V E R I F I E D V E R S I O N

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Effective Decision Making for the Successful Delivery of Significant Infrastructure Projects

Melbourne — 23 August 2012

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Professor C. Kilpatrick, Chief Executive Officer, Royal Children's Hospital (sworn).

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the inquiry into effective decision making for the successful delivery of significant infrastructure projects. On behalf of the committee I welcome from the Royal Children's Hospital, Professor Christine Kilpatrick, chief executive officer, and members of Parliament, departmental officers and members of the public. The media are also welcome.

In accordance with guidelines for hearings I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Only officers of the PAEC secretariat are to approach PAEC members. I remind members of the media to observe the guidelines for filming and recording proceedings in this committee hearing. Please note for the record that these proceedings are not being webcast. All evidence taken by the committee is taken under the Parliamentary Committees Act, which attracts parliamentary privilege and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is taken under oath or affirmation and is being recorded. Witnesses will be provided with proof versions of the transcript within 15 working days of the hearing, which are to be verified and returned to the committee secretariat within 30 working days if possible. They will then be posted on the committee website.

Following the presentation, as brief as it may be, from the chief executive officer the committee will ask questions about the inquiry and hopefully the evidence the chief executive officer gives will inform the committee in terms of the reference we are examining. I invite Professor Kilpatrick to make a brief opening presentation and perhaps give some context for the committee, but before doing so I acknowledge the professor's attendance today and thank her very much for making her time available. I know the time is constrained and this session will terminate promptly at 2.00 p.m., if not before. I invite you to make some contextual remarks. Thank you.

Prof. KILPATRICK — Thank you very much indeed for asking me to come along and follow up on the report we have already provided. I will begin by saying that the new Royal Children's Hospital is a magnificent building. I think anyone who would see it and certainly those who work in it and those who are unfortunate enough to have their children there would certainly commend the building. It really is a magnificent building.

My role as the chief executive officer has been over four years almost to the day. I have been there four years, and so I have not been there through the whole journey, as they say, but I have certainly been through a significant component of the latter part of the build and then the transition and move into it and now of course the settling in and what we refer to as realising the potential of the new RCH. I am very happy to answer questions.

The CHAIR — Thank you. The reason we have you here is that this is one of the projects that is probably successful — and the size of the gallery reflects the interest to a degree in projects according to whether they are controversial or not controversial, so by definition the smaller the gallery the more successful the project. My point is that this project by repute has been successful; there is a general view that it has been a good example, and that is why it has been selected by the committee as a case study. We have got projects on the one hand and other sorts of projects on the other hand. We are not here to create any embarrassment. What we are trying to do is dwell on lessons learnt and extract from those what we can. I might just lead into this by indicating that the sort of questions we will be asking will be in their nature about what it is that is uniquely and structurally positive about the way this project has worked and what it is that we can take out of that to apply to other projects.

On the issue of accountability and governance, in your written response to the committee you state that governance arrangements in the hospital needed to be amended to deal with the complexity of the project. I ask you to expand on that, and could you provide the committee with some further insight into that aspect of the project's oversight and management?

Prof. KILPATRICK — I begin by stating the obvious: it was a project that was undertaken between the state and CHP, with clearly the hospital very much involved — three parties, if you like. When I refer to the governance I am referring to the governance of our hospital components. I think that needs to be made clear. That is how we need to do what we have to do, and I will come to that in a second. And then there is how we related with the other parties.

The project agreement was between CHP and the state, not the hospital. We had an agreement with the state which made clear what our role was, so that was not a difficulty. What I am getting at in that comment is that when I first arrived — I can only really comment from 2008 — the role the hospital had in its duties and what it needed to do at that time was quite different to what it needed to do in perhaps the last 18 months before the move. In the first instance the governance structure was essentially to have an executive director of redevelopment who had a small team; I think that was alluded to in the report. That person reported to me and — I of course have an executive — other members of the executive.

Most of our work in those early stages was around the changed management as in the changed processes we needed to undertake. I do not mean cultural change so much, where it is all tangled, but the processes we needed to change to move into the new hospital — to be prepared to move. I think one of the successes of the new hospital, as it seemed to me, was that it was deliberately designed to create a new way of doing things. To do that meant we all had to change the way we worked. I can expand on some of these aspects later if you wish. We worked through 30-odd changes that we needed.

