get doctors or experts to talk. We know that there is something wrong, but we are laypeople and we cannot prove that there is something wrong. How do you connect them to those affected communities?

Prof. BISHOP — I think, to put it in context, the VCCC is a program that has been under construction. It was under construction like the building was under construction, which I am not talking to you about. We have started along these routes. We have not got everything. I said to a number of people that I think it is the end of the beginning. We have only just got our act together to get some of this stuff done. The fact is that groups are coming together around important issues. One of our leaders is actually talking about grand challenges now. The grand challenges are not what you might think. They are how you actually tackle diesel fumes or how you tackle the incidence of melanoma — those sorts of grand challenges.

Now that the building busyness is behind us — and it took a lot of time; people worked for a decade on building construction and user groups — I think they are now looking at the freedom of actually starting to do what the program should be doing, which is starting to deliver for the people of Victoria. I think we are at that stage where these sorts of ideas are now something that we can start to develop and talk about.

Ms HARTLAND — I will definitely be emailing you. It sounds very exciting.

Prof. BISHOP — Yes, sure. I can put you in touch with the people who are starting to think through some of what the research is telling them. But we are going to be producing the research evidence; it is really our job, I think, and to do that as quickly and relevantly as we possibly can.

Ms HARTLAND — It is very exciting. Thank you.

Mr BOURMAN — Thanks for your presentation, Professor. Pure speculation: do you see this as revolutionary or evolutionary, the concept — obviously not the building — of having everyone in the same area? Given what has happened overseas, are we likely to see steps or is this just the end of the beginning sort of thing?

Prof. BISHOP — I think it is transformational. In Victoria we have a tradition of individual hospitals and hospital boards, and it has been like that forever, and we have got a very high-quality system as a result of that, so it has benefits. I come from New South Wales, so there they have health services across a number of hospitals. But I have to say that the permission that we give as part of working as a VCCC network is permission for people to work more closely together. So a person from Peter Mac can just go and start talking and working with their Austin peer, with their peer from St Vincent's and hopefully more broadly. So we have given permission for people to get out of their silos, think about the issues that should be confronting them and see if they can do something about it. We provided a vehicle which should transform.

I would have to say that, just looking at the reports on the NCI program — and really they call that their flagship program; that is their flagship solution to control cancer, their CCC program — we think there is more to that.

We have a much better, I think, public health program in this country than in the US. I worked in the US, and they do not have public screening for breast cancer, for example; it is all paid for by private doctors. So we have a lot of, I think, private infrastructure that is to the benefit of our population. Having said that, I do think the CCC is a great idea. We can make it work and we can change it to make it more Australian, but it is transformational in my opinion.

Mr BOURMAN — I guess the way I am seeing it is it is removing barriers.

Prof. BISHOP — It is.

Mr BOURMAN — As you said, you have one specialist able to go to another specialist almost over lunch and talk about something rather than having to wait for a conference, or make a phone call or email or whatever.

Prof. BISHOP — Yes. We are also putting some structures in place, if I may say. We are putting down research leads that have a VCCC label. So they are VCCC research leads, and they will be on particular cancers and things like that. That person has permission to go and ask what they are doing at St Vincent's or Western Health about a particular cancer and then assist them in linking across to research that they might know about in another centre or working together to develop a new opportunity or do a new clinical trial. You sort of give them the ability to work across because of the structures that we are hoping to develop, and we have developed a number of these now.

Mr BOURMAN — Excellent; thank you.

The CHAIR — Just a couple of final questions, if I might. Obviously there are a lot of exciting things happening on the 13th floor, but I am just wondering if there is still any empty space on the 13th floor that has not been allotted to a potential tenant as they come in.

Prof. BISHOP — As far as I am aware, I think the space is allocated. The project team would be the one to get all the detail, but, as far as I am aware, the VCCC board had put forth a proposal for the southern pod, if you like. And the northern pod, which could occupy two groups, I believe has been allocated. The minister made that announcement. So I do not think there is additional space there now.

Having said that, the building has been built for some future developments and, without putting too fine a point on it, you can actually build a second tower above the garden if you actually ever wanted to spend another $400 million. I am sure there will be others who will think there is a better way to spend that.

The CHAIR — Great. Obviously there are opportunities for future expansion of the VCCC. Are there any other spaces currently unused at the VCCC. Are there any spaces unallocated to a future use?

