Public Accounts Committee

Building Foundations for Value

An analysis of the processes used to appoint Serco to provide non-clinical services at Fiona Stanley Hospital - Western Australia's largest ever services contract

Report No. 16
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Legislative Assembly
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Presented by

Hon John Kobelke, MLA

Laid on the Table of the Legislative Assembly on 21 June 2012

Chair's Foreword

During recent years, the Public Accounts Committee has looked at State Government policies and procedures intended to improve decision making processes for the procurement of major infrastructure. The policies have been designed to more accurately cost major infrastructure projects and achieve the best possible results with this expenditure.

These improved arrangements for the approval of such projects give agencies and the community greater confidence that the best possible value is derived from these large amounts of public expenditure. But this is only true if these procedures are followed in the decision-making processes for major projects. We have found that for a range of reasons these procedures are not always being followed, resulting in cost escalations and doubts about the value for taxpayers.

Two recent examples are the Perth City Link Project, to underground three hundred metres of railway in the centre of Perth, and the Perth Waterfront Development. The City Link Project was proposed by the Premier with a total cost of $263 million. With the project not even half completed, the cost is almost $750 million. Construction of the Perth Waterfront Development was costed in the 2011–12 Budget at $369 million. Without a major contract yet to be awarded the cost is now $560 million.

The contract awarded to Serco Australia at Fiona Stanley Hospital (**FSH**) is a facilities management (**FM**) contract for non-clinical services costed at $4.3 billion over twenty years. It was at the time the largest services contract ever awarded by the Western Australian Government.

From the outset, Fiona Stanley Hospital was to be a showcase hospital at the leading edge of modern hospital design and service delivery. It is expected that the quality of clinical and non-clinical services will be of a very high standard.

The facilities management contract to achieve this goal covers 28 services, with hard and soft services intended to be delivered in an integrated and seamless manner. This contract is not a public private partnership (**PPP**), particularly as it does not involve the construction of hospital buildings. However, the size and complexity of the contract—well beyond anything previously undertaken in this State—led to Infrastructure Australia's PPP Guidelines being utilised for the procurement process.

How can we know if:

- The taxpayers of Western Australia are getting value for money from this contract?

- The contracting out of non-clinical services at FSH will result in better quality services at a competitive price?

This Inquiry was not an attempt to judge the merits of contracting out to the private sector work which has previously been carried out by government. Nor was it an attempt to determine how much this contract will actually cost the State. Given that the hospital is not yet open, it was not about seeking to define whether or not this contracting out of facilities management for Fiona Stanley Hospital would deliver quality service at a lower cost to government.

What the Inquiry did do was examine the procedures and processes used to establish the contract with Serco Australia. Government sets standards and procedures, which its agencies are expected to follow in order to maximise the advantage to the State by achieving a contract which delivers the best possible value. The level of confidence that can be placed in the contract delivering real value rests on the extent to which these required procedures and standards underpinned the procurement processes.

The assessment of value for money is not a straight forward issue. To judge the extent to which the contract is likely to achieve value for money, the Committee looked to two key areas:

1 The development of a thorough and independent analysis of the cost of delivering the same quantum and quality of services through a direct employment model. This is referred to as a public sector comparator (**PSC**).

2 The existence of sufficiently qualified suppliers to ensure there is a market with the depth and strength to provide vigorous private sector competition to deliver quality outcomes at a good price.

The public sector comparator and all the major financial advice relating to the negotiation of the contract with Serco was undertaken by a company called Paxon. Paxon is a small Perth based company with a history of undertaking work for government agencies, including hospital-related work.

State Cabinet committed to contracting out the non-clinical services at FSH in July 2009. From this time, the Department of Health (**DoH**) knew it had a mammoth task requiring significant financial and technical advice, which it would need to contract out. Paxon was then engaged to do this work for DoH through a series of contracts costing over one million dollars, without any real competitive tendering. DoH engaged in contract splitting with the result that all the work went to Paxon and the larger national companies that normally provide this advice were never allowed to submit a bid for the work. Regardless of tight timeframes or other factors, the decision to deliberately exclude any element of market competitiveness in acquiring such important advice can only be viewed as counter to the goals set for contracting out FM for FSH.

Such blatant rejection of expected transparent market processes amplifies the concerns that arise when we look to other problems in the conduct of the procurement process.

The delay in finalising the essential service specifications meant that the earlier PSCs were of limited value. The final PSC was available to DoH on 12 July 2011, only 13 days before Cabinet accepted the contract with Serco. This is a very much expedited Cabinet process with limited opportunity for the PSC to be assessed. The PSC concluded that the Serco contract was 18 per cent cheaper than doing the work with government employees. Where other states have released publically the price difference between their hospital PPP contract price and their PSC, they range from one per cent to 11 per cent.

A number of sources in the United Kingdom expressed doubt about the usefulness and credibility of PSCs in deciding whether a private provider or a public sector run hospital service is the cheapest or best quality. In addition to the inherent deficiencies in PSC modelling, there was evidence of PSCs being biased in order to achieve the desired outcome of contracting to the private sector.

Although the report finds evidence of some inputs to the PSC not following the Infrastructure Australia PPP guidelines, there is no evidence to suggest that the PSC, or its inputs where deliberately manipulated to achieve a particular outcome.

PSCs are only a model of what it might cost to deliver a hypothetical public sector option and are based on a number of assumptions. The work Paxon did in developing the PSC may be of a high standard, but the contract splitting used to appoint them leaves a cloud over their work.

A market for the provision of facilities management services with a strong field of competing companies also gives confidence that DoH would be likely to achieve value for money. This assumes that the procurement processes are handled well and DoH does not allow itself to be out-smarted in the contract negotiations. While the problems and delays in finalising the service specifications may have strengthened Serco's negotiating position, all the procedures were run and documented in an appropriate way.

There were only two companies in the final bidding process, as the third withdrew before the service specifications were finalised. The documentation makes it clear that Serco were always the clearly preferred company. DoH did not document concerns regarding the lack of depth in the market nor did it reconsider its approach to try and get greater competition. Why was serious consideration not given to restructuring the contract and restarting the process to bring some greater element of competition?

Serco knew that DoH had a very tight timeline if it was to avoid the political and other costs arising from failing to open FSH on time in April 2014. That the negotiation process went on longer than DoH had anticipated strengthened Serco's negotiating position.

It is regrettable that we are left with real doubts over the level of competition involved with the awarding of this contract. The quality of the financial advice provided to the DoH in negotiating and assessing the value of this contract is called into doubt due to the way in which the financial advisor, Paxon, was appointed.

The evidence provided to the Committee in both public hearings and in confidential documents was more than 4,000 pages and has been of great assistance to our work.

I am most appreciative to all those agencies and individuals who have assisted the Committee with information, particularly the Department of Health, which has responded on numerous occasions to our requests for attendance at public hearings and the provision of documents, many of which they requested be kept confidential. The Committee has not questioned whether or not there is a real need for these documents to be kept confidential, but has sought to maintain—to the greatest extent possible—the confidentiality sought by the Department of Health.

The volume of the material provided and the complexity of such a large contract have required a great deal of work from our research staff and the Committee.

I am most appreciative for the many hours of hard work by our Principal Research Officer, Mathew Bates and Research Officers Alice Jones and Foreman Foto. They have put in an incredible effort to sift through and analyse such a wide range of complex information.

HON JOHN KOBELKE, MLA
CHAIR

Contents

Executive Summary

This report examines the processes used by the Department of Health (**DoH**) to award to Serco Australia (**Serco**) the Facilities Management Services Contract (**FMSC**), a facilities management and integrated services contract encompassing all non-clinical services at the 783-bed Fiona Stanley Hospital (**FSH**). The FMSC will operate for up to 20 years if both five-year extension options are taken. This is Serco's first hospital contract in Australia, although it has experience in the UK health market.

Procurement

This report examines the procurement process that led to Serco being awarded the FMSC in July 2011, and examines the time pressures that DoH was under to open FSH in April 2014. It is clear that the Department was significantly behind schedule, yet it did not have the luxury to extend the Hospital's opening date. In order to meet that deadline, DoH sacrificed many best practice procurement processes. These processes would have assisted the Department in ensuring that it was able to achieve value for money (**VfM**) over the life of the FMSC.

The report finds that significant time pressures have been exerted on DoH to ensure the Hospital opens in April 2014. These pressures have meant that:

- The procurement plan endorsed by State Cabinet was not based on detailed service specifications, rather a poorly scoped 'services matrix'.
- The commercial advisor, Paxon Consulting Group (**Paxon**), was awarded contracts to provide critical financial advice worth over one million dollars without the benefit of a competitive selection process.
- The Department did not finalise the public sector comparator (**PSC**) before the request for submissions (**RFS**) was issued.
- Service specifications initially released to RFS respondents were not developed to reflect the full scope of the FSH.
- DoH was vulnerable to the practice of hold-up during contract negotiations with Serco.

Market Depth

Changes to the key performance indicators during contract negotiations were overwhelmingly in Serco's favour, despite DoH stating that initial versions of the specifications represented international best practice.

The FMSC is a highly ambitious project and Serco has acknowledged that it is larger than any of its other international hospital contracts. While the Department has sought to achieve significant cost savings and efficiencies from bundling together 28 services, it may have sacrificed the benefits of competition in deciding to make the FMSC so large and complex.

From early on in the procurement process, it should have been clear to DoH that Serco was the only tenderer able to adequately address all of the demands of the proposed FMSC. Such a low level of competition decreased the ability of DoH to use a competitive market to achieve VfM.

Advisors

The report also examines the way in which DoH appointed its commercial advisor. During the course of the Inquiry, it became clear that the Department split contracts when engaging its commercial advisor:

- Many of the contract numbers assigned to the contracts are in close order;
- The contracts are for similar services or different components of the same service;
- Three contracts were signed on the same day;
- The contracts are with one supplier, the Paxon Consulting Group;
- The estimated values of each of the three contracts let on 9 April 2010 was $136,400; and
- The estimated values for almost all of the contracts fall just below the threshold requiring competitive tendering processes.

Public Sector Comparator

The PSC was one of the key mechanisms used by DoH when electing to proceed with the FMSC. The PSC is a complex model which will have different results depending on the assumptions underpinning its development. This is demonstrated in the four different PSCs developed by DoH and its commercial advisor. Each of the four different PSCs were developed using widely varying assumptions:

- The first PSC, developed in September 2009, assumed a contract length of 25 years and was based a poorly scoped ‘services matrix’ rather than the detailed service specifications that would later be taken to the market.
- The second PSC, developed in May 2010, assumed a contract length of 10 years and excluded two of the three most expensive elements of the contract from its

calculations – the managed equipment service (**MES**) and the information and communications technology (**ICT**) service.

- The third PSC, developed in August 2010, reflected the correct contract length of 20 years, but excluded services totalling approximately 28 per cent of the total value of the contract signed with Serco on the basis that scopes for these services were 'relatively unknown' or because not all bidders included the services in their bids.

- The fourth PSC, developed in July 2011, reflected the contract as signed with Serco, and was probably the first opportunity for DoH to gain an accurate understanding of the contract's potential VfM.

The use of the discount rate in the development of the PSC provides a good example of the malleability of the assumptions used when calculating the PSC. The Committee identifies changes to the asset beta—a measure of systematic risk—that appeared not to reflect the risk profile of the project.

The Committee also finds that the wrong risk-free rate was used in the calculation of the discount rate. The Commonwealth 10-year bond rate was used, rather than the equivalent State 10-year bond rate.

A challenge remains for the Department to ensure that risks stay transferred through the life of the contract. However, it is a fact that political risks cannot be transferred. In the event of a significant failure by Serco, political risks encountered may make the State less willing to enforce the contract.

Contract in Operation

The FMSC covers three distinct phases of the Hospital's operational life: pre-operational, transitional, and operational. Pre-operational milestones have been set for Serco, and the Department has advised the Committee that so far, all of these milestones have been met. Serco is still to complete all management and service plans to the required operational level.

Important details about how Serco would deliver the services at FSH were not finalised at the time that the contract was signed. These details will continue to be refined in the lead-up to the commencement of operations at the hospital in April 2014. Many of the KPIs against which Serco's performance will be measured require Serco to perform tasks in accordance with detail contained in the service plans. Many of the service plans have not been completed to the level of detail that describes how Serco should deliver the services.

Information about the performance of Serco in delivering the services at FSH will be recorded through the centralised Helpdesk, which is a service also provided by Serco. It is the Committee's recommendation that DoH should robustly and regularly audit the quality and accuracy of information being recorded by the Helpdesk in order to verify that the services are being delivered in accordance with the contract.

The FMSC defends the State's position by establishing the level of performance expected of Serco. If Serco's performance across the range of services is sufficiently below standard in any given month, it may see 100 per cent of its monthly payments abated as a result. Service failure can lead to contract termination or the removal of individual services from Serco's control.

Although the performance security provisions in the FMSC are generally sound, some aspects are not ideal. For example, there is a general preference for bank guarantees to be used rather than insurance bonds for the purposes of performance security on infrastructure projects. Despite this, the significant majority of the performance security offered by Serco is in the form of insurance bonds.

Assiduous contract management remains critical. DoH should closely monitor the effectiveness of the performance measurement regime in use at FSH and be prepared to negotiate changes with Serco should it prove not to provide the level of performance assurance required. Furthermore, the Department should:

- develop education packages for clinical staff to ensure that they are aware of the performance requirements of Serco under the contract; and
- actively engage clinical staff in the monitoring of Serco's performance of its contracted responsibilities.

The FMSC provides DoH with the opportunity to disclose the following information about Serco's performance:

- The quantum of failure points incurred by Serco;
- Monthly service abatement amounts; and
- Any liquidated damages incurred.

It is the Committee's recommendation that DoH disclose this information publicly each quarter, in order to subject both the Department and Serco to the kind of public scrutiny that leads to better performance.

In order to achieve the savings projected as a result of the PSC process, DoH will need to manage its contract well, ensure that risks that it has paid to transfer to Serco remain transferred, and enforce the quality provisions of the contract through the

appropriate use of performance regimes and payment abatements. It is hoped that in the operation of the contract the question about the achievement of VfM will be answered and answered in the affirmative.

Ministerial Response

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Public Accounts Committee directs that the Treasurer, the Minister for Health and the Parliamentary Secretary representing the Minister for Finance report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

Findings and Recommendations

Finding 1 **Page 10**

The Department of Health was facing a range of pressures to ensure that no further delays to the opening of Fiona Stanley Hospital were encountered, including:

- The political imperative to commence operations at the hospital in April 2014;
- Significant financial costs of between $250,000 and $400,000 per day for each day that the hospital did not open as scheduled; and
- Its part in the reorganisation of health services in the Perth metropolitan area to better meet increasing demand.

Finding 2 **Page 12**

The Facilities Management Services Contract was signed with Serco approximately nine months later than planned in the project's procurement plan.

Finding 3 **Page 14**

The procurement plan developed by the Department of Health and endorsed by State Cabinet in November 2009:

- Was based on a poorly scoped 'services matrix' rather than the detailed service specifications that would later be taken to the market; and
- Contained financial modelling based on a 25-year contract rather than a 20-year contract.

Finding 4 **Page 15**

Regardless of time pressures, the Department of Health did not follow proper processes when it appointed its commercial advisor, particularly as the:

- Appointment took place without the benefit of a competitive selection process; and
- Commercial advisor was carrying out work, sometimes for as much as two months, without a contract in place.

Finding 5 **Page 16**

The Department of Health did not finalise the public sector comparator before the request for submissions was issued. This is in breach of the Infrastructure Australia Guidelines, which requires the completion of the public sector comparator before the release of the request for submissions.

Finding 6 **Page 17**

The fact that the Department of Health was operating under significant time constraints, and that it had failed to fully scope the project before going to market, would have been obvious to respondents. This exposed a potential weakness in the State's negotiating position.

Finding 7 **Page 19**

Many of the service specifications initially released to the market when the Department of Health issued its request for submissions had not been developed to reflect the actual scope of the Fiona Stanley Hospital. Instead, they had been taken from other projects and were applied without consideration as to the ability of a facilities manager to deliver the outcomes sought.

Finding 8 **Page 19**

The Department of Health's commercial advisor excluded services totalling approximately 28 per cent of the total value of the contract signed with Serco from the public sector comparator it developed in August 2010. It did so on the basis that the scopes of the excluded services were 'relatively unknown'.

Finding 9 **Page 21**

The prices offered by Serco for the provision of individual services at Fiona Stanley Hospital changed substantially during the negotiation process. It seems likely on the available evidence that these changes occurred because of any combination of the following reasons:

- The size of the hospital increased following the inclusion of the Mental Health and State Rehabilitation facilities.
- The scope of many of the services in the service specifications, including the more expensive services (i.e. ICT and estates management) was changed during the negotiation process with Serco.
- The key performance indicators outlining the standard to which Serco was expected to deliver the services, and establishing the penalties if those standards were missed, were altered.

Finding 10 **Page 26**

The Department of Health was vulnerable to the practice of hold-up during contract negotiations with Serco.

- The Department originally estimated that contract negotiations would take between two and four months. The negotiations ultimately required nine and a half months to complete.

- Two of the most expensive elements of the contract—the information and communications technology (ICT) service and the managed equipment service (MES)—appear to have only been considered once negotiations were well advanced.
- In the case of ICT, the State acknowledges that it signed a high-risk contract with Serco.
- In the case of MES, the performance regime was substantially altered from the form that was initially taken to the market.

Finding 11 **Page 37**

The Department of Health's use of a market sounding exercise was consistent with best practice internationally for the procurement of complex and costly projects.

Finding 12 **Page 37**

The market sounding report concluded that there was a 'high to very high' level of interest for the proposed contract from the providers of facilities management and integrated services.

Finding 13 **Page 38**

An objective of the market sounding process was to establish the capability of the market to deliver the facilities management strategy being sought by the Department of Health.

Finding 14 **Page 38**

The procurement plan, which helped inform the October 2009 State Cabinet decision, stated that there was an 'interested and viable market' for the private delivery of the proposed FMSC. However, the market sounding report on which this conclusion was based did not provide any commentary on the capacities of the companies taking part in the market sounding process.

Recommendation 1 **Page 38**

The Department of Finance should develop guidelines for the use of market sounding exercises by government agencies for projects over a determined value. These guidelines must include the requirement that agencies conduct a detailed examination of the capabilities of companies taking part to deliver the mix of services being sought in the proposed contract structure.

Finding 15 **Page 39**

The Department of Health expanded the scope of its proposed facilities management contract to include portering and sterilisation services following the market sounding process.

Finding 16 **Page 41**

The Department of Health's evaluation of the expressions of interest received was well-documented, as was the evidence underpinning the evaluation panel's decisions.

Finding 17 **Page 42**

The Department of Health evaluated Serco's expression of interest as being between 23 and 26 per cent better, on a weighted percentage score, than its two closest competitors.

Finding 18 **Page 42**

The Department of Health consistently expressed confidence in Serco's response to the selection criteria used for assessing the expressions of interest; however, the Department documented a number of reservations against these same criteria for the other two companies recommended for inclusion in the request for submissions process.

Finding 19 **Page 43**

One of the three short-listed respondents withdrew from the selection process because it appears to have concluded that it could not provide a solution that would deliver what the Department of Health was seeking.

Finding 20 **Page 45**

The Department of Health did not appear to consider whether defects in the scoping or management of its proposed Facilities Management Services Contract led to the early withdrawal from the selection process of the third short-listed respondent, raising serious concerns regarding the level of competition in the whole process.

Recommendation 2 **Page 45**

The Department of Finance should develop guidelines to assist agencies should there be limited interest from the market in a project, or if bidders withdraw from the competition leaving a limited field. These guidelines would require agencies to review whether:

- there are any defects in the scoping or management of the project that may explain the low level of market interest and could be remedied in time for a re-run of the competition; and
- the bids on the table offer a good competition and are likely to lead to a value for money solution.

Finding 21 **Page 46**

The Department of Health's evaluation of the request for submissions was well-documented, as was the evidence underpinning the evaluation panel's decisions.

Finding 22 **Page 47**

At the conclusion of the request for submissions stage, Serco had maintained its very large lead in the evaluation scores from the expressions of interest stage, indicating that there was only ever one likely supplier taking part in the tender process.

Finding 23 **Page 48**

The Department of Health, whilst seeking to benefit from the bundling of many services into a single contract, failed to achieve a genuinely competitive procurement process.

Finding 24 **Page 52**

By using the *Project Management Services Panel* rather than the *Audit Services and Financial Advice Panel* to select its commercial advisor, the Department of Health was unable to consider any of the leading firms that provide commercial advice on major projects.

Finding 25 **Page 53**

The available evidence suggests that the Department of Health engaged in contract splitting when appointing its commercial advisor:

- The contracts are for similar services or different components of the same service;
- Three contracts were signed on the same day, each for $136,400;
- The contracts are with one supplier, the Paxon Consulting Group; and
- The estimated values for almost all of the contracts fall just below the threshold requiring competitive tendering processes.

Finding 26 **Page 55**

The Department of Health split the contract for the provision of commercial advice into a series of smaller contracts over the life of the procurement of the Facilities Management Services Contract. This allowed the Department to directly appoint its preferred commercial advisor without a competitive selection process.

Finding 27 **Page 55**

Given that Cabinet had decided to procure such a large and complex range of services through the Facilities Management Services Contract, the Department of Health should not have used a series of rolling contracts to employ Paxon to provide commercial advice. Rather, it should have tendered for a single engagement covering the life of the procurement process.