I will give you one quick example to explain. We had a centralised pharmacy in the old hospital. In the new hospital there is a component which is centralised but there are satellite pharmacies around the wards. That group of the staff and the nurses and doctors they interact with had to work through how we were going to do that in the new hospital. So that is a piece of work — what we call a transformation redesign. We had a group who worked with them to assist them with that. They had a pretend satellite on one of the floors to try and imitate what it would be like, so they worked through that. There are many other streams of work.

The governance of that was one thing. Once we had worked through most of that, then in the last 12 to 18 months we developed what we call the new Royal Children's Hospital steering committee. That had a finance group, a communications group, an HR group. There were still some of the change issues and resign issues that I alluded to at the tail end of those. Also we had training and education to train our staff to be ready to move into the new hospital. And very importantly we had a move group. The move took about 18 months to plan. We would meet once a month with written reports from each of those groups, and they would go through where they were up to, to date. It was mainly an accountability process. It had a risk register for each, which as you can imagine was significant, and it addressed those at every one of those meetings. That became weekly once we got very close to the end, but it took us through those last 18 months — a different phase to what we had earlier, which I am sure even before I arrived was a different phase when they were doing the design and the user groups. What I was saying was that my learnings were that you needed to be flexible in your governance structure on the way through because the needs changed.

The CHAIR — Can I just pick up on a point? Earlier into that evidence you used a phrase, 'we had to change the way we worked'. I was not quite sure whether you were just talking about the governance issues or operationally.

Prof. KILPATRICK — I meant operational. The pharmacy is just one example. We went from large wards with often at least four patients in a ward to single rooms. It has all sorts of implications, and nurses and doctors work together. We went from decentralised outpatient clinics all over the hospital to a centralised model, which was very different. We went from very much an office-based culture where you worked in an office to an open plan — not entirely, but very much an open plan.

We went from what is often referred to as an institution model. I will explain that in health terms that means you tend to have your ward — let's say your ward is cardiology — together, the doctors would have their offices very nearby, their outpatient clinic would be very nearby and they might even have a research component nearby. That often has a lot of appeal to clinical staff, but it is actually not a patient and family-friendly model, and I would advocate that it does not have the same efficiencies in the long term.

We went to having all the wards in one place, all the offices in one place and all the outpatients in one place. That was a very different way of working, and that could not really be practised until we got in there, but we worked with people to understand what it meant to work in open-plan offices, for example, and communal kitchens — it often sounds trivial, but it is very important — and that is what I meant by that. Most people ended up working in a different manner, but still in paediatrics and still with sick children.

The CHAIR — So there was a lot of adaption, and in terms of that adaption has that caused a lot of cultural change with problems and benefits?

Prof. KILPATRICK — It certainly is a cultural change; that is obviously true, of course. It caused a lot of challenges before we got there, because the average person found it difficult to work out that working in an open-plan office would be better than working in a single office or even an office shared with two others. With single rooms there was concern about what that would mean from a nursing point of view, and particularly the number of nurses needed point of view. Yes, it caused some anxiety, and we worked closely with that throughout the process. Since we have got there it has been hard of course to please every member of staff — with 4500 members of staff — but the vast majority of staff are enjoying the new environment.

The other point is that co-locations of wards had to be redeveloped. In the old hospital, for example, you might have had neurology sharing a ward with gastroenterology for various reasons, and so those staff would be used to working together. For various reasons the new hospital groupings were different. We put a lot of work into working out how they would be. We had to then re-employ people in wards, and nurse unit managers had to be reappointed. There were a lot of changed processes.

Mr PAKULA — Professor, we had the Department of Health in before lunch and they gave us some evidence, but I would be interested for you to expand on the design of the hospital in terms of the availability of space for the different models of care that the hospital is likely to confront. I understand that part of the design is about it being a very flexible, physical space. We heard about the shell ward and the vacant spaces that allow for growth. Can you just give us some more information about that design feature of the hospital?

Prof. KILPATRICK — Firstly, the hospital is built for the future, not just for today or tomorrow obviously, and I guess for at least 25 years, but the old one was 50, so I guess it could be 50 years. We will concentrate first on the inpatient beds, because that is often what people do focus on, but of course hospitals do a lot more than that — very much more than that. In fact of all the children who come to our hospital only about 20 per cent would actually be in inpatient beds. The vast majority is outpatients, day care or out in the community. That would apply to most hospitals.