Prof. BISHOP — There is some shell space still in the building, but it is tending to shrink as time goes on, as you might expect. The real opportunity for the future is around the site now in terms of what might happen with the future development of the Royal Melbourne Hospital, which I think would offer new opportunities for a higher level of infrastructure support. Obviously the university has quite a lot of land around there, which surprisingly is available, particularly the Ford site and other sites. If you are talking to the railway people, they think they would need that, but I think there are other sites around.

The trick is co-location. I think it is really important to do this carefully so you put together the right people who can actually make a difference to our health. I think that whole precinct is becoming very precious the way it is designed and built for the future, and you are going to have a lot to say about that, I am sure, as time goes on.

The CHAIR — Indeed. Has that future shell space that you refer to got an allocated purpose into the future?

Prof. BISHOP — No. It is relatively small now, but the answer is no. It is not very much anymore. The main space was the 13th floor.

The CHAIR — Where is that current shell space at the moment?

Prof. BISHOP — I just have to check. I do not run the building so there is additional space there somewhere, but it is just a small amount of space. There have been some recent developments, as you know,

with the Sony Foundation expanding the adult, young adult and adolescent cancer program, which is taking up some of that space.

The CHAIR — Great. Just one final question from me: in your view, would the co-location of a private hospital in the VCCC have improved access to care for patients?

Prof. BISHOP — Well, I come from the Royal Prince Alfred Hospital. They have a very good approach to private-public medicine in my opinion in that they co-locate substantial private activity next to public facilities, and that has been the New South Wales approach if you look at the Royal North Shore, for example, or some of the other hospitals in Sydney.

My own view about private medicine is that we want the best people to be geographically full time on site; whether they are on-site in a private activity or a public activity is probably less important than having their expertise there. That applies to whether you are talking about Monash or The Alfred or anywhere, because I think we benefit from people who work both in private and in public. This is different from Singapore, for example, where you cannot do both; you have got to do one or the other.

My view would be that you need to build a proper private hospital there. I am actually unfortunately thinking bigger than you might think about. I do think to develop an optimal medical model where you build the opportunity to expand both public and private medicine you need to think a lot bigger than a floor; you need to think a hospital. I think there needs to be a co-located private hospital of substantial size in the precinct to take full advantage of bringing in all the people that you need to populate these programs in the future. I would build a proper private hospital there. But what am I? I have no say. I am here just to answer your questions.

The CHAIR — Indeed. Thank you so much, Professor. Certainly I think and concur with all my colleagues when I say it is very exciting what is happening. It is great to see that Melbourne is on the cutting edge of cancer research. So thank you for all the work that you do, and thanks for your attendance today.

Witness withdrew.

T R A N S C R I P T

STANDING COMMITTEE ON THE ECONOMY AND INFRASTRUCTURE

Inquiry into infrastructure projects

Melbourne — 20 September 2016

Members

Mr Joshua Morris — Chair
Mr Khalil Eideh — Deputy Chair
Mr Jeff Bourman
Mr Nazih Elasmar
Mr Bernie Finn
Ms Colleen Hartland
Mr Shaun Leane
Mr Craig Ondarchie

Participating member

Ms Samantha Dunn

Staff

Secretary: Lilian Topic

Witnesses

Mr Paul Crowe, executive director, head of origination, and
Mr Glenn Hay, chief operating officer, Plenary Group.

The CHAIR — I reopen our Standing Committee on the Economy and Infrastructure public hearing. The committee is hearing evidence today in relation to the infrastructure inquiry and today's evidence is being recorded. This hearing is to inform the third of at least six reports into infrastructure projects, and witnesses may be invited to attend future hearings as the inquiry continues. All evidence today is protected by parliamentary privilege. Therefore you are protected in relation to what you say in here today, but if you go outside and repeat those same things, those comments may not be protected by the same privilege.

Thank you, gentlemen, once again for your attendance today. I might hand over to your good selves for any introductory comments, and then we will move into some questions from the committee from there. Over to you.

Mr CROWE — No problems. We might read an opening statement, but, first of all, I am Paul Crowe, and I am the head of origination for Plenary Group, and on the VCCC I was the bid director, so I led the whole project. Glenn, you might as well introduce yourself.

Mr HAY — I am the chief operating officer for the Plenary Group, so I am responsible for construction, delivery and ongoing asset management of our asset portfolio, for which I was overseeing VCCC during the delivery phase.