Finding 28 **Page 57**

The Department of Health claimed to have only considered price, rather than skills, experience or ability, when selecting firms to make submissions for the only piece of commercial advice work awarded through a competitive selection process.

Finding 29 **Page 57**

In its explanations to us, the Department of Health consistently failed to demonstrate that it understood that not all firms on panels are equal and that they have varying levels of skills and abilities.

Finding 30 **Page 58**

The Department of Health awarded Paxon the work of providing critical advice for the State's largest ever services contract without any real element of competition in the selection process.

Finding 31 **Page 61**

The Department of Health combined the provision of commercial and technical advice from one advisor, an unusual approach when compared to the management of advice on other PPP-type contracts in Western Australia.

Finding 32 **Page 63**

Poor coordination between the Department of Health (DoH), the Office of Strategic Projects and Building Management and Works resulted in delays to the formal signing of contracts for the provision of commercial advice for the Facilities Management Services Contract. However, it was DoH's responsibility to have those contracts in place in time.

Finding 33 **Page 63**

On several occasions the Department of Health's commercial advisor was completing work before contracts were in place exposing the State to risks that the contract would have minimised, including the risk of substandard work and cost escalations.

Finding 34 **Page 63**

As a result of delays from the Department of Health in making Building Management and Works (BMW) aware of the need for contracts for commercial advice, BMW was not able to play an oversight role in the Department of Health's use of panel contracts.

Finding 35 **Page 65**

On the evidence provided to the Committee, and the responses provided by the Department of Health (DoH) when pressed on these matters, DoH went to some lengths to ensure that competitive processes for the selection of its commercial advisor did not occur.

Finding 36 **Page 68**

The Department of Health sought to develop the public sector comparator for the Facilities Management Services Contract in compliance with the requirements of Infrastructure Australia's public private partnership Guidelines.

Finding 37 **Page 73**

The Department of Health did not appear to have a solid understanding of the work being completed by its commercial advisor. The Auditor General arrived at similar conclusions about the quality of the Department's supervision of advisors in an earlier report regarding the construction of Fiona Stanley Hospital.

Finding 38 **Page 76**

At least four different public sector comparators were developed for the Department of Health by its commercial advisor during the procurement of the Facilities Management Services Contract.

Finding 39 **Page 77**

Each of the four different public sector comparators (PSCs) examined during this Inquiry were developed using widely varying assumptions:

- The first PSC, developed in September 2009, assumed a contract length of 25 years and was based a poorly scoped 'services matrix' rather than the detailed service specifications that would later be taken to the market.
- The second PSC, developed in May 2010, assumed a contract length of 10 years and excluded two of the three most expensive elements of the contract from its calculations—the managed equipment service and the information and communications technology service.
- The third PSC, developed in August 2010, reflected the correct contract length of 20 years, but excluded services totalling approximately 28 per cent of the total value of the contract signed with Serco on the basis that scopes for these services were 'relatively unknown' or because not all bidders included the services in their bids.
- The fourth PSC, developed in July 2011, reflected the contract as signed with Serco. Given that this was the first PSC to be developed using the full scope of the contract, this was probably the first opportunity for DoH to gain an accurate understanding of potential value for money achievable through engaging with the private sector.

Finding 40 **Page 78**

The accuracy of the raw costs included in all but the final public sector comparator appear to have been undermined by the use of poorly scoped service specifications.

Finding 41 **Page 84**

The Department of Health acknowledges that the information and communication technology components of the Facilities Management Services Contract are high-cost and high-risk.

Finding 42 **Page 84**

The information and communication technology (ICT) service contingency payment has been designed to cap the financial impact of risks arising from the ICT components of the Facilities Management Services Contract, whilst retaining the possibility of variation due to unforseen events.

Finding 43 **Page 86**

The State's exposure to the risk of cost escalation in the delivery of the information and communication technology (ICT) components of the project may not be capped, as the Department of Health states, if Serco requires variations to the contract in order to deliver the services identified on the ICT compliance document.

Finding 44 **Page 89**

The only competitive neutrality calculation applied to the public sector comparator for the Facilities Management Services Contract related to the exemption from the payment of payroll taxes by State Government bodies.

Finding 45 **Page 93**

Two different measures of systematic risk were applied to the public sector comparators (PSCs) completed in August 2010 and July 2011.

- The information and communications technology (ICT) components of the project were excluded from the August 2010 PSC; however, they were included in the PSC developed in July 2011. ICT is generally considered to be a high-risk infrastructure type reflected in the risk-banding assigned by Infrastructure Australia (IA).
- ICT represents a significant proportion of the total cost of the Facilities Management Services Contract.
- The measure of systematic risk applied to the August 2010 PSC was greater than that assigned to the July 2011 PSC despite the exclusion of high-risk ICT from the earlier version.

- This is a counter-intuitive shift in measurement that is not supported by the evidence or the guidance contained in the IA Guidelines.

Finding 46 **Page 94**

It seems likely that the Department of Health did not have sufficient understanding of the work of its commercial advisor to adequately scrutinise important assumptions that were being applied in the public sector comparator.

Recommendation 3 **Page 94**

The Department of Treasury needs to apply a greater level of scrutiny to the work being carried out by commercial advisors on public private partnership (PPP) and PPP-type projects on behalf of State Government agencies.

Finding 47 **Page 95**

Despite representing a significant proportion of the total cost of the Facilities Management Services Contract, and belonging to the higher risk band, the ICT components were not taken into account when calculating the discount rate used to analyse bids.

Recommendation 4 **Page 95**

The Department of Treasury needs to ensure that the asset beta used for projects with significant information and communications technology (ICT) elements reflect the risk associated with ICT projects when calculating discount rates.

Finding 48 **Page 96**

The Department of Health's commercial advisor did not follow the Infrastructure Australia Guidelines when it used the 10-year Commonwealth Government bond rate, rather than the equivalent Western Australian bond rate, to determine the risk-free rate used during the calculation of the discount rate for the project.

Finding 49 **Page 104**

Important details about how Serco would deliver the services at Fiona Stanley Hospital were not finalised at the time that the contract was signed with Serco. These details will continue to be refined in the lead-up to the commencement of operations at the hospital in April 2014.

Finding 50 **Page 105**

Many of the key performance indicators against which Serco's performance in delivering the services will be measured require Serco to perform tasks in accordance with detail contained in the service plans.

Finding 51 **Page 105**

Many of the service plans, including the cleaning service plan, have not been completed to the level of detail where Serco has outlined how it will deliver the services. This means that the key performance indicators are making specific reference to Serco's obligations in the service plans before those obligations have been agreed to in detail.

Finding 52 **Page 106**

Information about the performance of Serco in delivering the services at Fiona Stanley Hospital will be recorded through the centralised Helpdesk, which is a service also provided by Serco.

Recommendation 5 **Page 106**

The Department of Health needs to regularly audit the quality and accuracy of information being recorded by the Helpdesk in order to independently verify that the services are being delivered in accordance with the requirements established in the contract.

Finding 53 **Page 109**

If Serco's performance across the range of services is sufficiently below standard in any given month, it is possible that 100 per cent of its monthly payments could be abated as a result of the performance failures.

Finding 54 **Page 110**

The contract with Serco can be terminated by the State if, during any rolling three month period, the number of failure points accumulated for all services exceeds an amount established in the contract.

Finding 55 **Page 112**

There is a general preference for bank guarantees to be used rather than insurance bonds for the purposes of performance security on infrastructure projects. Despite this, the significant majority of the performance security offered by Serco is in the form of insurance bonds.

Recommendation 6 **Page 116**

The Department of Health will need to closely monitor the effectiveness of the performance measurement regime in use at Fiona Stanley Hospital and be prepared to negotiate changes with Serco should it prove not to provide the level of performance assurance required.

Recommendation 7 **Page 118**

The Department of Health needs to:

- develop education packages for clinical staff to ensure that they are aware of the performance requirements of Serco under the contract; and
- actively engage clinical staff in the monitoring of Serco's performance of its contracted responsibilities.

Recommendation 8 **Page 120**

The Department of Health should be required to publicly report, on a quarterly basis:

- The quantum of failure points incurred by Serco;
- The specific performance failures that led to Serco incurring those failure points; and
- The monthly service abatement amounts.

Finding 56 **Page 121**

- The delivery of non-clinical services at Fiona Stanley Hospital will in all matters need to conform to the signed contract between Serco and the Department of Health.
- All such contracts are incomplete inasmuch as they are incapable of covering every eventuality that may arise in a contract which is likely to last 20 years.
- The success of this contract with Serco will rest on both the details of the contract and the quality of the working relationship between the contract partners.

Chapter 1

Introduction

The Fiona Stanley Hospital

The Fiona Stanley Hospital (**FSH**) is a 783-bed tertiary health campus currently under construction in Perth's southern suburbs. It is due to open to patients in April 2014. The hospital will be publicly-run for public patients. FSH was developed following the release of the 2004 Reid Report, which identified a need for hospital services to be located closer to where people live.[1]

Since its inception, FSH was always intended to be the State's flagship hospital encompassing the full suite of clinical services and embracing the principles of a fully digital hospital. The innovations that would be rolled-out at FSH were designed to lead to large-scale efficiencies for the State in the operation of a major tertiary hospital.

Although the major political parties have endorsed the notion that FSH would be a world leader in hospital innovation, the change of the government following the election in 2008 resulted in a decision that the private sector should provide the innovations being sought in the operation of the non-clinical aspects of the hospital through a Facilities Management Services Contract (**FMSC**).

The Facilities Management Services Contract

The FMSC is an extensive facilities management (**FM**) contract encompassing 28 individual hard and soft services. The initial contract period is 10 years, including three years of pre-operations and transition services during which time Serco will be expected to take necessary actions to ensure that it can commence providing services once the hospital opens in April 2014. The contract includes two options for five-year extensions, the first in 2021 and the second in 2026.

In broad terms, the services that Serco will be performing at the hospital will fall into the following categories:

- Management, procurement and integration services: Although the contract with Serco includes the provision of 28 individual services—often by separate sub-contractors—Serco will be expected to deliver the services in a seamless and integrated fashion. In effect, this means that one of the services that Serco is being contracted to provide is its experience in managing complex service contracts.

1 Health Reform Committee, *A Healthy Future for Western Australians* (the Reid Report), Department of Health, March 2004, p vi.

- Hard facilities management services: Serco will be responsible for maintaining the fabric of the built environment. Examples of hard FM services include maintenance of lifts, plumbing and electrical systems and general building maintenance.

- Soft facilities management services: Serco will be responsible for providing patient catering, cleaning services and other soft services at the hospital.

- ICT services: Serco will be responsible for delivering an integrated ICT solution at the hospital, ranging from providing Wi-Fi access through to integrating an electronic records management system with DoH's own tailored IT solutions.

Is the FMSC a PPP?

The FMSC is not a traditional public private partnership (**PPP**); nor is it a standard outsourcing arrangement. Instead, it is something of a hybrid, combining elements of PPP projects—including long contract life and risk transfers to the private sector—with more traditional models of outsourced service delivery, including the retention in public hands of the asset.

Broadly, a PPP can be defined as a 'long-term relationship between the state and a private contractor for the construction, maintenance and operation of infrastructure assets and procurement of related services'.[2] As a type of outsourcing arrangement, however, the FMSC is distinct from a PPP as the State is responsible for the construction and design of the infrastructure and maintains ownership, while the private contractor provides non-clinical services which are paid for by the State.[3]

The FSH project clearly diverges from this in that the design, construction and ownership of the hospital remains the State's responsibility. However, the FMSC has many of the characteristics of a PPP, including an extended contract life of 20 years, an allocation of risk to the private partner, and a small but not-insignificant requirement for Serco to finance some of the capital elements of the project.

The key characteristics of a PPP are, according to the Infrastructure Australia national guidelines (**IA Guidelines**):

- Provision of a service involving the creation of an asset involving private sector design, construction, financing, maintenance and delivery of ancillary services for a specific period;

2 English, L., 'Public Private Partnerships in Australia: An Overview of their Nature, Purpose, Incidence and Oversight', *UNSW Law Journal*, vol. 29, no. 3, 2006, p. 251.

3 English, L., 'Public Private Partnerships in Australia: An Overview of their Nature, Purpose, Incidence and Oversight', *UNSW Law Journal*, vol. 29, no. 3, 2006, p. 251.

- A continuation by government through land, capital works, risk sharing, revenue diversion, purchase of the agreed services or other supporting mechanisms; and
- The private sector receives payments from government once operation of the infrastructure has commenced and contingent on the private sector's performance in supplying the services.[4]

Despite not being a PPP, DoH elected to use IA Guidelines when procuring the FMSC as there were no specific guidelines for the development of a service project on the scale of the FMSC. This has required that we make continued reference to the IA Guidelines throughout this report, as these Guidelines provided much of the procedural basis underpinning the evaluations used when procuring the project. Where the Department made material departures from the requirements of the Guidelines, we have noted this throughout the report.

The Inquiry

Objectives

At a total cost of $4.3 billion, the FMSC is the single largest contract ever signed by a Western Australian government and it commits the State to engaging with Serco for a period of up to 20 years to provide services at FSH. It is therefore important to ensure that proper processes were followed in the selection of the provider, and that the State fully evaluated the extent to which it could achieve value for money (**VfM**).

Arising from this simple imperative, during the course of the Inquiry we have focused on whether the:

- Department allowed sufficient time to run the procurement process and to ensure that it was not subject to opportunistic behaviour on the part of Serco during contract negotiations;
- Ambitious nature of the FMSC could deliver a sufficiently broad range of companies credibly able to deliver the project, thus ensuring that the Department benefitted from the market discipline introduced by competition;
- Department received the best possible advice from its commercial advisors during the procurement process, and whether those commercial advisors were appointed in ways consistent with best practice;
- Public sector comparator (**PSC**) was credible and allowed for meaningful comparisons between private sector and public sector provision; and

[4] Infrastructure Australia, *National Public Private Partnership Guidelines: Overview*, Commonwealth of Australia, December 2008.

- Contract as signed is likely to ensure that the State derives value for money from the arrangement over its 20-year life.

We have not sought to concern ourselves with the philosophical arguments both for and against out-sourcing arrangements and PPP-type contracts. These are issues that go beyond the Terms of Reference for this Inquiry, which require that we focus on the processes used by the Department of Health (**DoH**) when electing to appoint Serco to provide the services under the contract.

Finally, it is important to state what this Inquiry is not. It is not an examination of Serco, its business practices or its involvement in the detention or justice industries. Our examination of Serco has been limited to the company's experience managing similar healthcare contracts in the UK. Should there be any shortcomings associated with the services delivered by Serco, the ultimate responsibility will rest with the government for, firstly, agreeing to the details of the contract signed with the organisation and, secondly, its management of the performance of that contract. Accordingly, our focus has been on the government's decision making process and its role in choosing the private provision of services and its future role in managing a complex contract.

Conduct

During the course of the Inquiry, we have received 39 individual submissions from a range of respondents, including:

- 16 submissions from DoH;
- 7 submissions from the Department of Treasury (**DoT**);
- 3 submissions from the Department of Finance (**DoF**);
- 3 submissions from Serco;
- 2 submissions from the Paxon Consulting Group; and
- 8 submissions from a range of non-government organisations, including unions and private citizens.

Evidence provided by DoH to the Inquiry has alone totalled more than 4,000 pages.

In addition to written submissions, we have also held four public hearings with DoH in addition to hearings with DoT, DoF, Serco and Paxon.

In February 2012, members of the Committee travelled to the United Kingdom to speak to a number of expert witnesses about that country's experience of long-term hospital contracts. Witnesses included:

- FM contract managers working for the UK's National Health Service;
- Senior managers of the private companies operating hospitals under the UK's PPP schemes;
- Participants in the PPP market, including commercial advisors, and others with experience in corporate finance;
- Health sector stakeholders, including union representatives and the British Medical Association; and
- Academics specialising in the study of long-term contracts in the health sector.

Whilst in the UK, we also inspected the Forth Valley Royal Hospital, which is a hospital operated by Serco and which served as a basis for Serco when it was making its bid for the Fiona Stanley Hospital FMSC.

Given the volume of evidence received by the Committee, and the complexity of the processes that we have undertaken to examine, it has not been possible to examine every aspect of DoH's decision making processes in exacting detail. Nonetheless, the issues that we have examined in this report are informed by the information provided to us during our review of international experience with similar projects, and also from the evidence we received from expert witnesses during our study visit in the United Kingdom.

Chapter 2

Procurement

If time is your 'enemy' in a negotiation you are likely to end up making concessions in order to complete the deal within your timescale.[5]

Good procurement takes time

Successful project outcomes require solid planning and solid planning requires time. The evidence from our examination of the Department of Health's (**DoH**) management of the procurement process for the Facilities Management Services Contract (**FMSC**) suggests that the Department was under significant pressure to meet timelines as it sought to finalise a contract. This would appear to have impacted upon the level of planning undertaken by DoH and also upon the way in which it ran the procurement process.

In a major report in 2010, Infrastructure Australia (**IA**) concluded that infrastructure projects that develop from long term plans and which have robust business cases are likely to be most successful.[6] IA went on to note that 'robust business cases, developed and tested over a number of years, help to ensure that the final project design and specification meet the needs of users and the wider community'.[7] Although the IA report was focused on planning for built infrastructure, its lessons can be transferred to any type of complex procurement, including the FMSC. In the major report on infrastructure delivery that this Committee completed in 2010, we observed that fast-tracked projects—that is, projects being procured on an expedited basis—should still be subject to the rigorous planning and evaluation required by the State's Strategic Asset Management Framework. Fast-tracking projects due to political imperatives often leads to governments committing funding without the benefit of having completed in-depth planning and analysis. In general, the earlier the detail of a project is determined, the more certainty and less risk for the State.[8]

Whilst DoH might have been planning the operation of the Fiona Stanley Hospital (**FSH**) for several years, it only focused on the detail of facilities management a few months before State Cabinet approved the decision to out-source non-clinical services at the

5 Chris Lonsdale, 'Post-contractual Lock-in and the UK Private Finance Initiative (PFI): The Cases of National Savings and Investments and the Lord Chancellor's Department', *Public Administration*, vol. 83, no. 1, 2005, p. 80.

6 Infrastructure Australia, *Infrastructure Planning and Delivery: Best Practice Case Studies*, December 2010, p. 7.

7 Infrastructure Australia, *Infrastructure Planning and Delivery: Best Practice Case Studies*, December 2010, p. 7.

8 Private briefing.

hospital. The procurement plan and associated cost modelling was not based on a set of settled service specifications, but rather a more limited services scope. Several services—including portering and sterilisation—were only added following feedback from market participants provided only a short time before Cabinet considered the procurement plan.

During the course of this Inquiry, it became clear that the FMSC was in many respects a fast-tracked project:

- The procurement plan provided to State Cabinet to assist with its decision making was not based on a full understanding of the project or its costs.
- DoH appointed its advisors hastily, circumventing the competitive selection processes typically used to procure commercial advice on similar projects.
- Despite suggesting that its procurement of the FMSC was following the IA Guidelines, in many important instances DoH commenced elements of the procurement without having finalised important documentation, including the public sector comparator (**PSC**).
- The Department issued its request for submissions (**RFS**) without a full suite of service specifications, and several of those specifications were poorly scoped.

Table 2.1 on the following page provides an overview of the major events associated with procuring the contract and gives some indication of the compressed timescale on which the project was procured.

The evidence suggests that the project was fast-tracked, and the same evidence suggests that DoH was acutely aware of the fixed deadline to which it was working. A number of early documents establish the Department's preferred milestones for procuring the FMSC. Each of these milestones is missed and sometimes by several months; however, the one constant was the opening date of the hospital itself, April 2014. It is perhaps not surprising, then, that in response to slipping deadlines, DoH expedited normal processes as it sought to have a contract in place that would not hinder the opening date of the hospital.

In this chapter we examine the evidence of where this expedition took place and the impact it may have had on the procurement process.

DoH faces political and financial pressures to ensure FSH opens as scheduled

Significant pressures were—and continue to be—exerted on DoH to ensure that the FSH opens as scheduled in April 2014.

Table 2.1: Fiona Stanley Hospital procurement timeline[9]

Date	Decision Points	Consultants/Advisors	Process
April 2009		Market sounding takes place	
8 July 2009		Paxon engaged to provide 'Business Case Analysis of FM Models'	
July 2009	MHISC[10] endorses private procurement of FM services		
16 July 2009		Paxon signs first contract – BMW 2559209	
21 July 2009		Paxon completes the 'preliminary financial analysis' contained in the procurement plan	
2 November 2009	Procurement plan approved by Cabinet		
17 December 2009			EOI bids closed
2010			2010 version of the Clinical Services Framework
29 January 2010	Three EOI bidders were selected for the RFS process		
19 February 2010			RFS released to shortlisted EOI respondents
February–March 2010			Service specifications refined
2 March 2010			One of the three shortlisted respondents withdrew—before receiving full service specifications[11]
9 April 2010		Paxon awarded three contracts, including work on PSC	
31 May 2010			RFS closing date after two extensions from 31 March
16 August 2010		Paxon awarded contract	
18 October 2010	Cabinet approves Serco as the preferred respondent		
16 November 2010		Paxon appointed to provide commercial advisory services	
17 February 2011		IT Newcom appointed to advise on IT aspects of the PSC and negotiations	
1 April 2011		Paxon contract ($363,000)	
12 July 2011		Paxon completes final PSC	
25 July 2011	Cabinet approved contract with Serco Australia		
30 July 2011	Contract with Serco signed		

9 Submission No. 20 from the Department of Health, 6 February 2012.
10 Major Health Infrastructure Steering Committee
11 Department of Health, *Summary of Facilities Management Support Services Contract*, p. 7.