So with the inpatient beds, the easiest way of thinking about this is if you consider overnight beds — and I will just give you numbers — in the old hospital we had 261 overnight bed capacity, and in the new hospital we have a 293-bed capacity to date. In addition, there is a shell for another 30 beds, which could be fitted out relatively simply. That is a significant increase. At the moment we do not use 293. We use 251 overnight beds essentially at the moment. The hospital, as I said, was built for the future, and so the potential for future growth is certainly there. The new hospital has also been built with a different mix of beds. There are more intensive-care beds — what we call paediatric and neonatal intensive-care beds for very tiny babies — than in the old hospital, and there are more in ratios for what we call short-stay beds. These are for children who might stay up to 48 hours.

We know that the trends have been — and I suggest the trends will continue, but it is always hard to forecast — that if you are in hospital you are extremely unwell and you require almost intensive care, or you might be there fairly quickly. For people coming in, say, 20 years ago, the average length of stay was probably about 14 days. That does not happen anymore. It is a much shorter length of stay now, and so the needs are different. So the hospital has been designed trying to predict what those needs will be in the future. There are more day beds in this hospital as well, compared to the other one.

Mr PAKULA — Sorry, that number that you gave us, does that include day beds or are they additions?

Prof. KILPATRICK — No, does not include any beds in addition there are another 58 day beds in the new hospital.

Mr PAKULA — I am interested in what you had to say about the previous hospital. You said that it had a capacity of 261. By and large were those 261 beds generally fully occupied?

Prof. KILPATRICK — No. There are a number of reasons why beds are not occupied, but they were not always fully occupied. In peak periods they were, but not always.

Mr PAKULA — And the 251 now, is that a demand issue, the reason that there are 251?

Prof. KILPATRICK — In health, we have more beds (overnight and day beds) open this year than we had last year — in fact, 15 more this financial year than last year. Each year we discuss what we think the activity will be and the government gives us WIES payments for that and the budget, and then we work out what beds we should need. Then sometimes you do not have all your beds open because you have more high-dependency beds and that means you need more nursing staff per patient. We often have one nurse for two patients rather than one nurse for four if they are high acuity. Things have to move around. We also have to cope with vacancies, sick leave and various other things. It does move around.

The CHAIR — Effectively you are saying that the WIES is not directly related to the beds — that is, depending on the mix you are forecasting.

Prof. KILPATRICK — Yes, it is not a fixed thing. You get a WIES which relates to a number of cases and the complexity of cases, and that is part of our payment. We get other payments, not just WEIS.

Ms HENNESSY — WIES is weighted estimated inlier.

Prof. KILPATRICK — Yes. Each case attracts a certain amount of WIES based on their complexity and length of stay, and a WIES equals a certain amount of dollars.

Mr PAKULA — Weighted estimate — what does the 'S' stand for?

Prof. KILPATRICK — I should know this — weighted inlier equivalent separation.

The CHAIR — That is it; well done. Thank you; now we know.

Mr PAKULA — Thank you.

The CHAIR — It is an expression we should be familiar with because it has been around for nearly 20 years.

Prof. KILPATRICK — The other thing about beds is that if you look over the last two decades virtually every hospital has reduced its number of beds because the model of care has changed, particularly multi-day overnight beds. I see no reason why that may not go at the same rate.

The CHAIR — And the actual throughput of patients is increasing.

Prof. KILPATRICK — Yes, a shorter length of stay.

The CHAIR — It is quite an interesting relationship.

Ms HENNESSY — What is your average length of stay?

Prof. KILPATRICK — Our average length of stay for multi-day — that means staying not just one overnight — is usually 4.8 days, and if you take all our same-day in, it is down to about 2.9 days, which is very different from a decade ago.

Ms HENNESSY — Westmead would be your best kind of benchmarking comparator?

Prof. KILPATRICK — I cannot comment about Westmead specifically, but Victoria's average length of stay has always been lower than other states in the whole sector.

Mr MORRIS — Thank you for making time available, Professor. I want to ask about the stakeholder engagement and your response to question 6(a). In the response you talked about expenditure of approximately $7.4 million in total and an RCH contribution towards that of $420 000 or thereabouts. The figure is not important; it is just the area of activity I am interested in. I note in the organisational structure that DoH provided that there is provision in there for a manager of communications. I do not know whether that is related or not, but what I am interested in is whether you needed to obtain specialist services to manage the process or whether it is an area where you have plenty of expertise built in, in any case.