Mr CROWE — Chair and fellow committee members, thanks for the opportunity to address today's hearing. Plenary Group is an independent investor, developer and manager of public infrastructure. Established in Melbourne in 2004, we have since expanded to North America and now have a portfolio of 39 PPP projects worth more than $26 billion across Australia, Canada and the US. But most recently, this obviously includes the completion of the Victorian Comprehensive Cancer Centre.

For us, it is rare in a professional career that we are afforded the opportunity to work on a project of the scale and public importance as the VCCC. With one in two men and one in three women being diagnosed with cancer in their life, the output of the VCCC will touch many Victorians. The importance of the investment in the VCCC's work is reflected in the prominence of the site as a gateway to the Parkville precinct, which is an internationally renowned cluster of health, research and education. So it is with some understandable humility that we appear before you today to discuss our small contribution relatively to the fight against cancer.

For background, in 2011 the state government contracted the Plenary Health consortium to design, build, finance and maintain the VCCC for a 25-year concession period; however, our work on this project started well before that. We had to mobilise our team earlier than that and mobilise effectively as the scale and complexity of the project and the quality of the competing consortia represented a significant challenge. PPP proposals like the VCCC are rated against many metrics, and there is robust competition on each of these. Our highest early priority for the VCCC was to assemble the right team to deliver on the state's ambitions for a facility that created a centre of excellence for cancer treatment, translational research, education and care. A hallmark of Plenary's approach was to respond to a tight budget while still delivering quality architecture, and our team reflected this. We worked with a strong architectural team of Silver Thomas Hanley, DesignInc and McBride Charles Ryan — all proudly Melbourne-based design firms — to ensure that the building's architecture was symbolic and representative of the coming together of the VCCC alliance.

The consortium Plenary led also comprised a joint venture of Grocon and PCL for construction, and Honeywell for facilities management. The Grocon-PCL joint venture was chosen for its mix of local construction capability and health delivery experience in a PPP or similar process. Honeywell was chosen as the long-term facility manager due to their experience in servicing and maintaining complex and sensitive facilities, such as laboratories, hospitals and stations. The prospect of making a real difference to the lives of tens of thousands of people was a compelling incentive to our consortium members, as was the professional challenge of working on such a unique project. All consortium members brought their best people to the bid for an opportunity to deliver a true legacy project for Melbourne and Victoria.

Plenary's approach is different to others, where the parties that pull the bid proposal together often remove themselves after the transaction is complete. In Plenary we remain involved in the projects through the design, construction and then into the operations phase. In other words, we adopt a holistic approach to delivering the projects that embrace finance, design, construction, complementary commercial development and long-term asset management and operations. In this approach, continuity of personnel is critical from both the private and public sectors.

The VCCC project was set up from day one to benefit from the continuity of both public and private sector parties from the project's inception through to its completion. We congratulate the state and the departmental teams for their consistency in personnel over the period of construction as it contributed significantly to the delivery of the facility. It was important for the project to deliver on what it promised, including its architectural integrity, the building performance, the high-quality service delivery and the maintainability. We needed to ensure the VCCC was built to schedule but also that its quality was protected during construction to maximise its ability to achieve the state's prescribed standards over the operating term. Our combined responsibility towards both construction and operation of the VCCC represents a strong continuum as we are responsible for the assets for many years to come.

Successful public-private partnerships like the VCCC require an active hands-on partner who is accessible, accountable and ultimately responsible to the state. Plenary has delivered on the promise of a comprehensive cancer centre capable of being one of the top 10 facilities of its kind in the world, as per the state's original brief. We look forward to continuing our successful partnership with the state and to managing the VCCC to enable cancer patients and their families, staff and researchers to benefit from a facility that was designed with their needs top of mind. With more than 1.1 million Australians living today with a cancer diagnosis, including 256 000 Victorians, a facility like this has never been more important. Plenary is proud that after four and a half years of construction the VCCC opened to staff and patients on time and on budget in June this year. We hope this was useful in providing a high-level overview of the VCCC project, and of course we are here to welcome any questions you may have.