FSH had been beset by a series of delays and cost blowouts. When the FSH project was announced by the then Gallop government in 2004, the anticipated opening date was some time in 2010. Since then, there have been three subsequent alterations to the estimated opening date, which was finally established as April 2014 following the approval of the business case in early 2008. Delays to the opening of the hospital, and increases to its estimated budget, have created political difficulties for previous governments, and the expectation that the hospital opening not be further delayed is an obvious political imperative.[12]

In addition to political pressures, there are also financial costs associated with delaying the opening of the hospital beyond April 2014. In November 2010, Mr Brad Sebbes, the Executive Director of FSH, stated in an affidavit for proceedings in the Industrial Relations Tribunal that the cost to DoH of delaying the opening beyond April 2014 was estimated at between $250,000 and $400,000 per day.[13]

Furthermore, Mr Sebbes stated that there is a 'real need for additional hospital services in the Perth metropolitan area', and that any delay to the practical completion and subsequent opening of FSH would have a human cost.[14] The decision to outsource the non-clinical services for FSH may in part have been a consequence of the pressure on the Department to initiate substantial reforms to non-clinical services, while at the same time delivering an area-wide reconfiguration of the clinical services framework.[15] FSH has been sold as one of the most technologically advanced hospitals in Australia—the State's 'flagship hospital'.[16] In the 2012 FSH project summary, the Department admitted that it did not have the 'systems, capacity or experience' required to deliver the desired non-clinical service reforms.[17]

Finding 1

The Department of Health was facing a range of pressures to ensure that no further delays to the opening of Fiona Stanley Hospital were encountered, including:

- The political imperative to commence operations at the hospital in April 2014;

12 Questions about the opening date of FSH have been a frequent inclusion in Parliamentary debates in the past, and speculation about the hospital's opening date has appeared regularly in local media.

13 Mr Brad Sebbes, Submission No. 9 from United Voice, appendix 10, 17 October 2011, pp. 4-5. In 2004, when FSH was first announced, the estimated opening date was in 2010. This was then extended to December 2011 in 2005, then to May 2014 in 2008. Auditor General of Western Australia, *Fiona Stanley Hospital Project*, Report 5, June 2010, p. 19.

14 Mr Brad Sebbes, Submission No. 9 from United Voice, appendix 10, 17 October 2011, p. 4.

15 Department of Health, *Fiona Stanley Hospital Facilities Management Services Project: Project Summary*, February 2012, p. 4.

16 Dr Kim Hames, Minister for Health, *Serco Australia to run support services at Fiona Stanley Hospital*, Ministerial Media Statement, 30 July 2011.

17 Department of Health, *Fiona Stanley Hospital Facilities Management Services Project: Project Summary*, February 2012, p. 4.

- Significant financial costs of between $250,000 and $400,000 per day for each day that the hospital did not open as scheduled; and
- Its part in the reorganisation of health services in the Perth metropolitan area to better meet increasing demand.

DoH was unable to meet preliminary time schedules

At the time that Mr Sebbes made his sworn statement about the potential financial implications of a delayed opening to FSH, DoH's procurement timeline was already significantly behind initial estimates.

In May and June of 2009, DoH conducted a market sounding exercise, during which nine major facilities management and integrated services providers were briefed on the Department's plans for FSH. The briefing included a preliminary timeline, outlining the planned timeframe for the procurement of the FMSC. The schedule was further refined in the procurement plan submitted to Cabinet in September 2009. The most significant difference between the two proposed schedules was a delay of three months to the commencement of the procurement process. There were smaller differences of a month or two for other milestones. **Table 2.2** provides a summary of the changes to the planned timeline.

When Mr Sebbes signed the affidavit in November 2010, he was expressing DoH's awareness of the significant pressure that it was already under to open the hospital on time. According to the procurement plan, at the time Mr Sebbes made his statement, the Department had expected to have signed a contract with a selected company to provide the FMSC. In actuality the negotiations with Serco had only just begun and the signing of the contract was still eight months away.

Evidence of missed deadlines can also be found earlier in the procurement process. As **table 2.2** demonstrates, most early project milestones were missed, and DoH was forced to release RFS documentation in stages,[18] because the Department made a judgement that progressing the procurement process as quickly as possible was more important than going to the market with a complete set of tender documents. It is not clear that DoH considered how this rushed RFS process would be perceived by the bidders or its impact on the process itself.

The shortlisted respondents subsequently requested an extension to the amount of time made available to respond to the RFS process.[19] The deadline was extended from 31 March 2010 to 21 April, then to 31 May 2010.[20]

18 Submission No. 29 from the Department of Health, 3 April 2012.
19 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 24.

In examining **table 2.2**, it becomes immediately apparent that the one date that did not shift throughout this process was the estimated date for opening FSH. In effect, what this has meant is that as early procurement milestones for the FMSC were missed, the amount of time available to DoH to finalise preliminary costings, service specifications and other documents decreased. The implications of this are matters that we discuss in some detail in later parts of this chapter.

DoH, commenting on the information contained in **table 2.2**, accepted that the procurement process was run to a tight timetable and that the 'extension to the overall process should not be looked at unfavourably given the size and complexity of the FMC and the fact that the FM has been able to mitigate many of the program risks into a tighter program and provide greater certainty for the State'.[21]

Finding 2

The Facilities Management Services Contract was signed with Serco approximately nine months later than planned in the project's procurement plan.

The procurement plan and costings provided to State Cabinet were poorly scoped

The procurement plan submitted to State Cabinet in November 2009 contained the information on which Cabinet endorsed the decision to proceed with outsourcing of non-clinical services at FSH. The document contained a 'preliminary financial analysis' that was intended to provide an 'order of magnitude' of the cost of the FMSC. It was based on a 'services matrix' developed by the FSH project team which outlined the services to be included; however, as there were no detailed service specifications at the time, nor any key performance indicators (**KPIs**), they could not be incorporated into the costing models presented to State Cabinet.[22] Furthermore, the financial model was based around an estimated contract length of 25 years rather than the 20-year contract signed with Serco.

In October 2009, the Economic Audit Committee, a body established by the Barnett Government after its election in 2008, found that compressing planning to meet deadlines may result in in 'Cabinet making decisions about such projects on the basis of less than full information, to the potential detriment of the State'.[23] In such circumstances, 'Cabinet may decide to proceed with a poorly evaluated project that has an excessively low estimated cost or an overly optimistic completion date when

20 Submission No. 37 from the Department of Health, 22 May 2012, p. 6.
21 Submission No. 38 from the Department of Health, 14 June 2012.
22 Submission No. 20 from the Department of Health, 6 February 2012, p. 7.
23 Economic Audit Committee, *Putting the Public First Partnering with the Community and Business to Deliver Outcomes*, October 2009, p. 98.

Table 2.2: Comparison of estimated milestone completion dates with actual completion dates

Milestones/events	Market sounding[23]	Procurement plan[24]	Actual[25]
Release of EOI	July 2009	October 2009	4 November 2009
EOI closes	Not available	December 2009	17 December 2009
Shortlisting of proponents	November 2009	7 January 2010	27 January 2010
EOI shortlist approval by evaluation steering committee	Not available	13 January 2010	Not available
STRC endorsement of EOI evaluation report	Not available	During January 2010	27 January 2010
Request documentation completed	Not available	End January 2010	Not applicable
Release of RFS	January 2010	1 February 2010	19 February 2010
Proposals received from shortlisted proponents	March 2010	11 March 2010	31 May 2010 (extended from 31 March 2010 and 21 April 2010)
Request evaluation and recommendation completed	Not available	5 April 2010	June-August 2010
STRC endorsement of evaluation report	Not available	14 April 2010	1 September 2010
Preferred proponent selected	May 2010	Not available	18 October 2010
Negotiation with preferred respondent	Not available	May/June 2010	October 2010–July 2011
FM contract awarded	August 2010	Late 2010	30 July 2011
Soft FM and other services procured	2011-2012	Late 2011	For example, linen subcontract tenders closed 3 May 2012
Building practical completion	December 2013	Late 2013	December 2013 (estimated)
Operational commencement date	April 2014	April 2014	April 2014 (estimated)

24 Submission No. 18 from the Department of Health, 9 January 2012.

25 Department of Health, *Procurement Plan: Fiona Stanley Hospital – Facilities Management and Support Services*, October 2009, p. 20; in Submission No. 12 from the Department of Health, 21 November 2011.

26 Submission No. 20 from the Department of Health dated 6 February 2012, pp. 2–4

more extensive analysis would have given a clearer picture of the risks associated with the project'.[27]

Given that State cabinet endorsed a procurement plan that had been developed using 'less than full information', there is a risk that the problems identified by the Economic Audit Committee will eventuate with respect to the FMSC.

Finding 3

The procurement plan developed by the Department of Health and endorsed by State Cabinet in November 2009:

- Was based on a poorly scoped 'services matrix' rather than the detailed service specifications that would later be taken to the market; and
- Contained financial modelling based on a 25-year contract rather than a 20-year contract.

Appointment of the commercial advisor did not conform with good practice

Apparent shortcomings in the decisions made during the procurement process might have resulted from the time pressures. A key example of this is the unusual approach adopted by the Department when appointing its commercial advisor. **Chapter 4** outlines the Committee's concerns regarding apparent irregularities in the process used to appoint the commercial advisor.

DoH's commercial advisor, the Paxon Consulting Group (**Paxon**), was initially appointed without the use of a competitive selection process. Competitive selection processes can be a time consuming exercise, particularly given the need to invite tenderers and allow sufficient time for proposals to be developed by private providers and then assessed by an evaluation panel. Lack of competition in the procurement process was an almost constant feature of DoH's selection of Paxon's services. The company was only once subject to competitive tender, towards the end of the project, by which point it had a significant commercial advantage over its competitors due to its experience on the project.

The task of providing commercial advice to DoH constituted a substantial body of work and the selection of a commercial advisor would have benefited from the use of a competitive process. We sought on numerous occasions to gain an explanation from the Department about why Paxon was selected. Ultimately, the Director General of DoH, Mr Kim Snowball, indicated at hearing that one of the reasons for the appointment was that the company had prior experience with the project, and as such

27 Economic Audit Committee, *Putting the Public First Partnering with the Community and Business to Deliver Outcomes*, October 2009, p. 98.

would be able to complete the work more promptly than another company without first-hand knowledge of the project.[28]

On a number of occasions, the commercial advisor was instructed to commence work before contracts were signed. The obvious risks associated with this practice were disregarded by DoH due to the need to avoid delays. When questioned by the Committee, the Director General of the Department of Finance, Anne Nolan, reported that this practice is unadvisable, but does occur due to a sense of urgency and time constraints.[29] Several DoH representatives also admitted that this practice was not preferred, but that it was necessary to allow work to continue on the project.[30]

Finding 4

Regardless of time pressures, the Department of Health did not follow proper processes when it appointed its commercial advisor, particularly as the:

- Appointment took place without the benefit of a competitive selection process; and
- Commercial advisor was carrying out work, sometimes for as much as two months, without a contract in place.

IA Guidelines were not always followed

The Department maintained that it relied on the IA Guidelines when it was developing the PSC. These Guidelines are generally used to inform the development of more traditional PPP projects. While the FMSC cannot be classified as a public private partnership (**PPP**), it clearly has many elements that are substantially similar to PPPs. It is reasonable that the Department used these Guidelines to inform its development of the PSC; however, there is little or poor documentation justifying DoH's decision on the occasions that it did not choose to follow the Guidelines.

The IA Guidelines require that the PSC should be finalised before the RFS is sent to shortlisted bidders.[31] Despite this clear requirement, the Department's commercial advisor did not complete the PSC until the same day that the RFS bids were *received from* shortlisted bidders.

An important role of the PSC is to provide a like-for-like cost estimate comparing private sector and public sector delivery of the same outcomes. An accurate PSC can

28 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 16.
29 Anne Nolan, Director General, Department of Finance, *Transcript of Evidence*, 24 April 2012, p. 7.
30 Mr Wayne Salvage, Acting Executive Director, Resource Strategy and Infrastructure, and Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, pp. 17–18.
31 Infrastructure Australia, *Public Sector Comparator Guidance*, December 2008, p. 13.

only be developed once the output specifications on which the proposed project is based are completed. Any PSC completed using a different set of specifications will not allow for a meaningful comparison with private sector bids.

Given that the service specifications were not completed until after DoH had issued its RFS, it was impossible for the Department to comply with this requirement of the IA Guidelines. This meant that the Department could not have a full appreciation of anticipated costs before going to the market.

Developing the PSC early in the life of a project also contributes to ensuring that the scope of the project is well developed at the outset, which prevents delays during the procurement process and costly alterations in the final negotiations or variations once the contract has been signed.[32]

Finding 5

The Department of Health did not finalise the public sector comparator before the request for submissions was issued. This is in breach of the Infrastructure Australia Guidelines, which requires the completion of the public sector comparator before the release of the request for submissions.

DoH issued the RFS prematurely

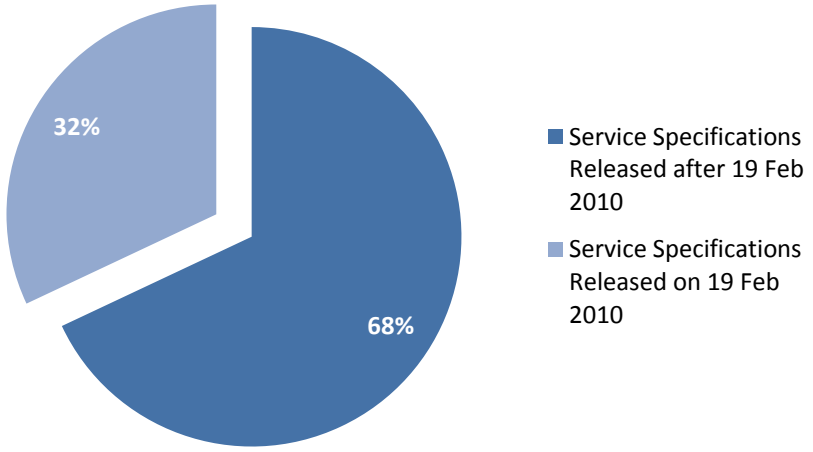
The PSC was not the only key piece of documentation that was not completed on time. According to the IA Guidelines, the service specifications, a key element of the final contract, should be included in the material sent to shortlisted bidders with the RFS.[33] However, in the case of the FMSC, the service specifications were released to the bidders in six stages from 19 February 2010—the date that the RFS was issued—through to 23 March 2010.

The information and communications technology (**ICT**) elements of the project represent 15 per cent of the total cost of the contract signed with Serco. ICT is significant both in terms of its financial cost and also its centrality to the effective operation of the Hospital. Despite this, detailed ICT service specifications were not included in the documentation made available to shortlisted respondents on 19 February 2010. A limited ICT 'services scope' was provided on 23 March 2010.[34]

The ICT service specifications were only one of 15 specifications that were not provided to shortlisted respondents with the RFS documentation. Also missing was the managed equipment service (**MES**) specifications. MES represents 12.5 per cent of the total contract value.

32 Private briefing.
33 Infrastructure Australia, *National PPP Guidelines: Practitioners' Guide*, March 2011, p. 18.
34 Submission No. 30 from the Department of Health, 17 April 2012, pp. 5–6

Figure 2.1: Service specifications expressed as a proportion of the total contract value released on or after 19 February 2010 with the RFS documentation[35]



As **figure 2.1** above demonstrates, cumulatively, 68 per cent of the service specifications for the contract by value were not made available to respondents on the day the RFS was issued. The remainder of the service specifications were provided to the shortlisted respondents during the three weeks following the release of the RFS on 19 February 2010. The schedule is reproduced in **table 2.3** below.

We raised concerns with the Department about its decision to release the service specifications in segments, particularly as the IA Guidelines indicate that agencies should have completed output specifications before going to the market.[36] In response, the Department indicated that the State Solicitor's Office (**SSO**) had provided advice on the matter.[37] Although the advice from the SSO may have been that there were no legal impediments to releasing RFS documents in tranches, the Department should have considered the risks involved and the signals it was sending to its market by proceeding in this fashion.

Finding 6

The fact that the Department of Health was operating under significant time constraints, and that it had failed to fully scope the project before going to market, would have been obvious to respondents. This exposed a potential weakness in the State's negotiating position.

35 Submission No. 30 from the Department of Health, 17 April 2012, pp. 5–6; and Submission No. 27 from the Department of Health, 30 March 2012.

36 Infrastructure Australia, *National PPP Guidelines: Practitioners' Guide*, March 2011, pp. 21–22.

37 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, pp. 20–21.

Table 2.3: Schedule of release dates for service specifications[38]

Date	Addendum No.	Specification
26 February 2010	1[39]	• Health record management and clinical coding service • Patient entertainment service • Pre-operational service • Safety and incident management service
3 March 2010	2	• Energy and utilities service • Fleet management service • Managed equipment service • Property management service • Supplies management service
5 March 2010	3	• Estate services • Management and integration service • Transitional service
8 March 2010	4	Audio visual service
9 March 2010	5	Human resource management service
19 March 2010	6	Amendments
23 March 2010	7	Optional ICT service scope
26 March 2010	8	Amendments
31 March 2010	9[40]	Amendments
6 May 2010	10	Amendments

Service specifications issued with the RFS were poorly scoped

The initial service specifications were poorly scoped and were incomplete when issued to the bidders. The service specifications for the FMSC were developed by DoH in consultation with a range of internal and external experts, including SG2, Ernst & Young and MBMpl.

In the PSC it completed in August 2010, Paxon Consulting Group elected to exempt ICT, MES and retail property management on the basis that 'the scope of these services were relatively unknown'.[41] Together, these three services represented approximately 28 per cent of the total contract by value.[42] Mr Sebbes acknowledged that the initially developed service specifications had been poorly scoped, as DoH had 'just picked up standards from other projects and some of those projects were physically much smaller than ours…'.[43] Mr Sebbes continued that many of the initial inclusions in the service specifications had been taken from other hospital projects, and that not enough

38 Submission No. 30 from the Department of Health, 17 April 2012, pp. 5-6.
39 Extended deadline from 31 March 2010 to 21 April 2010.
40 Extended deadline from 21 April 2010 to 31 May 2010.
41 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.
42 Paxon Group Commercial and Financial Analysis, July 2011, pp. 73; in Submission No. 27 from Department of Health, 30 March 2012
43 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 28.

consideration had been given to the capability of a facilities manager to deliver those KPIs.[44]

In later sections of this chapter and in **appendix 1**, we outline some of the changes made to the service specifications (including the KPIs) during the contract negotiations. It is reasonable to conclude that many of the changes were made because the specifications had not been developed in a way that fully reflected the actual scope of the hospital, or the scope of the services being sought through the FMSC. In this case, having a better understanding of project scope would have limited the extent to which the service specifications were not properly tailored for specific implementation at FSH. As we have seen, however, DoH does not appear to have left itself sufficient time to fully scope the project, and therefore develop accurate service specifications, before issuing the RFS in February 2010.

It is important to consider the impact of these poorly formed service specifications on DoH's negotiating position. In addition to not having a full suite of specifications when it went to the market in February 2010, the specifications—when they were finally released—had not been developed to reflect the bespoke nature of the hospital. The result is predictable: significant changes to the prices initially bid by Serco and finally signed in the contract.

Finding 7

Many of the service specifications initially released to the market when the Department of Health issued its request for submissions had not been developed to reflect the actual scope of the Fiona Stanley Hospital. Instead, they had been taken from other projects and were applied without consideration as to the ability of a facilities manager to deliver the outcomes sought.

Finding 8

The Department of Health's commercial advisor excluded services totalling approximately 28 per cent of the total value of the contract signed with Serco from the public sector comparator it developed in August 2010. It did so on the basis that the scopes of the excluded services were 'relatively unknown'.

44 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 28.

Table 2.4: Changes to bid prices between Serco's initial RFS response and the final contract[45]

Service	% change	Service	% change
Cleaning	214% ↑	MES	17% ↓
Electronic Records Management Service	66% ↓	Management and Integration Service	26% ↓
Energy & Utilities	49% ↓	Patient Catering	0.5% ↓
Estate	67% ↑	Patient Entertainment	36% ↓
External Transport	55% ↓	Pre-operational	29% ↑
Health Records Management and Clinical Coding	74% ↓	Reception	52% ↓
		Safety & Incident Mgt	96% ↑
Helpdesk	209% ↑	**Scheduling & Billing**	88% ↓
HR Mgt	22% ↑	Sterilisation	35% ↓
ICT	144% ↑	Supplies Mgt	104% ↑
Internal Logistics	2% ↑	Traffic Mgt	57% ↓
Linen	80% ↓	Waste Mgt	62% ↑
Total Contract Price 18% ↑			

Prices for services bid by Serco changed during the course of procurement

Table 2.4 above represents in percentage terms the differences between the prices submitted by Serco in response to the RFS and the final prices as agreed following contract negotiations. As the table makes clear, there were significant changes to the prices offered as a result of the contract negotiation process.