Prof. KILPATRICK — I think the challenge is that most of this is a once-in-a-lifetime experience, and the executive director of redevelopment had certainly done probably not the same size project but had certainly

done significant redevelopments not just in Victoria but interstate, so he certainly had experience, and some of the staff brought in did have experience. However, we did bring certain expertise in along the way, but a lot of the staff who worked out of that $7.4 million, who dedicated their whole working day to this project were seconded clinical staff who showed an interest, a desire to be part of it, and the benefit of that is that they knew the clinical world and they learnt some of the rest of it, I guess, on the job, that is for sure, but that, I think, was extremely useful. They understood the language rather than someone who might have built a factory or a museum or something, which would be very different, so that worked well.

A lot of these people have gone on to do similar projects interstate now, which is good career development for them. The rest of the executive really had not done it before and there is no doubt that throughout this four years the executive were still doing their day-to-day jobs plus all of this extra work, and it seemed to me you had to do it that way because you could not bring a whole group of people who were quite separate to it. I was the accountable person at the end of the day and this seemed to be the best way of doing it, so it worked well.

Communication was essential, and I think that was the purpose or one of the purposes of your question, and we certainly had a communications manager. However, there is no question the executive director of communications had a huge amount of time involved with this, so you need to use your own staff because you cannot separate out the day-to-day operations from all this other work. You cannot totally — to some extent it could be, but essentially, certainly towards the last 12 months, it could not be, and so we had a group of dedicated staff. Their day job, their whole job, was to focus on the new development, but there was plenty of work being done by all of the other staff who normally do just operational work.

Mr MORRIS — Just in terms of ongoing, I take it from that — I just need to ask the question to make sure, for clarity — that under normal operating conditions you would not have formalised procedures for stakeholder engagement, or was it just not on the scale that this required?

Prof. KILPATRICK — Stakeholder engagement — sorry, I apologise if I misunderstood your question — stakeholder engagement in the process was very significant, particularly with the community, so we obviously had many stakeholders. Our own staff was huge; our families and patients was big, and our local community, very local community, was significant and our broad community. We engaged with children and asked their opinion about various things — artwork and various other things. We had a number of meetings with the local community or anyone who was interested to come and hear what we were doing and where it was at in the process, so stakeholder engagement was very significant.

Now we are in this new phase we still have a degree of stakeholder engagement over stage 2, not quite the same, but we do have and we engage with our staff over that, and we also have a community advisory committee and we engage with our families over all other clinical matters.

Mr MORRIS — That is useful; thank you.

The CHAIR — Before we move on, I have to refer to some research that my research officer, Mr O'Brien, has undertaken. A WIES payment is a weighted inlier equivalent separation payment.

Prof. KILPATRICK — That makes good sense, and separation is a patient coming in and out.

Ms HENNESSY — How many sets per year does RCH have?

Prof. KILPATRICK — We do about 36 000, but remember, if I can just say — I hesitate to say that because the policy on how you count separation changes over time, so it is difficult to measure one year to another.

The CHAIR — Does that mean that the weighting in the WIES payment changes?

Prof. KILPATRICK — No, I did not mean that. I just meant what is called a separation changes, so work you can earn WIES through has changed.

The CHAIR — Yes, that is my point.

Prof. KILPATRICK — It is often compensated in other ways, but I am just saying if you look at separation to separation, there are challenges in looking at it year on year.

Ms HENNESSY — Professor, could you take us through what the role of the KPMG auditor was and is?

Prof. KILPATRICK — Yes. This was a board initiative, that the complexity of the project was noted, the work that needed to be done to safely deliver our elements of the hospital. At the end of the day it was very, very important to us that this was delivered appropriately, and the elements of the change program that I perhaps hinted at and the transition and then move into the new hospital was very significant, so the board suggested that as KPMG were and are our internal auditors we would have a specific project like we do with the internal audit on a number of projects each year, that we would have this over a two-year period really auditing what needed to be done during those milestones. There were in fact a total of six audits in the end that were undertaken and we agreed what should be achieved, and there were various phases. I can go through some of them, but they were about making sure that the change program was on track, that our staff training was on track. There was quite bit about culture, about governance, about the move, all sorts of elements, and it was a very — —

Ms HENNESSY — And would you say that genuinely added some quality or — —

Prof. KILPATRICK — Yes, it did.

Ms HENNESSY — Or did you kind of get the audit results back and go, 'Oh, God? More work.'?