The CHAIR — Thank you very much, Mr Crowe, and thank you, Mr Hay. We have certainly heard from a number of witnesses today, and I think what is happening at the VCCC is very exciting. It is something that I think we as Victorians and the people of Victoria should be very proud of, because it is a great leading edge. Obviously your work has been exemplary as well. I am certainly keen just to get a bit of an idea. You spoke earlier about the fact that you are involved in builds not only in Victoria and Australia but also around the world. I am just wondering what are the specific challenges that are present in building infrastructure here in Victoria?

Mr CROWE — In Victoria specifically? I might throw to Glenn on that. He might draw on some of the experiences we had.

Mr HAY — I think if you look at it, probably we split it into, say, procurement and delivery. Obviously if we look at procurement, internationally we have seen — and I think, Paul, add anything here from the procurement perspective — there is quite a clear pipeline of projects that are coming to the market in a procurement sense. Having that clear pipeline obviously enables resources to be better coordinated and costs can be managed because there is that clarity around the future of projects. Obviously in Victoria we have had quite a strong pipeline of projects, and we look forward to continuing that. I think from a procurement point of view that is very important. You see in some other states and jurisdictions that when that pipeline is not as clear, quite often it can be quite challenging to get the resources you need for a complex project when you are competing against other sectors and projects.

From a delivery perspective, I think, and from a broad, generalist experience, the importance of the state having a very clear and clearly specified project brief is very important. When they come to market with a brief, having that clarity and the clarity of the operator — and obviously Peter Mac was very clear in its requirements, which were reflected in the brief — means from day one, when you are responding to the bid or to the brief, knowing that clarity is there is very important for the project's success. You then respond to the brief and you then start the construction phase having the certainty of the scope and specification and the objectives that the government is looking to. I think one of probably the stand-out features in Victoria is that there has always been a very strong clarity of brief requirements, whereas in some other jurisdictions, both nationally and internationally, there has probably been a lack of clarity, which has meant that during construction when there is a greater level of ambiguity and you are trying to build at the same time as trying to meet the requirements, it can put pressures on the program and outcome. I think that has been a key success factor.

The CHAIR — So that is a success. Any specific challenges that relate to Victoria? Obviously that is positive to hear that the brief remains consistent. Are there any challenges in either of those phases that you spoke about that are specific to Victoria or more prevalent here in Victoria?

Mr HAY — Did you want to touch on it from a procurement perspective?

Mr CROWE — Yes, I think it is always a relative assessment. Victorian procurement is regarded very strongly as an international standard. I think we have a very strong discipline but also depth in personnel. Obviously in any procurement we need to be conscious of how stretched that depth of the talent pool is both on the private and on public sector sides. At times the volume of procurement, if there is not pre-planning and pre-warning within both the resourcing and government teams and flagging to the market that projects are coming, that challenges can be felt, but that is probably where we have seen most challenges — in resourcing. You cannot just build something very large in a couple of days time and announce it to the market.

The CHAIR — Are there any additional risks that you need to factor in when doing projects here in Victoria?

Mr CROWE — The only risks that get discussed around projects in Victoria relate to industrial relations, but that is something that the market is aware of, the environment, and those risks get factored in. That is often discussed by contractors that we partner with.

The CHAIR — Were there challenges with industrial relations on the VCCC build?

Mr CROWE — No, I think — and Glenn can add to this — for the VCCC, being, as we have just talked about, a project of significance with outcomes that affect a lot of Victorians, it is not a project that we saw any industrial relations challenges with.

Mr HAY — They were effectively very well managed and certainly were not detrimental to the project in any way.

The CHAIR — Very good. We have had some discussions today with previous witnesses about the 13th floor of the VCCC, and we are just hoping that you might be able to walk us through the history of that 13th floor. How was it that we ended up with the extra floor and what was proposed to be done with it and then what happened with the change when the state government rented it and where to now? I am just hoping that you might be able to give us a walking history of what has happened.

Mr CROWE — No problems. This is a challenge, not only of the VCCC, but we probably particularly focused on this because it is a constrained site. Quite often with these facilities there is a growth in demand for their services over time and it is not necessarily adequately forecast in the original business case because it is very hard to forecast these things. We saw an opportunity because of the constrained site. There was really only one opportunity to build it, which was to build it now, so we, as part of our offer and part of our risk, put in additional space. We put it in in three locations: level 1, level 9 and level 13. That was largely around level 1 being in our minds then a health expansion, level 9 being some general expansion space and level 13 more naturally fitting a research expansion. It was quite spread across the building so that we could flex any of the uses within the building or the client could flex those uses in the future.