The total price bid by Serco in May 2010 for the whole contract increased by 18 per cent during the negotiation period. Some of this increase would seem to be accounted for by increases in the size of the hospital to take account of the Mental Health and State Rehabilitation facilities, in addition to changes to how asset costs associated with Serco's delivery of the services would be handled.[46]

It should also be noted, however, that Serco's bid included eight services for which it did not make firm bids (these are in blue in **table 2.4**), because the prices would be subject to due diligence and/or further scoping.[47] Particularly in the case of the ICT service, it would seem quite likely that the further scoping related to the need to bring the service specification to an acceptable level of detail. Interestingly, cleaning, despite being a service for which Serco had made a firm bid price, increased the most dramatically between its initial submission in May 2010 and the contract being signed in July 2011.

45 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012; and Paxon Group Commercial and Financial Analysis, July 2011, pp. 76–77; in Submission No. 27 from Department of Health, 30 March 2012.

46 Paxon Group Commercial and Financial Analysis, July 2011, p. 73; in Submission No. 27 from the Department of Health, 30 March 2012.

47 Paxon Group Commercial and Financial Analysis, July 2011, p. 73; in Submission No. 27 from the Department of Health, 30 March 2012.

On the evidence available, it seems reasonable to conclude that the prices offered by Serco changed for any combination of the following reasons:

- The size of the hospital increased once the:
    - scope of the Mental Health facility had been finalised; and
    - State Rehabilitation Service was included in the overall FSH project.
- The scopes for many of the services in the service specifications, including the more expensive services (i.e. ICT and estates management) were changed during the negotiation process with Serco.
- The KPIs outlining the standard to which Serco was expected to deliver the services, and establishing the penalties if those standards were missed, were altered.

In considering the pricing changes outlined above, and the possible explanations for them, we note the advice of the United Kingdom's National Audit Office (**UKNAO**):

> *The tender price should not normally have changed after the preferred bidder has been appointed, other than for authority initiated changes to service specifications (though these should as far as possible be avoided).*[48]

And:

> *Design and/or operational changes should [be kept] to a minimum during [the preferred bidder] phase of the project.*[49]

In the context of the discussion in this chapter about the significant pressure that DoH was operating under, it seems reasonable on the available evidence to conclude that DoH was not in a position to have run a procurement process that would have allowed the good practice outcomes described by the UKNAO above.

Finding 9

The prices offered by Serco for the provision of individual services at Fiona Stanley Hospital changed substantially during the negotiation process. It seems likely on the available evidence that these changes occurred because of any combination of the following reasons:

48 UK National Audit Office, *A Framework for Evaluating the Implementation of Private Finance Initiative Projects*, Vol. 2, May 2006, p. 26

49 UK National Audit Office, *A Framework for Evaluating the Implementation of Private Finance Initiative Projects*, Vol. 2, May 2006, p. 26

- The size of the hospital increased following the inclusion of the Mental Health and State Rehabilitation facilities.
- The scope of many of the services in the service specifications, including the more expensive services (i.e. ICT and estates management) was changed during the negotiation process with Serco.
- The key performance indicators outlining the standard to which Serco was expected to deliver the services, and establishing the penalties if those standards were missed, were altered.

The negotiations

Hold-up is a risk during all complex contract negotiations

Hold-up is the practice whereby one party in a negotiation is able to force the other to accept a disadvantageous movement in the terms of the contract due to the lack of alternative solutions available.[50] The likelihood of this occurring is increased when the procurer—in this case DoH—is constrained by an unmovable deadline. Generally, as a deadline grows closer, procurers become increasingly reluctant to reverse the procurement process and hold another competition due to the limited time available.

This causes a significant shift in the balance of power during negotiations, which the supplier can exploit by renegotiating its successful bid.[51]

This renegotiation is rarely done in a single act. Generally, the supplier will invoke hold-up over a series of small movements in its favour. Each small movement will not be significant enough for the procurer to reverse the procurement process, but cumulatively will substantially alter the contract. The result of this opportunistic behaviour is known as 'pre-contractual drift'.[52]

The threat of hold-up can be minimised in two ways:

- Utilise the 'competitive dialogue' process during contract negotiations. This involves the maintenance of two or three suppliers for as long as possible until all have well-developed proposals. This strategy works to prevent pre-contractual drift by limiting the amount of time between preferred bidder selection and financial

50 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 685.

51 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 686.

52 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 685.

close (to approximately three or four months),[53] thereby giving the supplier fewer ambiguities to exploit, and giving the procurer the opportunity to make a credible threat to reverse the procurement process and select another final bidder.[54]

- Allow sufficient time to reverse the procurement process. The more pressure the buyer faces to meet a tight deadline, the more likely it is to persevere with a draft contractual agreement, despite being forced to surrender enormous financial territory.[55]

Did DoH's negotiations with Serco fall victim to hold-up?

As we have already seen from **table 2.2**, DoH was operating to a fixed deadline: the hospital was required to be operational by April 2014. The dates set for most other procurement milestones had been missed, some almost as soon as DoH embarked on the procurement process. This meant that DoH was susceptible to hold-up during its contract negotiations with Serco, because the time pressures it was operating under weakened the Department's position relative to Serco.

We asked DoH to provide a broad summary of the progress of the contract negotiations with Serco. This is reproduced in **table 2.5** below.

We also asked the Department about the strategies it used to overcome the possibility of hold-up during negotiations with Serco. DoH advised us that:

- A facilities management working group was appointed to progress the supporting documentation for the contract negotiation process.
- A six person contract negotiation team was appointed, and State Solicitor's Office and Freehills were engaged to provide legal advice.
- It established 'formal governance processes', and organised regular briefings with senior executives.
- Paxon was appointed as commercial advisor to assist the Department during the contract negotiation process.[56]

53 Private briefing.
54 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 685.
55 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 685.
56 Submission No. 36 from the Department of Health, 15 May 2012, pp. 6–7.

Table 2.5: Contract negotiation timeline[57]

Date	Events
October–December 2010	Identified and explored the issues raised by Serco in its RFS response. The issues at this stage were largely of a conceptual (rather than drafting) nature, and were dealt with through progressive mark-ups of a table of departures. This stage also involved Serco being required to progress draft service plans from level 1 to level 2. This involved workshops with DoH to clarify technical requirements.[58]
December 2010	Serco began returning draft service plans for some service lines.
January 2011	The State negotiation team identified some common issues with Serco's draft service plans and developed templates for Serco to follow, to avoid these issues in the future.
January–February 2011	Legal and commercial issues continued to be negotiated at a conceptual level through progressive mark-ups of a table of departures.
February 2011	Service plans, suitable for review, began to be delivered. Intensive review and negotiation of these service plans began.
23 February 2011	The State released a marked-up copy of the FMSC to Serco. From this point to financial close, marked-up contracts (rather than tables of departures) would be circulated amongst the parties.
Late February–early March 2011	Aspects of the KPI regime were negotiated.
Late March 2011	Early drafts of the tripartite agreement between the State, Serco and the Commonwealth Bank of Australia (**CBA**) exchanged.
March–April 2011	Negotiation of legal and commercial matters continued, followed by exchange of marked-up contracts. Intensive review and negotiation of draft service plans continued through March, and were largely settled in April.
Early April 2011	The Scheduling and Billing Service was in final or near final form. ICT specification documents were produced. The following service lines were stabilised: • Audio visual • Electronic records management • Energy and utilities • External transport • Fleet management • Grounds maintenance • Health record management and clinical coding • Helpdesk and communications • Internal logistics • Linen • Patient catering • Patient entertainment • Pest control • Property management • Reception • Safety and incident management • Sterilisation • Supplies management • Transitional • Vehicle and traffic management • Waste

57 Submission No. 37 from the Department of Health, 22 May 2012, pp. 2–5

58 These were to develop into the service plans required pursuant to Schedule 1 of the FMSC.

Date	Events
April 2011	Intensive negotiations of the tripartite agreement took place, with a number of drafts circulated. The MES model and performance regime were the subject of negotiations.
Late April 2011	Serco and British Telecom (**BT**)'s ICT solution documents were completed.
Late May	The pre-operational service specification had reached final form.
May–June 2011	Contract drafting negotiations continued. This involved negotiation followed by exchange of marked-up contracts. The tripartite agreement and other lease-related documents continued to be negotiated. The conceptual model for the MES was refined as MES-related contractual documentation was negotiated. The ICT solution and ICT documentation were also negotiated.
Early June 2011	The specifications for the following service lines were in final or near final form: • Cleaning • Estate • Human resources • Management and integration
Early July 2011	Intensive negotiation of the remaining MES issues continued before being closed out. Intensive negotiation of the remaining issues in relation to the tripartite agreement and other lease-related documents.
30 July 2011	The FMSC was executed.

We also note that DoH retained an advisor for the provision of advice relating to the ICT components of the FMSC. Although aware of the important contribution that the ICT advisor may have made to the State's negotiating position, we note that the contract for this support was not signed until February 2011.[59] By this stage, negotiations with Serco were well advanced.

Evaluating how successful the Department's strategies were at overcoming the threat of hold-up is a difficult proposition. On the one hand, the contract is a highly complex document covering the operation of a hospital over a 20-year period, so it should be expected that the length of time taken to complete negotiations reflects that same level of complexity. On the other hand, we have the expectations of the Department itself, which initially thought (depending upon which document is consulted) that negotiations would take between two and four months. Those involved with the negotiations also noted that getting the contract to financial close took longer than expected,[60] and the project's lead commercial advisor admitted that the negotiations, in addition to being the largest he had ever been involved in, were also the largest encountered by the State's legal advisor, Freehills.[61]

59 Submission No. 20 from the Department of Health, 6 February 2012, p. 10.

60 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 24.

61 Mr Michael Palassis, Director, Paxon Group, *Transcript of Evidence*, 12 January 2012, p. 12

It is also necessary to consider what the negotiation timeline in **table 2.5** tells us. For example, the first five months of negotiations appear to have been dominated by the service plans which Serco was required to submit. The service plans:

> *include all policies, procedures, resources, processes, systems, method statements, inspection plans, test plans, scheduled maintenance activity and any other relevant documents that provide a detailed understanding of how the Facilities Manager will provide the Services.*[62]

The KPI regime and service specifications appear to have been actively negotiated only after February 2011. These two elements serve, in effect, to outline what it is that Serco will be required to do, and establish how Serco's performance will be measured in implementing the services. The KPIs also play a key role in establishing the extent, if any, to which Serco's monthly fees will be abated should its performance fall below levels required by the KPIs and service specifications.

Two of the most expensive single elements of the contract, the ICT components and the managed equipment services (**MES**) were only finalised towards the conclusion of the negotiation process. In the case of the ICT services, it should be noted that one of the reasons that it was finalised so late in the development of the FMSC was DoH's failure to complete its own service specifications earlier in the process. Nonetheless, the Department has acknowledged that it assessed the ICT solution offered by Serco as being high-risk.[63] It is possible that DoH signed a high-risk ICT contract with Serco because negotiations had been subject to hold-up. Similarly, we note that the performance regime for the MES was varied 'to accommodate accepted market-based positions on asset performance'.[64] Given that the MES components were only negotiated after April 2011, it is also possible that hold-up to the negotiation was to Serco's advantage.

Finding 10

The Department of Health was vulnerable to the practice of hold-up during contract negotiations with Serco.

- The Department originally estimated that contract negotiations would take between two and four months. The negotiations ultimately required nine and a half months to complete.

62 Facilities Management Services Contract, Schedule 1, p. 21.
63 Submission No. 35 from the Department of Health, 15 May 2012, p. 4.
64 Paxon Group Commercial and Financial Analysis, July 2011, p. 40; in Submission No. 27 from the Department of Health, 30 March 2012.

- Two of the most expensive elements of the contract—the information and communications technology (ICT) service and the managed equipment service (MES)—appear to have only been considered once negotiations were well advanced.
- In the case of ICT, the State acknowledges that it signed a high-risk contract with Serco.
- In the case of MES, the performance regime was substantially altered from the form that was initially taken to the market.

KPIs changed substantially during the negotiation process

DoH provided us with two different versions of the service specifications: an April 2010 version—the version that the Department took to the contract negotiations—and the final, July 2011 version reflecting the contract signed with Serco. Using these two versions we were able to gain an insight into the extent of the changes made to the service specifications as a result of the negotiation phase with Serco.

Changes made to the KPIs were particularly significant as they substantially altered the amount of time that Serco has to rectify a number of potential failures. They also increase the permissible number of times that Serco can commit certain performance or availability failures before penalties are applied, and decrease the level of abatement that Serco will receive in the event of repeated failures. Details of these changes are illustrated further in **appendix 1**.

According to the Department, any changes made to the service specifications during the contract negotiation period were either to clarify definitions and tighten language or were in the Department's favour.[65] The Committee accepts that aspects of the service specifications relating to the content of the individual services were not substantially changed. It is clear, however, that the elements of the specifications relating to the performance regime—the KPIs—were significantly altered during contract negotiations.

A clear majority of the changes made to the KPIs for these services represent a material deterioration of the standards required from Serco and are therefore not in the State's favour.

To illustrate this point, the definition of what constitutes a 'repeated failure', or the number of performance or availability failures allowable within a specified 'failure period', was frequently increased. These changes are clearly in Serco's favour. Repeated failures do not benefit from the operation of a remedial period. In other

65 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 27.

words, if a fault is a repeated failure, penalties can be accrued immediately, whereas non-repeated failures will only accrue failure points once the remedial period (a period defined in the contract) has passed. By increasing the number of failures permissible before a failure is a 'repeated failure', the Department has in many instances weakened the penalty system and therefore the performance regime.

For example, KPI two of the cleaning service specification states that 'Scheduled Cleaning is only performed during the relevant Access Time for that area, unless otherwise agreed with the Principal in writing'.[66] The definition of repeated failure for this KPI was increased from six instances in three months to 30 instances in three months.[67] In effect, this means that Serco is able to fail to meet this standard an extra 24 times in each three month period.

Attendance and rectification times

The attendance and rectification times were substantially altered for many services. These changes illustrate the degree to which the KPIs were altered.

The attendance time refers to the amount of time Serco has to 'attend' to a fault from the time that the fault was reported, or from the time that Serco ought reasonably to have been aware of the fault.[68] The rectification time refers to the amount of time Serco has to rectify a fault from the time that the fault was reported, or from the time that Serco ought reasonably to have been aware of the fault.[69] In effect, these changes increase the amount of time that Serco will have to both attend to and rectify any fault. It is important to note, however, that DoH staff will maintain the authority to determine the level of urgency for each task.[70]

The changes to the managed equipment service (**MES**) attendance and rectification times are the most substantial, as two new classifications were introduced during the contract negotiation period. Group A and B, and levels 1 and 2 were introduced for these services, which allow DoH and Serco greater latitude in defining the urgency of a situation.

66 Legislative Assembly of Western Australia, *Key Performance Indicators for the Fiona Stanley Facilities Management Services Contract*, Parl. Paper 4315, 30 November 2011, p. 2.

67 Department of Health, *Key Performance Indicators – Cleaning*, July 2011, p. 1; and Department of Health, *Key Performance Indicators* – Cleaning, April 2010, p. 1; in Submission No. 20 from the Department of Health, 6 February 2012.

68 Department of Health, *Service Specifications – Cleaning*, July 2011, p. 1, in Submission No. 20 from the Department of Health, 6 February 2012.

69 Department of Health, *Service Specifications – Cleaning*, July 2011, p. 3, in Submission No. 20 from the Department of Health, 6 February 2012.

70 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 29

Table 2.6: Changes to attendance and rectification times for cleaning, estate and managed equipment services[71]

Categories	Emergency	Urgent	Non-urgent
Cleaning Service attendance time	No change.	No change.	100% increase.
Cleaning Service rectification time	No change.	33% increase.	25% increase.
Estate Service attendance time	No change.	100% increase.	300% increase.
Estate Service rectification time – peak operating hours	No change.	125% increase.	No change.
Estate Service rectification time – after hours	No change.	No change.	No change.
Managed Equipment Service Group A attendance time	100% increase.	No change.	Not comparable.[72]
Managed Equipment Service Group B attendance time	100% increase.	No change.	Not comparable.
Managed Equipment Service rectification time – Level 1	No change.	No change.	Not comparable.
Managed Equipment Service rectification time – Level 2	Same as Level 1.	500% increase.	Same as Level 1.

Table 2.6 above provides an overview of the changes to attendance and rectification times made to a number of the services during the negotiation process. This table details the changes that were made from the April 2010 version of the service specification in the July 2011 (final) version of the service specifications. The differences have been represented as percentages in order to avoid revealing commercially sensitive information. An increase to the attendance or rectification time represents the time available to Serco to attend to or rectify a fault has increased.

The impact of time pressure on the procurement

The Department of Health was facing a range of political, financial and clinical service demand pressures to ensure that FSH opens as scheduled in April 2014. It is clear that there were substantial delays during the FMSC procurement process when comparing the estimated time frames to the actual timeline (see **table 2.1**). Significantly, the contract with Serco was signed nine months later than was initially planned.

In effect, the time pressures meant that:

- The procurement plan that was endorsed by State Cabinet was not based on detailed service specifications, rather a poorly scoped 'services matrix'.

71 Department of Health, *Key Performance Indicators*, July 2011; and Department of Health, *Key Performance Indicators*, April 2010; in Submission No. 20 from the Department of Health, 6 February 2012.

72 The MES non-urgent attendance and rectification times were changed from 8 hours each to one business day (attendance times for Groups A and B) or to two business days (rectification times).

- The Department appointed it commercial advisor without the benefit of a competitive selection process, and the commercial advisor was carrying out work, sometimes for as much as two months, without a contract in place.
- The Department did not finalise the PSC before the RFS was issued.
- The service specifications that were initially released to RFS respondents were not developed to reflect the full scope of the Fiona Stanley Hospital.
- DoH was vulnerable to the practice of hold-up during contract negotiations with Serco. The Department originally estimated that contract negotiations would take two months. The negotiations ultimately required nine and a half months to complete.

With the above comments in mind, we also acknowledge that during any negotiation process there is a process of 'give and take' that results in concessions being made to the preferred positions of both parties. Our review of a sample of the KPIs, however, indicates that very few changes were made to the KPIs that favoured DoH.

Mr Snowball, the Director General of the Department, claimed that, despite the changes, the standards required of Serco remain higher than those in use in existing public hospitals in Western Australia.[73]

Having said that, Mr Sebbes himself acknowledged that the service specifications that DoH took to the market at the commencement of the RFS process were a 'combination of current best practice that we could find around the world, with some added comments of our own'.[74] Any step back from those specifications would have been a step away from best practice, although Mr Sebbes also went on to note that 'we set the bar extremely high in the contract documents as well, expecting to be pushed pack'.[75]

73 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 24 April 2012, pp. 28–29.

74 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 27.

75 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 29.

Chapter 3

Market Depth

For the most part it is competition that delivers enhanced value, not merely the involvement of a private provider.[76]

How ambitious is the FMSC?

The parties involved in the Facilities Management Services Contract (**FMSC**) for Fiona Stanley Hospital (**FSH**) readily admit to the contract's scope and complexity. For example, Mr David Campbell, Serco's Asia Pacific CEO, noted in October 2010 that:

> *Fiona Stanley Hospital is an extraordinarily significant win for Serco. While it builds upon services we already provide in the commercial, local government and health sectors, the scope and scale of the contract goes beyond what we currently do, establishes Serco firmly in the health market in Australia, and will support our growth ambitions across the globe.*[77]

Mr Joe Boyle, the Serco contract manager for the FSH project, has also been reported in the media as having noted that the FMSC is the biggest health-related project that Serco has ever been involved with.[78]

But just how big is the FMSC? To place it in the context of hospital PPP deals in Australia, we have compiled a table (**table 3.1** on the next page) comparing several different hospital contracts and the number of services being provided through those contracts. As can be clearly seen, the FMSC—with 28 individual services either provided or coordinated by Serco—is significantly larger than any other comparable contract signed in Australia in recent years. It is also significantly larger than Serco's contract at Forth Valley Royal Hospital in Scotland, a facility that provided a model for Serco's bid for the FMSC.[79]

The question as to whether or not the Department of Health (**DoH**) was being over-ambitious when it developed its plans for the FMSC is a significant one. The Serco

76 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 40.
77 Serco document provided in Submission No. 9 from United Voice, 17 October 2011.
78 Angela Powell, 'World recruiting drive needed to staff hospital', *The West Australian*, 19 April 2012, p. 6.
79 Mr Timothy Catterall, Director, Strategy and Business Development, Serco Australia, *Transcript of Evidence*, 30 November 2011, p. 16.

Table 3.1: The scope of services outsourced at FSH is significantly larger than any other health facility in Australia (source: various Departments of Health).