Prof. KILPATRICK — Well, one might think that, but there is no doubt it kept us absolutely focused. It is not that we were not before, and I think it helped us to work through what was an extraordinary amount of work and made sure we were not slipping with anything. So I would commend that.

Mr ANGUS — Professor, just referring to planning for future demand, and the Auditor-General in his May 2009 report under recommendation 4.2 commented in relation to forecasting models and made a recommendation in relation to that, does the hospital have any comment to make on the models that have been used and the quality of data used also in relation to planning for future demand?

Prof. KILPATRICK — I have read the report. Just to make sure, is this about the work that the Royal Children's Hospital does or is this about the engagement in the state's paediatrics?

Mr ANGUS — This is the department, centralised.

Prof. KILPATRICK — Perhaps to make two comments. First of all, I think one of the most challenging things in health is that forecasting demand is very difficult, and forecasting what models of care will exist in the future I think is extremely difficult, and health consistently is innovating and coping with demand. We understand resources are limited — they are not endless — and so we continuously try to see how can we deliver care to the children in our case, the children who need it, but in the most efficient way, and opening more and more beds is not the answer. I think the Auditor-General was suggesting we had to make sure that the data we had were working towards making sure the models of care in the new hospital were going to accommodate that.

As I said, it is hard to know in 10 years or 5 years, but at this point in time it was predicted that same-day work would be growing, and it is — we have accommodated that with extra space; we have 58 same-day beds now — that short-stay would change and that intensive care would increase. That is certainly what has happened. The build has accommodated those changes.

I think the other element was that we are building, I believe, the new Royal Children's Hospital in the context of a statewide approach to paediatrics. That includes the twofold issue: one being that there is a plan which talks about statewide paediatrics. There is now a statewide committee that looks at how we deliver paediatrics across the state. It essentially says that what I call secondaries — it is not the most complex of work — could be done at some of the secondary hospitals, such as — they are good hospitals — Northern, Geelong and those sorts of hospitals, and Sunshine Hospital. There is also an intention for Monash to grow and have much more in the way of paediatric beds. The Royal Children's Hospital has been built in those two contexts.

I think it is likely that the Royal Children's Hospital will become, in time and relatively, a more tertiary hospital. It already does a lot of tertiary work but we still do a lot of secondary work as well. I think it is likely that more

of that but not all of it will be done in peripheral — that is what I call them — hospitals. There already has been a growth.

Mr ANGUS — So just to clarify: there are 58 day beds. Did you say that is included in the 294 or not?

Prof. KILPATRICK — No, it is not.

Mr ANGUS — It is in addition to it.

Prof. KILPATRICK — Yes, so there are 58 day beds. We call them same-day beds.

Mr O'BRIEN — Thank you, Professor, for coming and for your evidence. One of the things I have identified in the audit report and I have touched on in your response is the business case. It is under 'Overall conclusion'. For our lessons to be learnt — it is a good example — I would like you to ask you to explore some of the issues that underlie this sort of comment. I will read you that comment:

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

That may have been partly departmental, but I am proceeding on the basis of your answer. I want to ask you about the input from hospital on that, because your answer is:

> The fact that the state has ended up with an excellent facility and the project journey was without any major disruption or contractual argument, tends to indicate that the initial contractual and output requirements were well specified.

Please take us through that process from the hospital's point of view — that is, the formulation of the business case — then I suppose some contractual documentation as well.

Prof. KILPATRICK — Again, I was not involved. I arrived when those decisions were made, so it is very difficult for me to comment on that. I guess the issue is about the PPP and whether that is a good way of procurement. Is that part of it?

Mr O'BRIEN — It is an aspect of it, because it is part of the decision taken.

Prof. KILPATRICK — I think is very difficult to comment on the business case for that.

Mr O'BRIEN — If you were not there, I accept that. That is your answer. If you were not there, that is fine, but if you could answer to the extent you are aware of these matters, or do you want to comment on what we call the model of procurement chosen — being the PPP in this instance.

Prof. KILPATRICK — Sure. I can comment on the latter in the sense of more or less what I have said there. It is no question that it is a magnificent facility. That is the outcome; that was the process. I can only say the process delivered a fantastic outcome for us. Along the way you had to understand the responsibility of CHP, the state and the hospital. It is a little bit more complex than it might otherwise be, but we did not have any major or significant problems along the way.

Mr O'BRIEN — Did you have project meetings regularly? I imagine you did. I know you would.