That was what we offered to government. Within that offer we offered government incentives to take over the space during construction, because otherwise we would need certainty to be able to lease that space over commercial terms. The state, the department of health, took over that space during construction and were at that time debating the use of that; hence the debate around a private ward and the use of level 13 as a private ward. But ultimately that debate was able to be had because we created flexible space in the first place and — —

Ms HARTLAND — Can I just stop you there?

Mr CROWE — Yes.

Ms HARTLAND — Was that the current government or the previous government?

Mr CROWE — The debate around utilisation of the space was held during the previous government, in the previous term. I am just trying to think of the exact dates.

Ms HARTLAND — No. That is fine.

Mr CROWE — It was an ongoing discussion.

Ms HARTLAND — Yes.

Mr CROWE — It is something that we — —

The CHAIR — Glenn, did you want to add something?

Mr HAY — Yes. I just want to say the important thing is ultimately in responding to the state's brief it was our initiative to include some additional expansion space that the state obviously assessed as part of our bid against others. We felt, from our experience, there would be a demand for those spaces and it was just through the initiative that we put forward that those spaces then were available for the state to take up during the process and to do with it what it ultimately decided to do.

Mr CROWE — Yes. I think that wraps it up. Ultimately we facilitated the state taking over that space and then investigated a number of different options around how they may utilise the space, which was both research and the private ward.

The CHAIR — What happened from there? The previous government made the decision surrounding Peter Mac Private and then the current government decided not to proceed with that. What happened along those lines from your view?

Mr CROWE — For us, we had very little visibility to that. The state is our client, irrespective of the timing of that, and we were just responding to the state's desired usage for the space because then we were looking at some of the challenges that the building faces around those uses. We responded to those and waited for the decision-making, which did not involve us.

The CHAIR — There has been some discussion around the suitability of the lift going to the 13th floor with regard to its capacity to fulfil the function of a private hospital in effect. Is that a genuine concern? Was that a concern the whole way through, or was it a concern as a result of a change to the project? Where has this concern arisen from?

Mr CROWE — The lifting for level 13 would have required an operational strategy from Peter Mac, so it was not a concern of the building asset owner. The lifting capacity was there; it is just about how you operate the lifts because of where level 13 is located relative to other health users in the facility. That was more an operational concern.

Mr HAY — Because essentially from the basement to level 6 is where more of the clinical spaces are. Obviously the design reflects that, with 7 being the transitional floor with common areas and meeting rooms. But then 8 to 13 was more of a research grid, so obviously it was designed with that capacity. So there would have been some operational work around what was required.

The CHAIR — For the 13th floor, how much rent will you receive from the state government this year?

Mr CROWE — I would have to take that on notice. I do not know that off the top of my head.

The CHAIR — That will be fine; thank you. I am just wondering if the state government does not give you the value for rent of that whole floor, is their design expansion in terms of the other 50 per cent? That 13th floor at the moment I am assuming the government is renting from you?

Mr CROWE — Correct.

The CHAIR — From there, when it is tenanted, those tenants are going to be taking over the payment of that rent, one would assume?

Mr CROWE — That is a budgeting issue for government, where government is effectively renting that space on a similar basis to the rest of the facility. Whether they use it for their own internal purposes or sublet that on to third parties is up to them. The payment terms for those are the government's or the departments.

The CHAIR — You mentioned expansion capacity on level 1 and level 9 as well. At this point in time are those spaces being utilised or are they vacant? What is the status of those spaces?

Mr CROWE — The government has taken back all of the spaces for flexibility in functional planning within the design process. Glenn, you are closer to where they are up to.

Mr HAY — So level 1, in addition to the country patient accommodation that was leased with Peter Mac to provide on-site units for country patients — Peter Mac, the state, just before commercial acceptance or completion, took up the space but they fitted out the Sony You Can Centre, providing support services to youth. So there is still I think a small area left on level 1, but that has mainly been taken up. Level 9 was largely taken up by research functions, which is being used as part of what was decanted from level 13, to make that level 13 a fully available level for, obviously, the recently announced tenants who will be going up there. So that space is effectively being utilised.

The CHAIR — I am just wondering in terms of the completion of the project was there any sort of a make-good payment to get commercial completion of the project, either to Peter Mac or the state government?