Project	Construction?	Services			Contract life
Fiona Stanley Hospital	No	• Audio visual • Cleaning • Electronic Records Management • Energy and utilities • Estate • External transport • Grounds maintenance • Health records management and clinical coding • Help desk and communications • Human resource management	• ICT • Internal logistics • Linen • Managed Equipment Services • Management and Integration • Patient catering • Patient entertainment • Pest control • Pre-operational	• Property management • Reception • Safety and incident management • Scheduling and billing • Sterilisation • Supplies management • Transitional • Vehicle and Traffic management • Waste management	20 years
Forth Valley Royal Hospital (Scotland)	Yes	• Portering • Linen • Waste Management • Domestic • Grounds & Gardens	• Pest Control • Utilities • Catering • General Services Switchboard • Estates	• Ward Housekeeping • Security • Car Park Management • Helpdesk • Reception	31 years
New Royal Adelaide Hospital	Yes	• Onsite catering • Hospital maintenance • Car park management • ICT and logistics • Security	• Linen • Orderly Services • Cleaning and domestic services • Utilities	• Waste management • Grounds and gardens • Internal roads • Patient support services • Pest control	35 years
Royal North Shore Hospital (NSW)	Yes	• Management services • Helpdesk • Building and FF & FE Maintenance • Grounds and Gardens Maintenance	• Utilities Management • Cleaning & Domestic • Pest control • Catering • Internal Waste Management	• Linen Distribution • Internal Materials Distribution • Portering/Wards persons • Security	28 years
Royal Children's Hospital (VIC)	Yes	• Facility related training • Helpdesk • Building management services • Utilities and medical gases management	• Waste services • Security • Cleaning • Car park services	• Grounds and gardens maintenance • Minor works • Pest control	25 years
Royal Women's Hospital (VIC)	Yes	• General services • Helpdesk • Utilities and medical gases management	• Cleaning and hotel services • Car park services • Building management services	• Grounds and gardens maintenance • Pest control • Security	25 years

Institute—a kind of out-sourcing think-tank established by Serco—has itself noted that the 'scale and duration of contracts can have a major impact on the depth of the market'.[80] The Serco Institute also noted that 'deeper markets lead to stronger competition and better value for money for government customers'.[81]

Given the decision by DoH to outsource so many non-clinical services in a single contract to Serco, there are a number of critical questions that must be considered:

- Were there sound reasons for deciding to outsource so many services as a single contract?
- Did DoH establish that the market could deliver what it was hoping to achieve and was it satisfied that the market was of sufficient depth to ensure meaningful competition?
- Was DoH being too ambitious with the scale of its proposed FMSC?

Many of these questions are relevant at multiple points during the procurement process. For example, by the very nature of the expressions of interest (**EOI**) and request for submissions (**RFS**) processes, DoH would have been able to establish the depth of the market—and therefore the extent of competition for the contract. If many respondent bids were found either to be of low quality or non-conforming, then an assessment about the lack of depth in the market would be made. Of course, normally by the time a procuring authority issues an EOI or RFS, the procurement process is well-advanced and the pressures to avoid scrapping procurement and starting again make this outcome unlikely. Market sounding exercises in advance of formally committing to a procurement model can be used to test the depth of the market, but they need to be used effectively if they are to ascertain whether meaningful competition can be achieved and establish that the procuring authority's proposals are deliverable by a number of market participants.

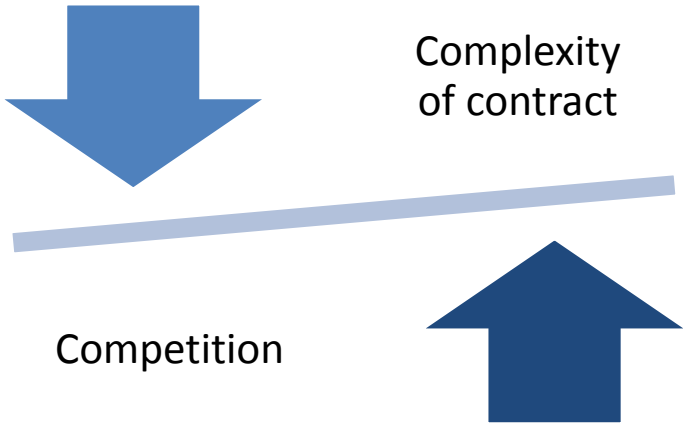
Does it matter that the FMSC was so ambitious?

Deciding to go to the market with a project as ambitious as the FMSC creates one consequence that is of particular interest and it is a consequence that should have been considered by DoH. Namely, as the complexity of the project increased, the number of companies able to deliver the project decreased. As outlined in later parts of this chapter, the Department ascertained early in the development of the Hospital that by bundling as many services as possible into the proposed FMSC, efficiencies could be realised that would help the State to achieve value for money in the operation of FSH.

80 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 46.

81 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 46.

Figure 3.1: As contract complexity increases, the number of market participants able to deliver the contract decreases, thus impacting upon the level of competition amongst private sector providers



This is because bundling allows synergies to form across the services that allow a single contract to realise efficiencies. These bundling-derived savings did not, however, exist in a vacuum; competition is also critical to achieving value for money. The question that is therefore immediately raised is whether DoH considered the impact on the extent of possible competition by bundling so many services into a single, large contract.

We take the view that competition is critical if a contract is to achieve the right mix of price, quality and risk transfer. **Figure 3.1** above provides a simplified explanation of the basic principle in action: as the complexity of the contract increases, the extent of competition decreases. Ideally, a contract will balance the two factors to achieve an optimal mix of savings arising from bundling and savings arising from competition.

As we outline in this chapter, we take the view that DoH did not give consideration to the impact of such a large project upon the level of competition for the provision of the contract it would gain when it went to the market. The result is a procurement process that could not benefit from the discipline introduced by any real competition.

Outsourcing-based savings were identified early

According to DoH, significant cost savings from outsourcing a large number of facilities management services had been identified during the development of the FSH business case.

Mr Kim Snowball, DoH's Director General, indicated that prior to the development of the business case in 2007, consultation with the health industry, other government departments and consideration of other Australian and international major projects had contributed to the development of a number of 'guiding principles', one of which concerned the involvement of the private sector. The view at this early stage was that

the Department should use the private sector where a benefit could be provided.[82] The decision to test the market for its capacity and interest in the project was made during the development of the FSH business case, which was endorsed by State Cabinet in April 2008.[83] This was in the context of government policy at the time, as well as an enterprise bargaining agreement with United Voice, ruling out any outsourcing of DoH cleaning or catering in existing facilities.[84]

The procurement plan identified expected savings from the proposed FM contract. Based on the preliminary financial analysis (an early version of the PSC), the Department expected to realise a saving of approximately 20 per cent, or $476 million in net present cost (**NPC**) terms.[85] The preliminary financial analysis was based on the FSH business case study and existing Health data. As has been examined in **Chapter 5**, this modelling was poorly scoped and did not accurately reflect the final scope of the services taken to the market.

Market sounding—a means to test market depth

DoH conducted a market sounding exercise in mid-2009

DoH approached nine facilities management (**FM**) providers in May and June 2009 to receive feedback on the proposed procurement model and to establish the level of market interest in providing FM services at FSH.

Market sounding activities are considered to be a critical means for engaging market participants in the procurement process as early as possible. This is said to allow an agency like DoH to integrate feedback and to gauge the level of interest from the market. Gary Sturgess, a former director of the Serco Institute, noted in evidence that market sounding can also be used to test the depth of the market before a particular procurement model is settled on.[86] It is also useful as a means for developing interest in a project before it is officially taken to the market.

Typically, market sounding activities are conducted by the commercial advisor appointed by an agency to assist with the development of the commercial aspects of the project. In the case of the FMSC, however, the market sounding exercise was carried out by Cary Consulting (later to become the Appian Group) through one of the

82 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 4.
83 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 2.
84 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 5.
85 Department of Health, *Procurement* Plan, October 2009, p. 43; in Submission No. 12 from Department of Health, 21 November 2011.
86 Mr Gary Sturgess, Australia and New Zealand School of Government, *Briefing*, 21 March 2012, p. 5

Table 3.2: Companies that took part in the market sounding exercise[87]

Company	Submitted EOI?[88]
Transfield Services	Yes
ISS Facilities Management	No
Compass/Medirest	In consortium with Brookfield Multiplex
Sodexho	No
Serco	Yes
United Group	Yes
Spotless	Yes
Honeywell	No
Brookfield Multiplex Services	Yes

many contracts given to that company in its role as consultant for the construction of FSH.[89] The market sounding exercise consisted of a number of two-hour meetings comprising a standard presentation which was then followed by discussion and questions and answers. The process took place in late May and early June of 2009 in Sydney, as most of the major companies involved in facilities management and integrated services are based in the eastern states.[90]

Table 3.2 above outlines the companies that took part in the market sounding exercise and also indicates whether the companies submitted an EOI for the FMSC when expressions were called for in 2010.

The market sounding report concludes that there was a 'high to very high' level of interest for the proposed contract from the providers of FM and integrated services. The proposed contract model taken to the market during the market sounding emphasised the key role that potential FM providers were expected to play in integrating the various services under a seamless management structure. This included procuring the subcontracted services that the provider had elected not to provide as part of its own bids. In this way, the emphasis was very much on allowing potential bidders to make their own judgements about which services they would directly provide, and which they would manage on behalf of the Department via sub-contract. Interestingly, during the market sounding, Serco noted that its level of interest in the FMSC would decrease if it became 'more of a management contract'.[91] It is probably worthwhile noting that despite the flexibility with respect to which services it could tender for, Serco ultimately elected to tender for all but a handful of the services.

87 Department of Health, *Integrated FM Market Sounding Report*, July 2009, p. 4; in Submission No. 18 from the Department of Health, 9 January 2012.

88 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 9; in Submission No. 29 from the Department of Health, 3 April 2012.

89 Submission No. 18 from the Department of Health, 9 January 2012, p. 1.

90 Department of Health, *Integrated FM Market Sounding Report*, July 2009, p. 5; in Submission No. 18 from the Department of Health, 9 January 2012.

91 Department of Health, *FSH Market Sounding Record Sheet*, May 2009; in Submission No. 18 from the Department of Health, 9 January 2012.

Finding 11

The Department of Health's use of a market sounding exercise was consistent with best practice internationally for the procurement of complex and costly projects.

Finding 12

The market sounding report concluded that there was a 'high to very high' level of interest for the proposed contract from the providers of facilities management and integrated services.

Market statements of capability were not critically assessed

An objective of the market sounding process was to ascertain the capability of the market to deliver what DoH was seeking; however, the market sounding report does not provide any commentary on the capacities of the companies taking part in the market sounding process.

The market sounding report notes that the market sounding activity was necessary because the proposed procurement strategy was significantly different from other facilities management contracts let within Western Australia. It can be reasonably assumed that this was an acknowledgement of the fact that the scope of the services being procured through the proposed contract was significantly wider than anything previously attempted. It seems likely that as a result, one of the objectives of the market sounding was to 'obtain feedback from the market on the procurement strategy and ensure it aligns with the *capability of the market*' (emphasis added).[92]

Almost all of the companies contacted as part of the market sounding process expressed interest in making bids to the project; only one of the nine companies approached indicated that it would probably not be interested in bidding for the full scope of services envisaged under the proposed contract.[93]

Despite explicitly stating that one of the objectives of the market sounding process was to establish the capability of the market to deliver what DoH was seeking, the market sounding report does not provide any commentary on the capacities of the companies taking part in the market sounding process. Indeed, commentary from the companies about the proposed structure of the contract is reproduced uncritically and no feedback is assessed in the market sounding report about experience in delivering an integrated, extensive and highly complex series of services as was being sought for the FMSC. Notwithstanding this, the market sounding report finds that it is 'highly likely that at least 3 EOIs will be received from highly capable FM organisations'. The finding

92 Department of Health, *Integrated FM Market Sounding Report*, July 2009, p. 4; in Submission No. 18 from the Department of Health, 9 January 2012.

93 Department of Health, *FSH Market Sounding Record Sheet*, May 2009; in Submission No. 18 from the Department of Health, 9 January 2012.

is made in a section of the report that is silent on the capabilities of the companies taking part, although it does note the level of interest as being 'high to very high'.[94]

A few months later, the procurement plan prepared for State Cabinet concludes that the market sounding had found an 'interested and viable market'.[95] Whilst there may have been an interested market, as we have already noted, the market sounding made no findings regarding the capabilities of the companies and was therefore in no position to make any conclusions about the viability of the market. Interest from the companies approached should not be confused with ability to actually deliver what was being sought.

As a consequence, DoH went to the market with the largest FM contract of its type in Australia without having establishing the capabilities of the companies that were most likely to respond. Arising from this, DoH did not know whether the market for FM provision was sufficiently deep to provide a level of competition that could better ensure enhanced value for the State.

Finding 13

An objective of the market sounding process was to establish the capability of the market to deliver the facilities management strategy being sought by the Department of Health.

Finding 14

The procurement plan, which helped inform the October 2009 State Cabinet decision, stated that there was an 'interested and viable market' for the private delivery of the proposed FMSC. However, the market sounding report on which this conclusion was based did not provide any commentary on the capacities of the companies taking part in the market sounding process.

Recommendation 1

The Department of Finance should develop guidelines for the use of market sounding exercises by government agencies for projects over a determined value. These guidelines must include the requirement that agencies conduct a detailed examination of the capabilities of companies taking part to deliver the mix of services being sought in the proposed contract structure.

Feedback from the market sounding was incorporated into the contract structure

The initial contract structure that DoH took to the market during the market sounding process did not include sterilisation or portering services. Feedback from the

94 Department of Health, *Integrated FM Market Sounding Report*, July 2009, p. 3; in Submission No. 18 from the Department of Health, 9 January 2012.

95 Department of Health, *Procurement Plan*, October 2009, p. 24; in Submission No. 12 from the Department of Health, 21 November 2011.

respondents—including Serco—indicated that the incorporation of portering services would maximise efficiency and create savings by encouraging multi-tasking by staff members.[96] Sterilisation was highlighted by participants because of efficiencies associated with the use of instrument tracking, which was described as a 'critical part of sterilisation processes'.[97]

As a result of the feedback from companies, DoH incorporated portering and sterilisation services into the proposed contracting model. It was also as a result of the market sounding exercise that the use of automated guided vehicles (**AGVs**) at FSH was considered.

Finding 15

The Department of Health expanded the scope of its proposed facilities management contract to include portering and sterilisation services following the market sounding process.

DoH did not accept all market sounding feedback

The market sounding process also sought feedback on the operation of performance incentives and abatements. In broad terms, the incentives consist of financial rewards given to companies for good performance, and abatements consist of the financial penalties incurred when performance is poor. The market sounding report noted that most organisations thought that abatements should be capped at a 15–20 per cent reduction in annual service fees in order to avoid levying 'punitive' fee reductions.[98] This request was not reflected in the final FMSC signed with Serco, which makes 100 per cent of payments to Serco subject to abatement for poor performance.[99]

What the EOI stage says about the depth of the market

In November 2009, DoH issued a call for EOI which signalled the commencement of the evaluation process that would ultimately lead to the signing of a contract with Serco in July 2011. A total of 10 companies responded, five[100] of which had taken part in the market sounding process described in earlier sections of this chapter. Very early in the evaluation process, four companies were eliminated either on the basis that non-

96 Department of Health, *Integrated FM Market Sounding Report*, July 2009, pp. 9–10; in Submission No. 18 from the Department of Health, 9 January 2012.

97 Department of Health, *Integrated FM Market Sounding Report*, July 2009, pp. 9–10; in Submission No. 18 from the Department of Health, 9 January 2012.

98 Department of Health, *Integrated FM Market Sounding Report*, July 2009, p. 12; in Submission No. 18 from the Department of Health, 9 January 2012.

99 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 11.

100 Note that Compass subsidiary Medirest bid in consortium with Brookfield Multiplex Services.

conforming bids had been submitted or on the basis that financial assessment threshold criteria had not been met.[101]

A robust evaluation process was used when considering the EOIs

DoH applied a multi-stage process when evaluating the expressions of interest. The submissions from the six remaining companies were assessed against four criteria, each of which were assigned a weighting. **Table 3.3** on the following page contains a summary of the criteria. In addition to a numerical score, comparative statements for each of the companies were made by DoH and these provided evaluative commentary on the information contained in the EOIs. From these evaluations, four of the six companies were recommended for shortlisting. Those four companies were required to provide 'reference sites' through which they were to demonstrate:

- Experience in integrating facilities management services that include both hard FM services and soft FM services; and
- Experience in the provision of services similar to the:
    - Hard FM services; and
    - Soft FM services.[102]

The four shortlisted companies were to provide sufficient access to the reference sites to validate claims made in EOI documents in relation to the provision of facilities management services at these sites.[103] Where information uncovered during visits lead to reassessments against the qualitative selection criteria, scores were suitably adjusted and explanations for those adjustments were recorded.

No adjustments were made to the score given to Serco as a result of the visits to the reference sites; however, two other shortlisted respondents were awarded small increases in their scores, whilst the score of the fourth shortlisted respondent was adjusted downwards.[104]

101 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, pp. 9–10; in Submission No. 29 from the Department of Health, 3 April 2012.

102 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 25; in Submission No. 29 from the Department of Health, 3 April 2012.

103 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 25; in Submission No. 29 from the Department of Health, 3 April 2012.

104 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 26; in Submission No. 29 from the Department of Health, 3 April 2012.

Table 3.3: Selection criteria used to evaluate expressions of interest[105]

Qualitative selection criteria	Weighting (%)
Suitability of the proposed high-level service plan to deliver sustainable quality services to FSH.	35
Demonstrated experience in the successful delivery of similar services to the Services in an environment that is of similar complexity to the Fiona Stanley Hospital, preferably for a major tertiary hospital.	25
Demonstrated capacity, experience and understanding of the scope clearly outlined in the proposed model and approach.	20
Details of the proposed consortium members/related parties in providing and managing the services including an overview of their relevant experience and proposed high level resources plan.	20

The three strongest companies assessed in the EOI process were then to be invited to take part in the request for submission stage of the process.

Finding 16

The Department of Health's evaluation of the expressions of interest received was well-documented, as was the evidence underpinning the evaluation panel's decisions.

The lack of depth in the market was exposed by the evaluation process

Whilst DoH may have run a thorough and well-documented evaluation process, the results of the process exposed the lack of depth in the market.

The numerical scores assigned by the Department are of critical interest because they reveal that the market that was not deep enough to provide a competitive field of companies capable of delivering the extensive array of services being sought by DoH. This meant that Serco finished between 23 and 26 per cent ahead, on a weighted percentage score, of its nearest two rivals.[106] This disparity indicated that Serco was simply superior to the other respondents. DoH's decision to emphasise management and integration in the contract and to bundle the large number of services included in the FMSC created such a large contract that the level of competition for the contract was reduced.

The vast gap between Serco and the other two companies is also revealed in the language used by DoH when it was writing its comparative statements against the selection criteria for each of the companies. **Table 3.4** below contains extracts from the comparative statements recorded by DoH for the three companies that would ultimately be asked to take part in the RFS process. As the table reveals, Serco was the only company that the Department's evaluation panel consistently expressed any

105 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 13; in Submission No. 29 from the Department of Health, 3 April 2012.

106 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, p. 26; in Submission No. 29 from the Department of Health, 3 April 2012.

Table 3.4: Extract of evaluations of respondent companies against the selection criteria[107]

	Serco	Company A	Company B
Selection Criteria 1	The Evaluation Panel was sufficiently confident with the Respondent's [redacted].	The Evaluation Panel had minor reservations with the Respondent's [redacted].	The Evaluation Panel had a few minor reservations with the Respondent's [redacted].
Selection Criteria 2	The Evaluation Panel was confident [redacted].	Given the complexity of the requirement, the Evaluation Panel had a few minor reservations with the Respondent's [redacted].	Given the complexity of the requirement, the Evaluation Panel was reasonably confident with the Respondent's [redacted].
Selection Criteria 3	The Evaluation Panel was confident that the Respondent had the [redacted].	Generally, the Evaluation Panel was reasonably confident that the Respondent had the [redacted].	The Evaluation Panel had a few minor reservations regarding the Respondent's [redacted].
Selection Criteria 4	Based on the company structure, the Evaluation Panel was confident the Respondent could provide [redacted].	The Evaluation Panel had a few minor reservations with the [redacted].	The Evaluation Panel had minor reservations with the [redacted].

confidence in. For the other two companies, in three out of four instances, the evaluation panel recorded some level of reservation with the responses received.[108]

The EOI evaluation process revealed that the market for the services being sought by DoH lacked depth: one high quality bid was received, whilst the next two closest bids were not adequate. A genuine market would have resulted in the three companies recommended for inclusion in the RFS stage having assessment scores that were much closer.

Finding 17

The Department of Health evaluated Serco's expression of interest as being between 23 and 26 per cent better, on a weighted percentage score, than its two closest competitors.

Finding 18

The Department of Health consistently expressed confidence in Serco's response to the selection criteria used for assessing the expressions of interest; however, the Department documented a number of reservations against these same criteria for the

107 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, pp. 16–24; in Submission No. 29 from the Department of Health, 3 April 2012.

108 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Expression of Interest,* January 2010, pp. 16–24; in Submission No. 29 from the Department of Health, 3 April 2012.

other two companies recommended for inclusion in the request for submissions process.

The RFS process further revealed the shallowness of the market

DoH released its formal call for submissions to the three selected bidders in February 2010. The Department initially requested that detailed submissions be received by 30 March 2010; however, following requests from the participants, extensions were granted to 31 May 2010.[109]

One of the three respondents withdrew from the process

On 2 March 2010, one of the companies withdrew from the RFS process, leaving only two companies in the running to be awarded the contract. It is worth noting that the third company withdrew before DoH had released the full suite of service specifications to the participants. The company explained its decision to withdraw from the process in the following terms:

> *The investment and commitment required to lodge a winning proposal is high. Our assessment of the WA Government's expectations derived from greater clarity provided to date has led us to the conclusion that our service delivery model for this contract may not be the correct fit for FSH.*[110]

In evidence, Mr Sebbes indicated that the company concluded 'that their business profile was unable to deliver against what we had requested'.[111]

It certainly seems likely that the third company formed the view that the scope of work involved with the project was beyond its ability to deliver it. Whatever the reasons for the company's withdrawal from the process, it was within its rights to do so, a fact confirmed by the State Solicitor's Office when DoH sought advice on the matter.[112]

Finding 19

One of the three short-listed respondents withdrew from the selection process because it appears to have concluded that it could not provide a solution that would deliver what the Department of Health was seeking.