Prof. KILPATRICK — Yes, we did.

Mr O'BRIEN — Good. How often were they, for example?

Prof. KILPATRICK — I met with CHP once a month but often informally more frequently than that. I met with Tony Lubofsky, the project director, once a month. It was a separate meeting. I was part of the steering committee which was chaired by Lance Wallace. That was every three months — that is, every quarter.

Mr O'BRIEN — Essentially every issue within the site were filtered through those — —

Prof. KILPATRICK — There were different ways. Sometimes they could be managed in that way and sometimes not in that way. They would be filtered through, yes. In terms of the steering committee, there was a

project report about how that was all travelling. There was the amendments issue that was managed particularly through the steering committee as well, which was relatively minor.

Ms HENNESSY — I was just wondering if you could talk us through any awards or recognition that has been given to the project. It looks fabulous and stuff like that, but what kind of external affirmation do we have?

Prof. KILPATRICK — There are a lot of awards. There are architectural awards and infrastructure awards, which is fantastic, which Department of Health and CHP have received. We are all very proud of that; they are obviously very proud. There has been a Dulux paint award and other lesser awards but important awards. That has been an affirmation of the building. I suggest that the opening ceremony was an affirmation of the building itself. It was opened by the Queen, who opened the first hospital 50 years earlier.

We have had many visitors to the hospital. We were part of Open House Melbourne. We had 1300 visitors through that as well. We have had a lot of one-on-one affirmations. Visitors have given affirmations and there have been many awards.

Ms HENNESSY — I understand there are all sorts of ways to measure clinical outcomes. To the extent that the patient is a customer, what sort of customer satisfaction measurement does the hospital undertake?

Prof. KILPATRICK — There are a few ways to measure customer satisfaction. One is we give a satisfaction survey to families. We have done that before hospital moved — obviously the old hospital — and we have done the new hospital. There is no question that the issues around the ambiance and family-centred approach to it have improved enormously. I have to say on the overall satisfaction surveys we always do extraordinarily well, but nonetheless that is very good. We also have more confidence now than we used to have. We have complaints as well. We measure complaints, and we manage those. We have focus groups with families about what we can do better. I think families are overwhelmingly delighted by the new physical space.

Ms HENNESSY — What would you say is the great challenge for the hospital going into the future?

Prof. KILPATRICK — The challenge for the hospital going to future is coping with demand. There is no question about that. We have seen an increase in emergency demand since we moved in. Interestingly, those people are still coming from the same postcodes. They are not coming from different suburbs; they are coming from the same area. We are part of a growth corridor, so it can be partly that. It can partly be about, 'It is a nice hospital and why don't we go there instead of the GP' perhaps. It is hard to know how much of it is about the new hospital and how much relates to the demand that would have been there anyway. Most of those are low acuity cases. They are not cases that require admission. That has not increased dramatically. Demand is an issue for us.

The other challenge for us is, because we are a tertiary hospital and see ourselves as being the leading hospital in this country, research and education are extremely important to us. We have fantastic facilities now — we have not touched on that — including the Murdoch Children's Research Institute, that has wonderful facilities that now allows staff to integrate much better than before, which people have commented on; and a fantastic education precinct as well. Education is very important to what we do. As training health professionals we continue to train our own people. One of the challenges is to make sure we continue to do that to improve the outcomes for children. That is a very important challenge and is all about realising the potential of this magnificent site.

Mr MORRIS — Professor, under the heading of 'What could have been done better …' you talk particularly about the longer term and some of the equipment that you perhaps might not want to still have around in 25 years time, even if well maintained, because of changes. I think we all know how much things have changed in the last 20 years. You conclude by saying:

> A better approach would be to have the items of equipment and furniture that change in accordance with hospital practices … better and more effectively managed as a state risk.

That seems like a reasonable comment to me. Has that been raised with the Department of Health?

Prof. KILPATRICK — No, I do not think that has been formally raised. I would like to qualify that a bit. There is no question that having maintenance of furniture and surrounds and even much of your equipment for 25 years is a very good place to be in, and from my point of view is extraordinarily beneficial. I make that very

clear. I think the issue has been raised that with some of the more technical equipment it may be that the types of equipment will change over the years and so that may be a challenge. It is yet to be seen whether it is. I do not think that is a huge issue, but it has been raised as an issue that we need to be aware of.