Mr HAY — There was a number of outstanding items that we worked through and had effectively resolved prior to commercial acceptance. There was a part of the commercial wrap-up under the agreement. The agreement provided that compensation could be paid for any services that may have been impacted by any delays through commissioning, and during a three-month window we encountered some delays in terms of accreditation and spaces, which had an impact on Peter Mac being able to get those spaces accredited. So there was a commercial outcome under the framework of the agreement worked through with respect to that. But all services are fully operational, and all accreditation has been concluded.

The CHAIR — Could you make those figures available to the committee?

Mr HAY — Yes, again off the top of my head — —

The CHAIR — No; absolutely taken on notice would be great, if you could. Just one final one from me. Obviously you have the ongoing maintenance of the building for the next 25 years.

Mr CROWE — Yes.

The CHAIR — I am just wondering if you might be able to provide us with — obviously you may need to take this on notice — how much approximately per annum it will cost to maintain the building?

Mr CROWE — Yes, I think that we will take it on notice as well.

The CHAIR — That would be fabulous.

Mr HAY — I think there are probably two elements to that which I think it is important to note. One is the day-to-day maintenance, which encompasses the maintenance of physical infrastructure but also security, cleaning and some other services, but also life-cycle upgrades. So factored into that number is also the upgrade of the systems, the infrastructure, for the 25 years — so carpet replacement, system replacement is all factored into that. Just to make the committee aware that 'maintenance' encompasses really a whole-of-life requirement that we have to hand the facility back to the state in a certain condition at the end of the 25-year term. So that is what drives those numbers.

The CHAIR — Okay, that would be great. I appreciate that; thank you.

Mr LEANE — Thanks for helping our committee today. Congratulations on an absolutely amazing project.

Mr CROWE — Thank you.

Mr LEANE — It is a billion-dollar project?

Mr CROWE — It is $1 billion in capital expenditure.

Mr LEANE — Yes, and you have referred to four and a half years of actually being on site?**Mr CROWE** — That is right.

Mr LEANE — Wow. So what sort of workforce? I know it is a hard question because it peaks and then it troughs. What sort of workforce do you need to build a — —

Mr HAY — It does peak and trough, but at its peak it was probably in the order of 1100 to 1200 workers on site, in that order, and it really depends upon the number of shifts. We were doing double shifts for a while

because obviously the completion date was very important to us. That is kind of the peak workforce that that would entail, and that is more just from a builder perspective; then obviously there are the consultants and all the other management teams that are supporting that effort.

Mr LEANE — Yes, and the procurement.

Mr HAY — Yes.

Mr LEANE — So there would have been jobs delivered off site —

Mr HAY — Yes.

Mr CROWE — Correct.

Mr LEANE — with support of the project. You mentioned Grocon and another company as a joint venture to build it. The other company?

Mr HAY — PCL.

Mr LEANE — Have they got an expertise in sort of medical installations?

Mr HAY — They are a North American builder who partner with us on many of our health PPP projects in North America. So they had a lot of, can I say, design and commissioning expertise in the health sector that were able to support, obviously, Grocon's local construction knowledge and experience. So that marriage worked very well for the construction.

Mr LEANE — Yes. I will declare to you that I used to be an electrician. I do not want to be one again, but there is that potential. I would imagine in the specialised nature of fitting out research laboratories I think I would struggle. Is it fair to say it is a specialised field as far as the trades that you have to bring in?

Mr HAY — Yes, very specialised.

Mr CROWE — Yes.

Mr HAY — We had I think in the order of just over 260 subcontractors, with various elements or areas of expertise. And obviously with Honeywell, as a facilities manager, their building control system is a proprietary system that was used to bring all that together — the hydraulics, electrical, mechanical — into an integrated solution that then controls all elements of the facility. So it does require very specialist service providers but also those who also have the ability to commission to very high standards that are required.

Mr LEANE — Was it hard to source those skills, the amount of skills that you needed for such a huge project?

Mr HAY — Look, I think in Victoria there are quite a number of providers who have that expertise, so there were quite good levels of, I think, contestability and competitiveness when the builder was sourcing those subcontractors. They had a number of key subcontractors on board as part of the bid, so even prior to submitting our bid the builder had already exclusively engaged with certain subcontractors for the project. But the market was fairly healthy in terms of that expertise.