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109 Submission No. 37 from the Department of Health, 22 May 2012, p. 6.

110 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, p. 18; in Submission No. 29 from the Department of Health, 3 April 2012.

111 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 22.

112 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, p. 19; in Submission No. 29 from the Department of Health, 3 April 2012.

Assessment of the impact of the withdrawal was limited

A shallow market limits the opportunities for competition. Competition is critical if a contract is to achieve the right mix of price, quality and risk transfer.

The withdrawal of the third company from the RFS process was a signal from the market that should have been heeded by DoH, particularly when the signal was considered in conjunction with the results of the EOI evaluation: the market lacked depth and was getting shallower. Market depth is critical for achieving genuine competition and competition is critical to ensuring that a contract achieves the right mix of price, quality and risk transfer. The impact of the withdrawal of the third company should have been assessed.

The National Audit Office in the UK notes the following, with respect to contracting:

> *Where only two viable bids for a project are received early on, or if bidders pull out of the competition, leaving the procuring authority with only two bids to choose from, there should be a review by the relevant sponsor Department. The review should consider whether:*
>
> - *there are any defects in the scoping or management of the project that may explain the low level of market interest and could be remedied in time for a re-run of the competition; and whether*
> - *the bids on the table offer a good competition and are likely to lead to a value for money solution.*[113]

We saw limited evidence that the impact of the withdrawal had been assessed. The project's probity auditor noted that a 'competitive environment was maintained' and that the two remaining companies had not been informed of the third company's withdrawal until after submissions had been received.[114] The focus of the probity auditor appears to have been on whether the withdrawal of the third company had been kept secret from the remaining two companies, and not on whether the withdrawal indicated the existence of defects in the scoping of the project that led to the low level of market interest. We note, however, that the probity auditor

113 National Audit Office (UK), *Improving the PFI Tendering Process*, March 2007, p. 6.

114 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, pp. 34–35; in Submission No. 29 from the Department of Health, 3 April 2012.

acknowledges that the remaining two companies may have been informed of the withdrawal of the third company via 'informal sources'.[115]

Although the RFS evaluation report notes that the evaluation team had decided that the 'two remaining Respondents constituted a competitive field', the reasoning behind this decision does not appear to have been separately recorded.[116]

Finding 20

The Department of Health did not appear to consider whether defects in the scoping or management of its proposed Facilities Management Services Contract led to the early withdrawal from the selection process of the third short-listed respondent, raising serious concerns regarding the level of competition in the whole process.

Recommendation 2

The Department of Finance should develop guidelines to assist agencies should there be limited interest from the market in a project, or if bidders withdraw from the competition leaving a limited field. These guidelines would require agencies to review whether:

- there are any defects in the scoping or management of the project that may explain the low level of market interest and could be remedied in time for a re-run of the competition; and
- the bids on the table offer a good competition and are likely to lead to a value for money solution.

The remaining two submissions were robustly assessed

The DoH evaluation panel assessed the respondents against the following selection criteria:

a) the extent to which the response in its entirety provides value for money to the State, taking into account, without limitation, the price criteria assessed in accordance with the pricing schedules;

b) the extent to which the response contains all information and details required by this RFS and is otherwise consistent and comprehensive;

115 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, pp. 34–35; in Submission No. 29 from the Department of Health, 3 April 2012.

116 Submission No. 37 from the Department of Health, 22 May 2012, p. 6.

c) the extent to which the respondents proposed solution for the provision of the Services is based and demonstrated on objective and demonstrable data, including drawing on the respondent's experience;

d) the response to the non-price criteria;

e) the nature, extent and effect of any proposed departures to the Facilities Management Contract, as contained in the departures table and the solutions proposed in respect of those departures; and

f) the nature, extent and effect of any dissatisfaction raised in relation to the documents specified at clause 1.12(b) of the Facilities Management Contract (other than the operations and maintenance manuals), as contained in the construction documents table.[117]

The evaluation panel also assessed the responses against the following non-price criteria:

a) Demonstrated experience, capacity and understanding of the scope;

b) Quality of individual service plans; and

c) Integration and quality of overall solution.

Although we are satisfied that the process used by DoH was robust, consistent and thorough, the results of the RFS evaluation process further reinforce the conclusion that we reached earlier in relation to the EOI process. It is, however, significantly more difficult to talk in generalities about this stage of the process—and thus protect the commercial interests of the unsuccessful bidders—particularly when only two companies submitted detailed bids.

Finding 21

The Department of Health's evaluation of the request for submissions was well-documented, as was the evidence underpinning the evaluation panel's decisions.

Serco maintained the size of its lead over the only remaining competitor

Once again, taking note of our intention to protect the commercial interests of the unsuccessful company, we must curtail the extent of detail used in this section of the report. Nonetheless, there is little doubt, based on the evaluation reports, that DoH made the right choice in terms of selecting Serco over the other short-listed respondent. In saying that, however, the problem of a lack of market depth is revealed

117 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, pp. 11–12; in Submission No. 29 from the Department of Health, 3 April 2012.

once again. According to DoH's RFS evaluation, Serco maintained its very large lead in the evaluation scores from the EOI stage[118] and once again demonstrated that there was only ever one credible supplier taking part in the tender process. As we have already outlined, this was an issue that arose directly as a result of DoH's decision to bundle such a large number of services in a single contract. The result was an absence of the type of competition necessary to ensure that the State achieves value for money.

Finding 22

At the conclusion of the request for submissions stage, Serco had maintained its very large lead in the evaluation scores from the expressions of interest stage, indicating that there was only ever one likely supplier taking part in the tender process.

Build dolphins, not whales

In its submission to the Western Australian Government's Economic Audit Committee in 2009, the Serco Institute reported that the 'success of government contracting is heavily influenced by the way in which services are originally procured.'[119] The Institute went on to note that one of the most frequent causes of failure in information technology (**IT**) procurement lies in the 'temptation to be overambitious' and it suggests that procurers should 'build dolphins not whales'.[120] Obviously, the FMSC is not an IT project, but the point expressed in the quote is relevant in this context. There should be little doubt about the ambitious nature of the FMSC – this fact was even tacitly acknowledged in the market sounding report. It seems reasonable to conclude that the FMSC is something of a 'whale' inasmuch as it is an FM contract unlike any other currently operating in Australia due to its size and cost.

Throughout the procurement process it should have been clear that not only was Serco's bid considerably better than those offered by competing companies, but that those other companies' solutions fell well short of DoH's expectations. It seems reasonable to conclude that the size of the contract limited the number of quality submissions received by DoH. If this was not clear to DoH at the conclusion of the EOI process, it should have been particularly clear following the early withdrawal of the third participant in the RFS process. That DoH did not stop and assess the impact of the design of the FMSC on the level of competition for the contract is problematic.

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118 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010, p. 12; in Submission No. 29 from the Department of Health, 3 April 2012.

119 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 40.

120 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 40.

Competition is critical if a contract is to achieve the right mix of price, quality and risk transfer. The Serco Institute offers a similar view:

> *For the most part it is competition that delivers enhanced value, not merely the involvement of a private provider.*[121]

Our concern, having considered the results of DoH's otherwise well-run evaluation process, is that only one company was actually able to deliver what the Department was seeking. If there was genuine competition in the market from a number of companies capable of delivering the FMSC, we would have expected the evaluation process to:

- Reveal companies that were judged capable of delivering what the Department was seeking and companies that were judged not to be capable of delivering what the Department was seeking; and
- Rank those companies judged capable of delivering according to the quality of their bid proposals.

Instead, the evaluation reports—particularly at the RFS stage—reveal that DoH itself was aware that only one bid delivered what the Department was seeking.

Finding 23

The Department of Health, whilst seeking to benefit from the bundling of many services into a single contract, failed to achieve a genuinely competitive procurement process.

121 The Serco Institute, *Payment on Performance: The use of competition and contracting in improving public services*, February 2009, p. 40.

Chapter 4

Advisors

The public sector has been guilty sometimes of appointing the cheapest, but not necessarily the best, advisers available.[122]

Getting help

Delivering a project on the scale of the Fiona Stanley Hospital (**FSH**) requires the use of a diverse range of highly skilled technical, financial and legal advisors. It is not possible—given the sporadic nature of major project work—for these specialists to be retained by government departments on a full-time basis and it should therefore not be surprising that the Department of Health (**DoH**) was required to employ via means of contract a number of advisors to assist with the development and evaluation of the Facilities Management Services Contract (**FMSC**) at FSH.

In 2010, the Auditor General made highly critical findings about the way in which DoH had managed the consultants it had engaged to provide advice for the project. In particular, the Auditor General found that:

- The project had relied on consultants because DoH lacked expertise.
- DoH had poorly supervised and managed the work of the consultants.
- Consultancy contracts had cost significantly more than agreed.[123]

The selection and use of advisors for the FMSC was a major focus during the Inquiry. Projects such as the FMSC generally rely upon advisors that fall into two broad categories:

- Commercial advisors: include financial and legal consultants that provide advice about the commercial and legal structures of the contracts signed with private sector providers. Commercial advisors have a broad range of roles, including identifying and valuing risks, advising on financing structures and 'commercialising' performance regimes. They also play a critical role during negotiations with the preferred bidder.
- Technical advisors: include specialists providing advice about service specifications (the documents outlining exactly what must be delivered by the successful

122 HM Treasury (United Kingdom), *Technical Note No. 3: How to Appoint and Manage Advisers to PFI Projects*, p. 2.

123 Auditor General for Western Australia, *Fiona Stanley Hospital Project*, June 2010, p. 24.

contractor), and also includes specialists that provide advice about costs, i.e. quantity surveyors.

The UK Treasury has developed a detailed 'technical note' which outlines how agencies in the UK should appoint and manage advisors on projects like the FMSC.

- Procuring agencies should consider and document at the outset all the skills inputs which will be required during the procurement.
- Advisors should be procured through the use of competition. Failure to introduce competition is noted as being 'contrary to good practice, unfair and imprudent'.[124]
- Appointment through competition should not be prejudiced by any earlier involvement of an advisor.
- Successful appointment relies upon a thorough investigation of financial skills and previous relevant experience.[125]

Our examination focused on the extent to which DoH engaged in an open and consistently competitive process when selecting its commercial advisor.

DoH initially chose its commercial advisor using a less than suitable panel

When initially appointing its commercial advisor—the Paxon Consulting Group (**Paxon**)—DoH did not use the *Audit Services and Financial Advice Common Use Agreement* (**ASFAP**). At the time, this was the only panel available to the Department from which commercial advisors 'are generally procured'.[126]

The Department elected not to use ASFAP when appointing its commercial advisor and instead opted to use the *Project Management Services Panel*. DoH told us that the panel was selected on the basis of 'direction' from Building Management and Works (**BMW**); however, representatives from BMW unequivocally stated that no such advice had been given.[127] At the time DoH was selecting Paxon, BMW's role in the use of panel contracts was as a facilitator of decisions already made by departments, rather than as an advisor directly involved in departmental decision making processes.

124 HM Treasury (United Kingdom), *Technical Note No. 3: How to Appoint and Manage Advisers to PFI Projects*, p. 4.

125 HM Treasury (United Kingdom), *Technical Note No. 3: How to Appoint and Manage Advisers to PFI Projects*, pp. 3–4.

126 Submission No. 11 from the Department of Treasury, 16 November 2011.

127 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 8; and Mr Graeme McLean, General Manager, Planning and Practice, Building Management and Works, 24 April 2012, p. 3.

What are panel contracts?

A panel contract is a contractual arrangement established with at least two suppliers for the anticipated provision of goods or services, as and when required over a specified period of time. The panel contract contains standard prices, terms and conditions under which the goods or services will be provided by panel members.

Panel contracts can provide major efficiencies for government departments, because they can reduce the amount of time spent procuring goods and services. Companies on the panel are evaluated for their suitability and then included on the panel if found suitable. Buying rules associated with most panels enable departments to directly select companies on the panel if the estimated cost of the procurement is less than $150,000.

Panels typically are developed to cover a specific type of procurement. For example, there might be panels for the provision of stationary supplies or cleaning. It is important that departments use the most appropriate panel to respond to the specific service being sought, as deliberate use of less than suitable panels might undermine the principles of impartial procurement practices.

The decision not to use ASFAP was critical, because ASFAP panel members include the leading providers of commercial advice on PPPs in Australia. The *Project Management Services Panel*, which is focused on project management services for BMW construction projects, does not include these firms.

This meant that when DoH selected its commercial advisor from the panel, it was not selecting from a panel that contained firms that were best able to provide the advice being sought. As if to underline the unsuitability of the panel used, only two firms on the *Project Management Services Panel* were later included in the specialist *PPP Commercial Advisor Panel* established in 2010.

Table 4.1 below has been sourced from data available from KPMG and contains an overview of the firms appointed to provide commercial advice on recent social infrastructure PPPs in Australia. None of the firms in the table are members of the *Project Management Services Panel*, which meant that they were excluded from providing advice to DoH for the FMSC. Each of these firms (with the exception of Macquarie) is available, however, through the ASFAP. As a result of the Department's decision to use a less than suitable panel, leading providers of commercial advice in the PPP market were not approached, let alone evaluated to do the work.

In addition to being composed of firms better suited to providing the advice sought by DoH, ASFAP is also unambiguous about its use as a means for agencies to procure advice about procurement and tendering, including specifically the use of PPPs.[128]

128 Department of Treasury, *Buyers Guide – Audit Services and Financial Advice* CUA, July 2008, p. 7; in Submission No. 17 from the Department of Treasury, 3 January 2012.

Table 4.1: Commercial advisors on recent PPP-type projects in Australia[129]

Advisor	Number of projects
KPMG	9
PwC	8
Ernst & Young	4
Deloitte	1
Macquarie	1
TOTAL	**23**

Although the scope of the *Project Management Service Panel* is broad, and allows for the analysis of 'options for service delivery, cost benefit analysis, Life cycle cost investment analysis and risk analysis',[130] it is important to remember that ASFAP is significantly more clear about its role in assisting in the development of PPPs. It also includes the leading firms in the market for the provision of commercial advice.

Further reinforcing the suitability of ASFAP to provide the services being sought by DoH, in early 2010 the Department of Treasury (**DoT**) used ASFAP to appoint commercial advisors on the QE2 Medical Centre Car Park (a public private partnership project) and invited submissions from a number of the leading firms outlined in **table 4.1**.

Finding 24

By using the *Project Management Services Panel* rather than the *Audit Services and Financial Advice Panel* to select its commercial advisor, the Department of Health was unable to consider any of the leading firms that provide commercial advice on major projects.

DoH engaged in contract splitting

In its management of the selection of Paxon, DoH engaged in practices consistent with contract splitting, thus bypassing competitive selection processes.

DoH has strongly resisted the suggestion that the three contracts let to Paxon on 9 April 2010 were deliberately split in order to allow a direct appointment process to occur, thus avoiding the need for competitive tendering:

> *For the record, the Department firmly and categorically rejects any implied or explicit suggestion that it engaged in contract splitting for these purposes. […] only one of the contracts signed with Paxon Consulting on 9 April 2010 directly related to the process of procuring*

129 KPMG Infrastructure and Projects Group, *Biosciences Research Centre: A PPP Case Study in the GFC*, 2010; available at: http://www.bond.edu.au/prod_ext/groups/public/@pub-btsd-gen/documents/genericwebdocument/bd3_013347.pdf (Accessed: 31 May 2012).

130 Submission No. 30 from the Department of Health, 17 April 2012, p. 3.

> *non-clinical support services under the Facilities Management contract. The other two contracts were unrelated.*[131]

The two contracts highlighted in green in **table 4.2** below are the contracts that DoH maintains were not related to the FMSC. Whilst DoH has refuted in strident terms the suggestion that the three contracts let on 9 April 2010 were deliberately split, it has been less strident on the question of whether its decision to issue the contracts to Paxon 'in components' over a period of two years also constituted contract splitting.

The manner in which the contracts were let to Paxon had the following characteristics:

- Many of the contract numbers assigned to the contracts are in close order;
- The contracts are for similar services or different components of the same service;
- Three contracts were signed on the same day;
- The contracts are with one supplier, the Paxon Consulting Group;
- The estimated values for the three contracts let on 9 April 2010 were all $136,400; and
- The estimated values for almost all of the contracts fall just below the threshold requiring competitive tendering processes.

The characteristics listed above are consistent with the findings of contract splitting made in the *Independent Inquiry into the Green Loans Program* conducted by Ms Patricia Faulkner AO, a former KPMG Partner.[132]

Furthermore, Mr Graeme McLean, General Manager Planning and Practice, BMW, acknowledged that there was 'no question' that the three contracts let to Paxon on 9 April 2010 appeared in hindsight to 'relate to the same core project'.[133]

It is based upon this evidence that we conclude that DoH split its contracts for the provision of commercial advice for the FMSC.

Finding 25

The available evidence suggests that the Department of Health engaged in contract splitting when appointing its commercial advisor:

- The contracts are for similar services or different components of the same service;

131 Submission No. 35 from the Department of Health, 15 May 2012, p. 1.
132 Department of Climate Change and Energy Efficiency, *Independent Inquiry into the Green Loans Program*, June 2010, p. 18.
133 Mr Graeme McLean, General Manager Planning and Practice, Building Management and Works, *Transcript of Evidence*, 24 April 2012, p. 6.

- Three contracts were signed on the same day, each for $136,400;
- The contracts are with one supplier, the Paxon Consulting Group; and
- The estimated values for almost all of the contracts fall just below the threshold requiring competitive tendering processes.

DoH did not competitively assess its commercial advisor

Almost all of the contracts used to engage Paxon were awarded without a competitive selection process taking place.

Competitive selection did not occur because the Department's commercial advisor was appointed through a rolling series of smaller contracts at semi-regular periods during the procurement of the FMSC. By splitting the provision of commercial advice on the project into a series of smaller contracts, the estimated cost for each engagement was kept below the threshold required for competitive tender processes. This resulted in over one million dollars' worth of contracts being provided to the commercial advisor without evaluation against competitors in the market. **Table 4.2** on the next page provides an overview of the contracts used to appoint Paxon.

This decision to split the contracts used to procure commercial advice has not been repeated on subsequent complex projects. We examined the processes used to appoint commercial advisors for the QE2 Medical Centre Car Park, the Midland Health Campus and the Eastern Goldfields Regional Prison. These were PPP-type projects initiated following the commencement of the procurement of the FMSC. For these projects, commercial advisors were procured through the use of a single, upfront contract at the commencement of the project. The commercial advice contracts covered the provision of advice from the early expressions of interest (**EOI**) stage through to the request for submissions (**RFS**) stage and, finally, financial close.[134] Because these contracts were so large, it was necessary to conduct a competitive tender process in order to select the commercial advisors for the projects.

DoH explained that contracting its commercial advisor 'in components' was appropriate because it was 'not always known that the next stage would proceed'.[135] However, once State Cabinet endorsed the procurement plan in November 2009, it should have been obvious to DoH that it had an ongoing need for the provision of commercial advisory services and should have contracted accordingly.

Although DoH noted that each individual engagement of the commercial advisor complied with the relevant buying rules of the panels used, the decision to split the appointment of the commercial advisor into a series of smaller contracts is not

134 Submission No. 22 from the Department of Treasury, 28 February 2012.
135 Submission No. 20 from the Department of Health, 6 February 2012, p. 11.

Table 4.2: Contracts used to appoint the Paxon Consulting Group

Date	Contract	No. of companies approached	Estimated Cost	Actual Cost
16 Jul 2009	BMW2559209	1	$20,000	$84,440
9 Apr 2010	**BMW0287810**	**1**	**$136,400**	**$139,280**
9 Apr 2010	**BMW0248910**	**1**	**$136,400**	**$139,900**
9 Apr 2010	BMW0247410	1	$136,400	$162,900
16 Aug 2010	D09052-006	1	$148,100	$163,509.84
16 Nov 2010	D09052-011	1	$148,100	$273,100
1 Apr 2011	D09052-019	5	$363,000	$318,700
Feb 2012	FSH0120201	1	$150,000 (up to)	Not Available

consistent with good contracting practice. In particular because DoH awarded a substantial body of work to a company without assessing the services and costs offered against competitors in the market. Competition is critical if a contract is to achieve the right mix of cost and quality.

Finding 26

The Department of Health split the contract for the provision of commercial advice into a series of smaller contracts over the life of the procurement of the Facilities Management Services Contract. This allowed the Department to directly appoint its preferred commercial advisor without a competitive selection process.

Finding 27

Given that Cabinet had decided to procure such a large and complex range of services through the Facilities Management Services Contract, the Department of Health should not have used a series of rolling contracts to employ Paxon to provide commercial advice. Rather, it should have tendered for a single engagement covering the life of the procurement process.

Major firms were not invited to bid when competitive selection occurred

When DoH finally used a competitive process to select its commercial advisor towards the end of the procurement of the FMSC, none of the major commercial advisory firms identified in **table 4.1** were asked to make submissions.