Mr MORRIS — Obviously, for example, no-one would say, 'We're putting in this computer network and we want it to last for 25 years', whereas something like this piece of furniture we are sitting at could obviously easily last twice as long. I asked the question because this is unlikely to be the last PPP in terms of hospitals that is undertaken in the state, and it would be useful to have that fed into the process.

Prof. KILPATRICK — With technical equipment it should be something to feed into the process. I do not think it is a huge issue, but it should be thought of.

Mr MORRIS — I agree.

Prof. KILPATRICK — Yes.

Mr ANGUS — Professor, in relation to the amount that was cited in the original documents and subsequently referred to a couple of times, the $35 million donation that was part of the original arrangements, can you make a comment and perhaps bring us up to date with where that is up to?

Prof. KILPATRICK — I cannot really comment on that. As I said, I came in 2008. I think the donation was raised before that, and I do not have any up-to-date information.

Mr ANGUS — Because it is a matter that the Auditor-General has raised. We might put that on notice with the department, perhaps in the next session.

I have not seen the accounts for the last financial year yet but in terms of the payments that are being made — I am talking about the quarterly payments in relation to the PPP arrangement — are they coming through your hands as the hospital or are they just going straight from DTF?

Prof. KILPATRICK — I believe — I could be wrong but I believe — they actually do come through our hands and then go through.

Mr ANGUS — Okay, so they will appear in your financial statements?

Prof. KILPATRICK — Yes, I think that is correct. I am saying what I believe is correct but I am not — —

Mr ANGUS — So the funding will come in and then money will go out.

Prof. KILPATRICK — I thought I heard that being said. I cannot be 100 per cent sure.

Mr O'BRIEN — Part of it is that in your answer, at question 6a, you identify that:

> To support the project, the Royal Children's Hospital was required to put a project team in place to coordinate all input during the design and construction phase from internal stakeholders.

Sorry if I have not made that clear. It is the first line. Do you need me to repeat that?

Prof. KILPATRICK — Yes, just repeat that. Sorry.

Mr O'BRIEN — That is all right. I was reading downwards.

> To support the project, the Royal Children's Hospital was required to put a project team in place to coordinate all input during the design and construction phase from internal stakeholders.

Again, I know you were not there, but the answer continues:

> The team, which had a core group of six, and varied in size … depending on the project demands, was set up in early 2004 and continued.

Prof. KILPATRICK — Yes.

Mr O'BRIEN — We heard some evidence in another session about some of the difficulties of implementing a project's management from a one-size-fits-all from the department in relation to the BER projects, and contrasting it with some state education peak MPs where the department and the schools themselves in that instance had taken that stakeholder ownership of the project, which were more successful. Maybe it is becoming self-evident, but in terms of your particular experience, how important is it that the end user — being at least the hospital, the doctors and in turn the patients and the community; you have gone down to the patients, including the children in some of your input — be a driver of a procurement model or project rather than perhaps a centralised one-size-fits-all being sent down for you to adopt?

Prof. KILPATRICK — I think it is essential. It is essential that the clinical staff and the non-clinical staff — there are many non-clinical people in hospitals, who are very important to make it all work — that the staff in general, but particularly the clinical staff, because you are talking about technical spaces to work in, have a significant input into the design of those spaces. I do not think they would especially have a need to have a say about the procurement — I do not think that is essential — but they do need to have a say in what a space should look like, what a ward should look like, how a ward should be designed. Absolutely.

Again I was not here in that early phase, but from my reading of what has been done part of the success is that overwhelmingly it has been designed the way the staff wanted it to be. Some people may not be absolutely happy about offices and those sorts of things, but I am talking about the clinical spaces. The wards were very much designed with an enormous amount of detail from staff. There were 70 user groups and over 1000 staff — and we have only got 4500 people — who were actually involved in the design work, so it was huge. I think that is a key positive learning. Clearly you have to put some boundaries around what can be achieved and what is achievable, but I think that is extremely important, because they work in that space. We are talking about technical spaces. They will know what will work and what will not work, so they have enormous say and input into how the theatre should be designed, which is extremely important. People like me would not really be able to add an enormous amount to that.

Mr O'BRIEN — Thank you very much for the answer.

The CHAIR — I think we are done. Thank you very much, Professor, for your attendance today. You will receive a copy of the transcript in a couple of weeks. We ask that you respond to that promptly with any corrections and we will post it on the website.

Prof. KILPATRICK — Thank you.

Witness withdrew.