Mr LEANE — Yes. I suppose it is not your concern at the moment, but just going forward there is a fair bit of health infrastructure in a short period of time, and it sort of is an issue for us to be mindful about. We had DHHS in this morning as witnesses and we had a short discussion with them around the environmental aspects that are built into new hospitals. With the VCCC can you expand on what aspects are there?

Mr HAY — Obviously the design drove a large focus on natural light and obviously trying to reduce energy consumption with the use of LEDs and some of the leading technologies, the building automation system that Honeywell use — the way that that is configured and calibrated to ensure that the building operates at the optimum from an efficiency point of view. Fittings, finishes, a lot of the mechanical equipment, with obviously high ratings from an energy perspective. So it has got quite a layered approach to energy-saving solutions and sustainability. That was a key part of the state's brief, and it is one that we had to strictly comply with.

Mr LEANE — Congratulations once again. It is just wonderful, fantastic.

Ms HARTLAND — Following on from Mr Leane's questions, in terms of obviously a very highly skilled workforce, is there enough training going on of young people to replace that skilled workforce in 5, 10, 15 years time?

Mr HAY — From my observation — obviously we are contracting the builder and the builder is kind of driving that and their subcontractors — we are seeing that the builders are having very high numbers of apprenticeships and training programs. I think there is an awareness of that, and I think the industry is responding to ensuring that that knowledge capture and transition over time is being appropriately managed, giving young workers the opportunity to grow and to learn. So I think for the tier 1 contractors that we generally deal with, they have pretty strong programs in that regard. It is not to say that more cannot be done, but certainly we do see evidence of it in what we do.

Ms HARTLAND — This may be something you cannot answer at all, but I go past there all the time, and it seems obvious in my head that Grattan Street should be closed off to make some open space between the Royal Melbourne and the cancer centre. Is that something that has ever been considered or was it ever part of your planning to just create some outdoor space that was really accessible?

Mr CROWE — It was never part of our brief. The reprogramming of Grattan Street is something that has been considered under the Melbourne Metro project around that side. There were some briefings that bidders were given during the time frame about potential changes to Grattan Street, but it seemed to be more a moving to one lane rather than closing off.

Mr HAY — What we did try to do though with our design was, because it was quite a constrained site, I think we have got 12 rooftop gardens. On level 7 we have probably got one of the largest rooftop gardens in Victoria, if not Australia. There are some secure gardens for staff and for some of the support services provided, but also for the public. So we did try to create, albeit within that constrained triangular site, that outdoor experience. The other element that we were quite strong on was in terms of bicycles. I think we can accommodate over 300 or 350 bikes within the facility. So we did try to deal with that within the constraints of the brief that we had.

Ms HARTLAND — That is impressive.

Mr CROWE — It is fair to say we were conscious of moving Peter Mac from its current location of gardens and those sorts of facilities — and coffee.

Ms HARTLAND — Yes, that is right.

Mr CROWE — We took particular attention of that.

Mr HAY — We learned from other experiences. I do not know whether you have had a chance to go to the facilities yet, but each of the cafes we have engaged directly. So we did not bring in a head tenant, and this is another issue. We are very selective about the retail offering at VCCC, which has been very well received by the community. It was not necessarily the square metre rate that was dictating the ultimate solution, which I think was something from a Plenary Health perspective we were very strong on from day one with our submission. So that is now realised and we see people interacting with that very well now, which is good.

Ms HARTLAND — So not a McDonald's outlet then?

Mr HAY — No, far from that.

Ms HARTLAND — Thank goodness.

Mr HAY — It was local providers, again all individual arrangements with us so we can control and manage. But we have seen a lot of staff and patients coming from across the road to visit, so hopefully we will create some competitive tension in the community there that will be good for everyone concerned.

Ms HARTLAND — Excellent; thank you. It does look very impressive, and I cannot wait to come and visit.

Mr BOURMAN — No questions. I just echo what everyone else has said about what a great project, and well done.

The CHAIR — At that point I thank you very much. I think everybody on the committee is very keen to come along and have a bit of a look and particularly to sample the coffees and the rooftop gardens. So thank you both very much again for your attendance here today, and I remind you that you will receive a transcript of evidence in the coming few weeks for proofreading and that transcript will ultimately be made public on the committee's website. Once again thank you for your contribution today.

Mr HAY — Thank you.

Mr CROWE — Thank you.

Committee adjourned.