The April 2011 contract for the provision of commercial advice on the project was estimated by DoH to cost a total of $363,000.[136] This figure exceeded the amount for which direct appointment of advisors is permissible and necessitated the use of a competitive selection process. This contract was let under a dedicated panel—the *PPP Commercial Advisor Panel*—established to provide streamlined access to commercial advisors on PPPs and other major projects.

136 Submission No. 20 from the Department of Health, 6 February 2012.

DoH asked five firms to make submissions for the work, including Paxon. The five firms were selected on the basis that their maximum hourly rates did not exceed a set figure that had been established by the Department as representing a 'value for money benchmark'.[137] This decision meant that leading firms in the market were not requested to make submissions for the only piece of commercial advice work that was competitively tendered, because the larger firms charge comparatively larger rates.

On a number of occasions we tried to get a better understanding from the Department of the processes it had used when selecting a company from panel contracts. DoH's response in this instance is consistent with answers that it had previously provided. For example, the Director General, Mr Kim Snowball, had earlier stated that the qualifications, experience and expertise of firms included on panels are a 'matter for the Department of Treasury and the Department of Finance'. He continued that the 'panels exist to enable agencies' to have 'certainty as to the capability and performance history' of those firms and that the process gave agencies a 'short list from which to select for the job you need'.[138] Earlier, in response to a direct written question about the processes used to initially select its commercial advisor, DoH told us that an evaluation was not required under the rules of the panel that was used to select the advisor.[139]

The explanations provided by DoH throughout the course of the Inquiry indicate that a view had formed within the Department that the initial evaluations of firms carried out by DoT or the Department of Finance (**DoF**) absolved DoH of any responsibility to evaluate firms before either directly selecting them to carry out work, or inviting them to take part in a competitive selection process. The arbitrary use of a payment cap as some kind of 'value for money benchmark' suggests that DoH was of the view that all firms on the panel are equally capable of delivering the work asked of them, and that all that separates the firms is the amount of money they charge. The Department's view implies that a large company—with many years of experience at providing commercial advice on complex projects—is the same as a small company with vastly less experience, simply by virtue of the fact that both firms happen to be on the same panel.

This is a notion rejected in the buyer's guide for both of the panels used to appoint the commercial advisors. The buyer's guide for the *Project Management Services Panel* explains that the 'composition [of the panel] is intended to accommodate an appropriate range of firm sizes and skills to have the capabilities to undertake contracts

137 Submission No. 30 from the Department of Health, 17 April 2012, p. 3.
138 Mr Kim Snowball, Director General, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 3.
139 Submission No. 20 from the Department of Health, 6 February 2012, p. 6.

of varying sizes and complexity'.[140] The buyer's guide for the *PPP Commercial Advisor Panel* offers similar advice, but in a more direct fashion, noting that Departments should consider the 'expertise and experience' of firms; the capability of key personnel and the capability of the firm itself; and the value of work given to the firm relative to its size.[141]

These are factors that do not appear to have been taken into account before DoH selected firms to submit responses to a request to provide commercial advice for the final stages of negotiation with Serco.

As a result, one of the companies invited to tender for the work was essentially a sole trader based interstate and its bid price was only 12 per cent of the total cost of the contract as estimated by the Department. In its evaluation report, DoH noted that it did not have confidence that the company understood the project or that it would be able to meet the deliverables of the contract.[142] The other unsuccessful company was noted to have had a broad range of experience in health projects and FM services, but that this experience was at 'initial phases of projects' and not within 'complex negotiations'.[143]

If DoH had used an evaluation process that was based upon more than a capped hourly rate, it would have been aware of these shortcomings and considered the experience and skills of the firms invited to tender for the contract. Instead, firms that could not provide meaningful competition to Paxon were selected, and the Department did not benefit from the use of a genuinely competitive selection process.

Finding 28

The Department of Health claimed to have only considered price, rather than skills, experience or ability, when selecting firms to make submissions for the only piece of commercial advice work awarded through a competitive selection process.

Finding 29

In its explanations to us, the Department of Health consistently failed to demonstrate that it understood that not all firms on panels are equal and that they have varying levels of skills and abilities.

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140 Department of Finance, *Buyer's Guide – Project Management Services Panel* 2005, September 2005, p. 3; in Submission No. 21 from the Department of Treasury, 28 February 2012.

141 Department of Treasury, *Buyer's Guide – Commercial Advisory Panel*, April 2010, p. 12; in Submission No. 17 from the Department of Treasury, 3 January 2012.

142 Department of Health, *Evaluation Report – Request for Commercial Advisory Services for Fiona Stanley Hospital Facilities Management Services,* March 2011, p. 11; in Submission No. 20 from the Department of Health, 6 February 2012.

143 Department of Health, *Evaluation Report – Request for Commercial Advisory Services for Fiona Stanley Hospital Facilities Management Services,* March 2011, p. 12; in Submission No. 20 from the Department of Health, 6 February 2012.

There is another element of the decision to use a competitive process for the selection of the commercial advisor at this late stage of the procurement of the FMSC. Namely, there would have been very few companies that could have provided meaningful competition to Paxon given the level of experience and knowledge it had developed about the project during the previous eighteen months. It would have been very unlikely that any competitor at this stage would have been able to overcome the built-in advantage enjoyed by Paxon given its intimate knowledge of the project.

Finding 30

The Department of Health awarded Paxon the work of providing critical advice for the State's largest ever services contract without any real element of competition in the selection process.

DoH sought an unusual combination of skills from its commercial advisor

The way in which DoH structured its requirements when contracting for the provision of commercial advice on the project was not consistent with the structure used for similar advisory contracts on other large projects.

In July 2009, the Department appointed Paxon to carry out many of the traditional functions of a commercial advisor on a public private partnership (**PPP**) project, but the advisor was also required under the contract to 'determine a base-line cost of the State providing each service contained in the services matrix'.[144] Typically, commercial advisors will not calculate the 'raw costs' of the services that are used as the basis for the development of the public sector comparator (**PSC**). For example, in the context of the FMSC, a commercial advisor would not have typically estimated the cost of government providing catering in a traditionally procured hospital, nor would it have estimated the costs of government management of facilities management services. The estimates for these raw costs—i.e. the estimated cost of the provision of non-clinical services once the hospital is operating—are provided by technical advisors: organisations that specialise in quantity surveying or providing facilities management advice.

Judging from its presence on both the *PPP Commercial Advisor Panel* and the specialist *FM Advice Panel*, it would seem reasonable to conclude that Paxon was capable of carrying out both tasks. This is not, therefore, an issue of Paxon's suitability, but rather

144 Department of Health, *Project Brief: RFP2559209,* July 2009, p. 3; in Submission No. 20 from the Department of Health, 6 February 2012.

The differing roles of Commercial Advisors and Facilities Management Advisors

Commercial advisors undertake the following key activities:

- The development of the public sector comparator – the PSC is a complex financial model that calculates the hypothetical cost of delivering the project under the most efficient form of State procurement.
- Assisting in the development of the project agreement, including specialist input into commercial and financial matters such as:
  - Refinancing provisions – these provisions, inter alia, define how refinancing gains will be calculated and shared amongst the parties.
  - Payment mechanism provisions – that set out how payments to the private sector will be calculated.
  - Termination provisions – PPP contracts need to describe the financial framework to calculate any termination payouts under a number of different scenarios.
  - Insurance requirements.
  - Change in control provisions.
- Commercial opportunity structuring – PPP projects often contain co-located commercial opportunities, ranging from cafe's to child care centres and hotels. If acceptable to the State, these elements need to be carefully integrated into the project from a commercial and financial perspective.
- Provide accounting advice to the State – it is important for Treasury to understand the impacts a PPP project will have on its balance sheet. This complex and highly specialised task is performed by the project's commercial advisor.
- Evaluation of private sector bids – the commercial advisor will be heavily involved in evaluating the commercial and financial aspects of EOI and RFP bids, including:
  - An assessment of the financial strength of the key members of each consortium.
  - A full review of the financial model of each bidder.
  - An evaluation of the strength and competitiveness of the private sector financing proposals.
  - An evaluation of any departures to the proposed contractual arrangements.
  - A review of the tax structure of each bid.
- The commercial advisor will also be involved during the final negotiation process and will assist in structuring the financial close process whereby the State and the project's financier locks in 'base interest rates' for the purpose of the final model.

Facilities management (FM) advisors focus on the operating phase of the project and provide key input in relation to the identification of the services to be included in the PPP scope, as well as defining the required levels of service (and the associated abatement regime if services are not delivered to the required standard).

Key activities include:

- Assessment of the suitability of services for inclusion in the PPP scope. This will require a contemplation of a number of factors including the expertise of the client, private sector market depth and appetite, industrial relations issues and any central purchasing arrangements.
- Defining the scope of each service. For each service the FM advisor will develop a detailed 'output-based' service specification that sets out minimum performance standards. Each service specification needs to be clearly articulated and capable of measurement (so as to be enforceable)
- Abatement regime: The FM advisor will assist the State in developing and calibrating an abatement regime that will support the delivery of the services specification. This is a complicated task that requires a detailed understanding of operational environments.
- PSC inputs: The FM advisor will provide detailed recurrent and lifecycle costings to the commercial advisor for the purpose of calculating the PSC. The development of these costs requires a detailed and contemporary understanding of the State's operating practices.
- EOI and RFP evaluations: The FM advisor will be responsible for evaluating the merits of the operating solution contained in each private sector bid. Operational responses are very detailed, and the FM advisor role will include a consideration of work method statements, rostering strategies, lifecycle profiles, asset management plans and equipment regimes.
- The FM advisor will also be involved during the final negotiation process insofar as it relates to operating phase issues.

an issue as to why DoH elected to combine substantial elements of the technical advisory role[145] with the commercial advisory role. As far as we have been able to ascertain this is an unusual occurrence and meant that the Department was not able to benefit from an independent review of the raw costs developed for inclusion in the PSC.

DoH reported that a number of factors 'weighed heavily' in its initial decision to appoint Paxon in July 2009. These were:

- The scale of the work initially contemplated (the initial contract for advisory services was estimated at $20,000);

145 Note that some elements of the technical advice were provided by specialist advisors. MBMpl was called upon in January 2010 to review service specifications and KPIs and Appian Group 'provided advice around lifecycle assumptions for the building assets, fixtures and fittings included in the analysis'. MBMpl also provided assistance in determining the building and infrastructure efficiencies. See: Submission No. 36 from the Department of Health, 15 May 2012, p. 6.

- The commercial advisor had completed similar work for the Department in the past; and
- The commercial advisor was considered by DoH to be good at costing hospital service delivery.[146]

From this explanation, it would seem that the Department provided a heavy weighting to the cost modelling aspects of commercial advice. As the summary on the previous page indicates, however, the role of commercial advisors does not typically include cost modelling of individual services. By weighting this aspect so heavily, DoH appears not to have given sufficient focus to other aspects of the work of commercial advisors, and this may have been the reason the Department selected its advisor from a panel that was not the most suitable.

DoH's decision to combine the technical and commercial aspects of procurement advice is unusual and does not appear to have been repeated in other recent procurement activities in Western Australia. We examined the scope of works given to commercial advisors on three Western Australian PPP projects that went to market shortly after the FMSC: the QE2 Medical Centre Car Park; the Eastern Goldfields Regional Prison; and the Midland Health Campus (**MHC**).[147] In the case of the MHC, for example, DoT has contracted KPMG to provide commercial advice and has appointed quantity surveyors and other technical advisors to provide technical advice. An overview of the type of services typically provided by commercial advisors and facilities management advisors (a type of technical advisor), can be found on the previous page.

Finding 31

The Department of Health combined the provision of commercial and technical advice from one advisor, an unusual approach when compared to the management of advice on other PPP-type contracts in Western Australia.

Contracting activities were poorly coordinated between DoH and BMW

DoH acknowledged that on several occasions Paxon was carrying out work before a contract had been signed.

We examined contract documents relating to work undertaken by Paxon under contracts signed in April 2010. As a result of our inquiries, it became obvious that Paxon had been submitting completed work under the contracts as early as January 2010—a gap of some four months between completion of work and a contract being signed.[148] DoH explained that the reason for the gap was the requirement for

146 Mr Wayne Salvage, Acting Executive Director, Resource Strategy and Infrastructure, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 5.
147 Submission No. 22 from the Department of Treasury, 28 February 2012.
148 Submission No. 25 from the Department of Health, 20 March 2012.

BMW to finalise the contracting process.[149] Representatives from DoF noted that having firms carry out work without a contract in place is not 'the most desirable course of action' and that it was not 'sanctioned'.[150] In particular, it exposes the State to risks that contracts would otherwise minimise, including those relating to payment disputes, quality of work and exposure to any liabilities.

Both DoH and BMW failed to adequately manage the contracting process. In three separate letters dated 4 December 2009, DoH invited Paxon to submit offers for three different contracts before 2.30 pm on the same day. The letters required Paxon to make its submissions to an officer employed by BMW; however, the submissions appear to have been made directly to DoH and it was a month later—5 January 2010—before those submissions were forwarded to BMW.[151]

The price offers made by Paxon for the three contracts were only binding for a period of 42 days, which meant that BMW needed to action the contracts before 15 January 2010 to accept the initial prices offered. In the event, BMW only approved the contract in March 2010 which required Paxon to resubmit its offers, even though by this stage it had already completed work and submitted it to DoH.

We asked DoF—the agency now responsible for the management of BMW—to explain why there was such a significant delay between being advised by DoH of the need for the contracts and then actioning those contracts:

> *There appears to have been a lack of communication between the key parties on the process that was required, the status of the contracts and the urgency for the contracts to be finalised. The key parties in this case were Building Management and Works, the Office of Strategic Projects and the Department of Health.*[152]

There are a number of critical issues that arise from the management of the contracts in these instances:

- Despite being instructed in the documents to make its submission to BMW, Paxon appears to have submitted directly to DoH, a violation of the terms of the offer contained in the offer letter.

- BMW was only made aware of the contracts one month after DoH had sent the invitation for offer and by this stage Paxon was already working on aspects of the

149 Mr Wayne Salvage, Acting Executive Director, Resource Strategy and Infrastructure, Department of Health, *Transcript of Evidence*, 3 April 2012, pp. 17–18.
150 Ms Anne Nolan, Director General, Department of Finance, *Transcript of Evidence*, 24 April 2012, p. 7.
151 Submission No. 34 from the Department of Finance, 8 May 2012.
152 Submission No. 34 from the Department of Finance, 8 May 2012.

request. Effectively, this meant that BMW could play no role in overseeing selections from the panel.

- By allowing work to be completed by Paxon before a contract was signed, DoH was exposing the State to risks that a signed contract would have minimised, including the risks arising from potential substandard work and cost escalations.

Finding 32

Poor coordination between the Department of Health (DoH), the Office of Strategic Projects and Building Management and Works resulted in delays to the formal signing of contracts for the provision of commercial advice for the Facilities Management Services Contract. However, it was DoH's responsibility to have those contracts in place in time.

Finding 33

On several occasions the Department of Health's commercial advisor was completing work before contracts were in place exposing the State to risks that the contract would have minimised, including the risk of substandard work and cost escalations.

Finding 34

As a result of delays from the Department of Health in making Building Management and Works (BMW) aware of the need for contracts for commercial advice, BMW was not able to play an oversight role in the Department of Health's use of panel contracts.

Management of the commercial advice panels was poor

DoH's use of the less suitable panel contract when selecting its commercial advisor might have been avoided if a central agency had been acting to supervise appointments from the panel contracts. At the time that Paxon was appointed by DoH, BMW was acting in a facilitating role and did not scrutinise decisions made by the agencies it was assisting. According to BMW, the level of supervision it now exercises over the use of panels has increased;[153] however, the lack of coordination demonstrated by agencies when it comes to establishing panel contracting arrangements is concerning.

Was Paxon given enough time to complete the work?

There is also a question regarding the amount of time made available to Paxon to complete the work required under the initial contract signed in July 2009. Time, as we have seen, is a critical issue for the procurement of the FMSC. As we outline in **chapter 5**, there was a significant amount of work associated with establishing the

153 Mr Graeme McLean, General Manager Planning and Practice, Building Management and Works, *Transcript of Evidence*, 24 April 2012, p. 6.

assumptions that underpin the reference project, including interviews with senior staff in operational hospitals and an examination of hospital budgets. Paxon signed the contract to provide this work (which included a preliminary PSC) on 16 July 2009 and submitted its work to DoH five days later.[154] We asked the Department about the commercial advisor's ability to provide such detailed work in such a short period of time. DoH reported that its advisor had initially been advised via email by a member of the FSH project team on 1 July 2009 that it had been selected to carry out the work associated with the preliminary financial analysis, including the development of the reference project.[155]

At a hearing, we expressed the view that 21 days was still not sufficient to allow for the completion of the detailed work required. In response to our doubts, DoH revealed that Paxon had previously completed work on the business case for FSH and that this work had included developing recurrent cost modelling for the Hospital.[156] The implication from this statement is that Paxon was able to deliver the work so quickly because of its familiarity with the costing models for operating the Hospital.

Selecting the right advisor matters

Throughout this report, we have expressed our support of the general principle that competition is necessary if any contract is to achieve the right mix of price, quality and risk transfer. This principle is true if the contract is a $4.3 billion multi-year contract, or a small one-off contract. As we have seen, the processes used by DoH to appoint Paxon did not benefit from competitive selection processes. Indeed, it seems that the Department did all it could to ensure that a competitive selection process did not occur. As a result, DoH could not be sure that it was receiving the best possible advice on the largest contract in the State's history, because it failed to run competitive selection processes for all but one of the contracts used to engage Paxon.

On the one occasion when a competitive selection process was used, the combination of Paxon's inbuilt advantage (having worked on the project for nearly two years) and the failure to invite leading firms to take part in the process ensured that Paxon's selection was never really in doubt.

The next chapter provides additional detail of the work required by commercial advisors, but it is fair to say that commercial advisors have complex jobs and will often rely upon skill and experience to make important judgements about the assumptions used in the PSC. When it elected not to use competitive selection processes, DoH denied itself the opportunity to assess Paxon's experience and skills against

154 Submission No. 20 from the Department of Health, 6 February 2012, pp. 4–5.

155 Mr Wayne Salvage, Acting Executive Director, Resource Strategy and Infrastructure, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 16.

156 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 15.

competitors in the market. Paxon may well have been the best company for the job, but in the absence of an evaluation-based selection process, DoH has struggled to adequately explain why it chose Paxon.

This is particularly unacceptable given the unprecedented scale and cost of the FMSC.

Finding 35

On the evidence provided to the Committee, and the responses provided by the Department of Health (DoH) when pressed on these matters, DoH went to some lengths to ensure that competitive processes for the selection of its commercial advisor did not occur.

Chapter 5

The Public Sector Comparator

A dollar today is worth more than a dollar tomorrow.[157]

What is the public sector comparator?

Western Australia's Department of Treasury (**DoT**) describes the public sector comparator (**PSC**) as an estimate of the net present cost (**NPC**) to government if it was to deliver a project through traditional procurement methods. DoT goes on to describe the PSC as containing forecast lifetime cash flows for a government delivered reference project based on the infrastructure and output specifications provided to bidders. As the 'C' in PSC suggests, it is developed to provide a comparison of the value for money to be achieved through the use of a public private partnership (**PPP**) procurement scheme.[158]

The purpose of the PSC, and the principle of its use, is reasonably straight-forward; however, the means through which a PSC is developed, and the series of assumptions on which it sits, are complex and have been the source of some criticism, particularly in the United Kingdom.

In Australia, the PPP procurement process is outlined in a series of documents published by Infrastructure Australia and referred to throughout this report as the **IA Guidelines**. In November 2008, all Australian governments endorsed these guidelines, which effectively replaced previously existing policies and guidelines in the various jurisdictions.[159] Discussion of the IA Guidelines requires us, at this point, to briefly revisit the question as to whether the Facilities Management Services Contract (**FMSC**) at Fiona Stanley Hospital (**FSH**) is a PPP as traditionally understood. This is no mere academic question: the existence of the guidelines, and Western Australia's subscription to them, requires that PPP projects be procured according to the Guidelines' prescriptions.

Although we have accepted that the FMSC is not a PPP, the Department of Health (**DoH**) itself noted that in the absence of 'specific guidelines for the development of a

157 Infrastructure Australia, *National PPP Guidelines: Discount Rate Methodology*, December 2008, p. 8.

158 Department of Treasury (WA), *Public Private Partnerships: Public Sector Comparator Policy – Additional Policy Guidance*, August 2011, p. 3.

159 Infrastructure Australia, 'National Public Private Partnership Policy and Guidelines', April 2011. Available at: http://www.infrastructureaustralia.gov.au/public_private/ppp_policy_guidelines.aspx

service project of this scale, the National PPP Guidelines have been used as a reference, particularly with regard to the development of a public sector comparator'.[160]

Electing to follow the IA Guidelines in the development of the PSC is a decision for which DoH should be commended. **Figure 5.1** on the opposite page is a summarised form of the inputs required in the IA Guidelines for the development of the PSC. By relying upon these inputs, DoH was able to consider its options with a system that provided a theoretically robust means of analysis. Many of the elements identified in the diagram are examined in further detail in this chapter. However, before commencing with this examination, DoH's use of and adherence to the IA Guidelines requires further comment.

The IA Guidelines do not simply limit themselves to providing advice for the development of the PSC; they also contain information on good practice for the procurement of PPP projects from the early stages through to financial close. This includes providing guidance on output specifications, the development of the reference project and the use of advisors. Perhaps the most important piece of guidance relates to timing: that is, the stages at which certain parts of the procurement process should be finalised.

During our review of DoH's procurement processes, we found a number of occasions on which it was clear that the Department had departed from the IA Guidelines in relation to when important elements of the procurement process had been completed, including the PSC itself. When we raised these issues, DoH advised that only the development of the PSC was run according to the IA Guidelines and that all other aspects of the procurement were run according to the State Supply Guidelines.[161]

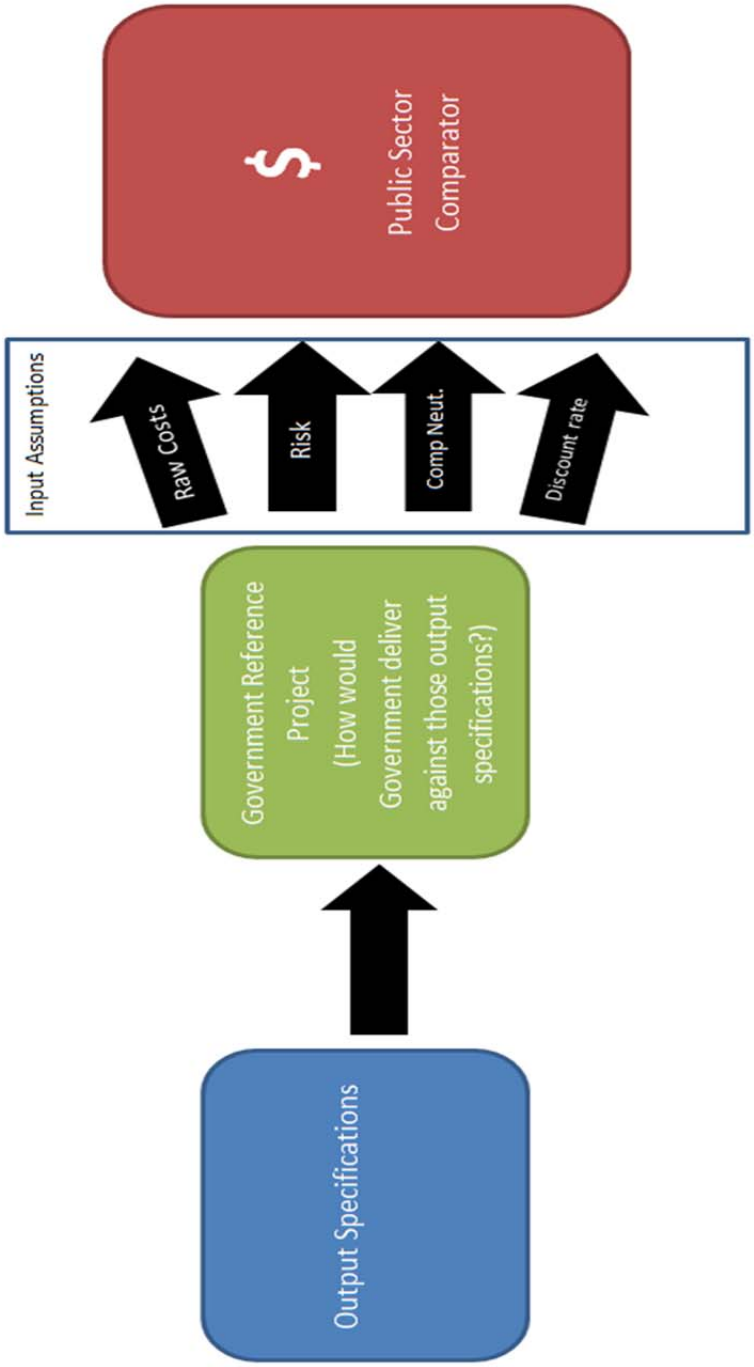
Finding 36

The Department of Health sought to develop the public sector comparator for the Facilities Management Services Contract in compliance with the requirements of Infrastructure Australia's public private partnership Guidelines.

160 Submission No. 20 from the Department of Health, 6 February 2012, p. 1.

161 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 3 April 2012, p. 21.

Figure 5.1: Summary of the PSC development process



Chapter 5

The reference project

According to the IA Guidelines, the reference project should represent the most efficient means of public sector delivery of the output specification developed for a project. The output specification[162] is the series of documents—often several hundred pages long—that provide the information necessary for the private sector to place bids for the infrastructure project. The reference project can therefore be said to be something of a public sector bid against the output specifications, representing a type of 'best and final offer' for government-sourced project delivery. It is upon the reference project that the PSC is developed. Infrastructure Australia has itself noted that developing a 'clear and complete' reference project is particularly important for identifying material project risks and risk valuation.[163]

The reference project was based on costs from existing metropolitan hospitals

DoH reported that the reference project was developed from the following information sourced from existing hospitals in metropolitan Perth:

- The reference project for the FMSC was constructed using Royal Perth Hospital and Sir Charles Gairdner Hospital as reference sites.
- The general ledger structures of the hospitals were examined at the cost centre level to identify the costs of services currently provided.
- Interviews were conducted with service and cost centre managers to identify the cost structures to be incorporated in the service costs.
- Service managers were consulted in order to determine the impact upon costs of the service specifications and the performance standards.[164]

This information was then adjusted for variations with the proposed Fiona Stanley Hospital physical and services design as compared to the reference sites. This included adjusting for appropriate cost drivers for each service including: bed numbers, gross floor area or inpatient separations.[165]

Arising from these consultations, a document was compiled by DoH's commercial advisor containing the sources and assumptions used in the development of the PSC. This document is dated May 2011 and runs to some 54 pages.

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162 The 'output specification' is a broad classification of information that contains a number of subsets, including technical and architectural specifications and service specifications. Given the nature of the FMSC, it is only the service specifications that are of interest. For more information, see: Infrastructure Australia, *Practitioners Guide*, December 2008, pp. 21–22.

163 Infrastructure Australia, *Public Sector Comparator Guidance*, December 2008, p. 67.

164 Submission No. 12 from the Department of Health, 21 November 2011, p. 4.

165 Submission No. 38 from the Department of Health, 14 June 2012, p. 8.

DoH was confused as to when the reference project was developed

DoH failed to adequately explain when the reference project was developed, and in so doing failed to demonstrate that it had a solid understanding of the work it was asking its commercial advisor to complete.

The Department initially indicated that the reference project was developed by the Paxon Consulting Group (**Paxon**), its commercial advisor, as part of the work that it undertook on the preliminary financial analysis in July 2009.[166] Completing the reference project at this early stage would contradict the guidance of Infrastructure Australia, which has recommended that the development of the reference project should only commence after a project has reached an advanced stage.[167] DoH itself has admitted that, at the time the preliminary financial analysis was undertaken, service specifications had not yet been developed and that its commercial advisor had relied upon a 'services matrix' developed by the FSH project team.[168] If the reference project was completed without referral to well-developed service specifications, then the credibility of the PSC developed for the project would be critically undermined.

The Department's suggestion that the commercial advisor completed the reference project in July 2009 is therefore difficult to accept as credible.

During our fourth hearing with the Department, the issue of the reference project was raised once more, this time in the context of the 'sources and assumptions' document compiled by Paxon. This document clearly contains the reference project around which the commercial advisor constructed the PSC. DoH reported that work on gathering the information for inclusion in the sources and assumptions document—and which on the evidence more closely resembles a reference project—commenced after the procurement model had been endorsed by Cabinet.[169] Presumably this means that work on gathering the information commenced some time in December 2009. It was thought that the work took approximately four months to complete.

This explanation is significantly more credible than the earlier explanation offered by the Department, although it is troubling that DoH was not able to provide a clear answer to the question until late in the progress of our Inquiry.

DoH was uncertain about which companies developed the reference project

During the early stages of the Inquiry, DoH reported that its commercial advisor was the only company engaged to develop the reference project.[170] However, the sources

166 Submission No. 20 from the Department of Health, 6 February 2012, p. 5.
167 Infrastructure Australia, *Public Sector Comparator Guidance*, December 2008, p. 67.
168 Submission No. 20 from the Department of Health, 6 February 2012, p. 4.
169 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 16.
170 Submission No. 20 from the Department of Health, 6 February 2012, p. 5.

and assumptions document—which as noted above we have taken to be the reference project—completed by the commercial advisor indicates that a number of companies contributed to the development of the reference project.

In particular, expert advice was sought for the project's 'bespoke' ICT requirements and technical advisors were consulted for advice about:

- Property management;
- Construction costs;
- Biomedical technology; and
- Facilities management.[171]

DoH was not across the detail of the work of its commercial advisor

The different answers provided by DoH to our questions about when the reference project was developed suggests two possible explanations: either the reference project was developed very early and without the use of detailed output specifications or, perhaps more likely, DoH did not understand the questions asked or the importance of the reference project. If the former is true, it would raise serious questions about the adequacy of the work carried out by the Department's commercial advisor, but as we have already outlined, the reference project was most likely developed once many of the detailed specifications had been finalised in early 2010. That leaves the possibility that DoH simply did not understand the role of the reference project and could therefore not answer our questions.

That DoH did not understand the role of the reference project seems quite likely. In 2010, the Auditor General released a report highly critical of DoH's management of the construction of the FSH. The Auditor General was particularly critical of the Department's management of the consultants engaged to provide advice for the project. In particular, the Auditor General found that:

- The project had relied on consultants to provide much of the required expertise because neither DoH nor the former Department of Housing and Works had the expertise to manage such a complex building project.
- DoH had poorly supervised and managed the work of the consultants.
- Consultancy contracts had cost significantly more than agreed.[172]

The Auditor General's findings would appear to be of continued relevance. DoH's ability to supervise and manage consultants is undermined if it does not understand the work it is asking the consultants to undertake. This is, perhaps, the most disappointing implication of the Department's responses to our questions about the

171 Department of Health, *Serco Bid Model and PSC Model: Sources and Assumptions*, May 2011, p. 9; in Submission No. 31 from the Department of Health, 20 April 2012.

172 Auditor General for Western Australia, *Fiona Stanley Hospital Project*, June 2010, p. 24.

reference project and it ultimately raises doubts about DoH's level of ownership over the processes used to award the contract.

Finding 37

The Department of Health did not appear to have a solid understanding of the work being completed by its commercial advisor. The Auditor General arrived at similar conclusions about the quality of the Department's supervision of advisors in an earlier report regarding the construction of Fiona Stanley Hospital.

The raw costs in the PSC

The raw costs in the PSC represent the base cost to government of producing and delivering the reference project. The raw costs are the first step in transforming the reference project into a spread-sheet model forecasting costs and expected revenues.[173] **Figure 5.2** on the following page provides an overview of the various raw costs identified in the final PSC created for the FMSC in July 2011. The three most significant items are the provision of information and communications technology (**ICT**), estates management services (i.e. hard FM provision) and the managed equipment service (**MES**).

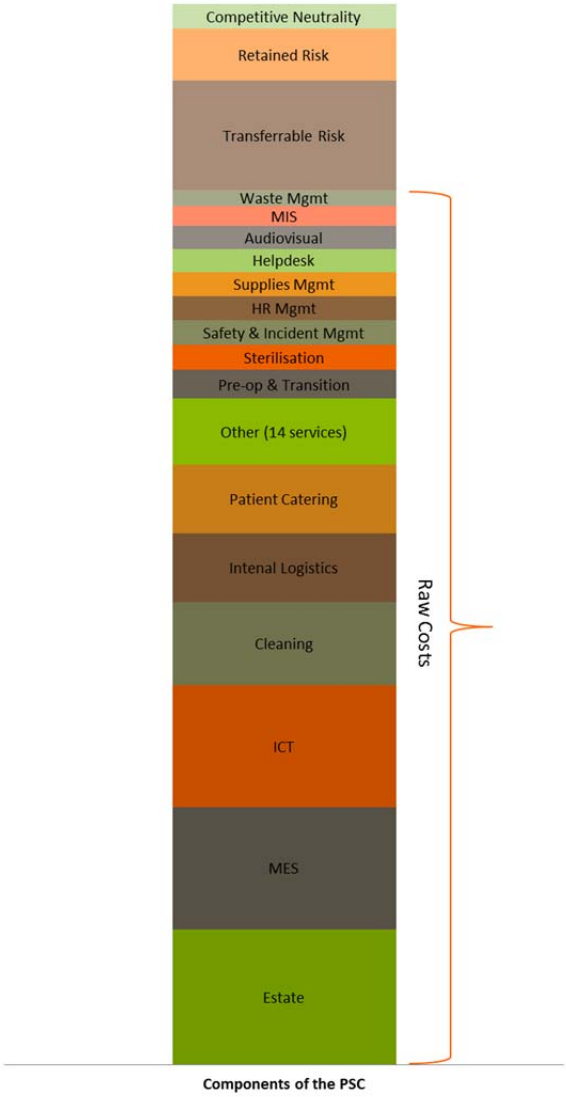
The IA Guidelines require that the raw PSC take into account capital costs, maintenance and lifecycle costs, direct operating costs and fixed, variable and semi-variable costs. There may also be some indirect costs that need to be included.[174]

The reference project and the raw costs of the PSC are obviously closely related. One would not be able to exist without the other, but they are very different. In the case of the FMSC, for instance, the reference project would be expected to establish how particular services would be delivered under a traditional procurement approach. The reference project might assume a certain number of cleaning staff would be required to clean a maternity ward to the level required in the service specifications. The reference project would also contain information about the equipment required for staff to carry out the cleaning duties.

That information is then used to calculate the raw cost of providing that service—at the levels established in the service specifications—for the life of the contract. In the case of cleaning, calculating the cost over the life of the project might involve making a series of assumptions about wages and wage increases, and also about the type and quantity of equipment and materials required, and any cost escalations. The PSC is developed based on these costs for a project that will most likely never exist, solely as a means to provide a comparison with a private sector bid. This means that the results of the PSC are subject to a great deal of uncertainty. The UK National Audit Office has

173 Infrastructure Australia, *Public Sector Comparator Guidance*, December 2008, pp. 17.
174 Infrastructure Australia, *Public Sector Comparator Guidance*, December 2008, pp. 19–21.

Figure 5.2: Relative composition of the raw costs in the July 2011 PSC (NPC figures)[175]



noted that given the inherent uncertainty of the calculations underpinning the PSC, there is a limit to the level of accuracy that can be achieved.[176]

Multiple PSCs were developed during the procurement process

The Department of Health has provided us with copies of at least four different PSC results, although there may be more that we have not seen. Developing a number of PSCs is not atypical, as the results contained in the PSC will be refined as the scope of

175 Submission No. 31 from the Department of Health, 20 April 2012, p. 3.

176 UK National Audit Office, *The use of PSC in decisions on PFI deals*, 2003. Available at: http://www.publications.parliament.uk/pa/cm200203/cmselect/cmpubacc/764/764w02.htm

the project becomes clearer or, once the contract with the preferred bidder has been negotiated, to reflect the changes to the specifications signed in the final contract.[177] **Table 5.1** on the following page provides an overview of the results of the four PSCs that DoH provided to us during the course of the Inquiry.

The initial PSC was completed in September 2009 and included in the procurement plan developed for review by State Cabinet. This result was developed using a 'services matrix' rather than detailed service specifications, as detailed work on the service specifications had not yet commenced. The result has been described by DoH as providing 'an order of magnitude' for the cost of the project.[178]

The second PSC was completed in May 2010 and was based on the service specifications that had been provided to the companies invited to take part in the RFS process. IA Guidelines require that this PSC be completed before RFS documentation is released; however, it was only provided to DoH on the same day that submissions were provided by the invited companies. This particular PSC is also noteworthy for the fact that it calculated costs for a 10-year contract period rather than a 20-year period and excluded MES, ICT and retail property management (**RPM**).

The third PSC was completed in August 2010 and helped the Department to assess the bids received from the companies that made submissions as part of the RFS process. Like the previous PSC, this was developed using the service specifications released to the market in February and March of that year. A wider range of exclusions were made in this PSC on the basis that they were, at that stage, inadequately scoped and because not all bidders included the services in their bids. Interestingly, the non-discounted value of the PSC was cheaper than the bid offered by Serco at this stage of the procurement process. When the figures are converted to net present values, as required by IA Guidelines, and risks calculated, the bid from Serco represented better value.[179]

The final PSC was completed in July 2011 and reflected the full detail contained in the contract signed with Serco.

As **table 5.1** below indicates, there were significant changes to the estimated cost of the PSC as the project was developed. This was a reflection of the significant changes made to the service specifications—on which the reference project and raw costs are

177 See, for example, the examination conducted by the Auditor General of Victoria of the Royal Women's Hospital: Auditor General for Victoria, *The New Royal Women's Hospital – a public private partnership*, p. 36.

178 Submission No. 20 from the Department of Health, 6 February 2012, p. 7.

179 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

Table 5.1: Outline of the various versions of the PSC developed for the FMSC [180]

Date	Amounts (NPC)	Contract Length	Services Excluded from PSC Calculations	Notes
Sep 2009	$2.84 billion	25 years	N/A	The initial modelling completed for inclusion in the procurement plan.
May 2010	$1.09 billion	10 years	• MES • ICT • Retail Prop Mgt	The PSC calculated using service specifications released to market in February and March 2010.
Aug 2010	$1.87 billion	20 years	• MES • ICT • Retail Prop Mgt • Childcare • Fleet Mgt • Grounds • Audio Visual • Pest Control	PSC calculated to support evaluation of bids. MES, ICT and RPM were excluded as 'the scope of these services were relatively unknown'. Other services were not included as bidders did not bid against them.[181]
Jul 2011	$2.897 billion	20 years	N/A	Final PSC reflecting the contract as signed with Serco. Now includes Mental Health facility and State Rehabilitation Service.[182]

calculated—during the project's procurement process. It also reflects the fact that DoH was attempting to procure the contract whilst the scope of the Hospital itself was still evolving: the Mental Health facility and State Rehabilitation Service were only finalised in time for inclusion in the final PSC.[183]

Given the variability in the results of the PSCs, and the changes made to the scope of the project during the procurement process, DoH would have been given its first opportunity to accurately assess value for money after the final PSC was completed in July 2011. All earlier PSCs were severely compromised by assumptions about contract length or poorly scoped service specifications.

It is important to note, however, that the PSC needs to be updated to reflect changes to the project as the understanding of the project improves.

Finding 38

At least four different public sector comparators were developed for the Department of Health by its commercial advisor during the procurement of the Facilities Management Services Contract.

180 The information in the table has been sourced from multiple submissions made by the Department of Health.

181 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

182 Submission No. 38 from the Department of Health, 29 May 2012, p. 1.

183 Submission No. 38 from the Department of Health, 29 May 2012, p. 1.

Finding 39

Each of the four different public sector comparators (PSCs) examined during this Inquiry were developed using widely varying assumptions:

- The first PSC, developed in September 2009, assumed a contract length of 25 years and was based a poorly scoped 'services matrix' rather than the detailed service specifications that would later be taken to the market.
- The second PSC, developed in May 2010, assumed a contract length of 10 years and excluded two of the three most expensive elements of the contract from its calculations—the managed equipment service and the information and communications technology service.
- The third PSC, developed in August 2010, reflected the correct contract length of 20 years, but excluded services totalling approximately 28 per cent of the total value of the contract signed with Serco on the basis that scopes for these services were 'relatively unknown' or because not all bidders included the services in their bids.
- The fourth PSC, developed in July 2011, reflected the contract as signed with Serco. Given that this was the first PSC to be developed using the full scope of the contract, this was probably the first opportunity for DoH to gain an accurate understanding of potential value for money achievable through engaging with the private sector.

Raw cost calculations depend upon accurate service specifications

In **chapter 2**, we examined the implication of poorly scoped service specifications upon the accuracy of prices initially submitted by Serco. Poorly scoped specifications also have an impact upon the accuracy of PSCs developed during the course of the procurement process. This is because an accurate PSC result relies upon accurate calculations of raw costs, and these can only be provided if the service specifications for the project are accurate and robustly developed.

There were substantial changes to the estimated costs for the services in the May 2010 PSC and the July 2011 version. For example, the cost of providing the estate service decreased by 34 per cent between the two versions of the PSC, whilst the estimated cost of cleaning increased by 2,430 per cent.[184]

184 Paxon Group, *Facilities Management Contractor Model Financial Analysis,* May 2010; in Submission No. 27 from the Department of Health, 3 April 2012, p. 8; and Paxon Group, *Commercial and Financial Analysis*, July 2011, pp. 76–77; in Submission No. 27 from Department of Health, 30 March 2012.

These are, quite apparently, substantial changes between the two versions of the PSC, even taking into account the fact that they estimate costs over different periods of time. As we noted in **chapter 2** in the discussions regarding changes to the prices bid by Serco, a number of factors may have contributed to those changes. The same is true for changes to the raw cost estimates in the PSC:

- The size of the hospital increased once the:
    - scope of the Mental Health facility had been finalised; and
    - State Rehabilitation Service was included in the overall FSH project.
- The scopes for many of the services in the service specifications, including the more expensive services (i.e. ICT and estates management) were refined during the negotiation process with Serco.
- The KPIs outlining the standard to which Serco was expected to deliver the services, and establishing the penalties if it failed to meet those standards, were altered.

DoH also explained that one of the reasons for the significant differences in PSC results for cleaning arose from changes to the way in which cleaning was represented in the PSC. In the initial version, costs for cleaning were allocated to a number of services, whereas in later version cleaning costs were represented in a single item under 'cleaning'.[185] Changes to the estimated costs for the provision of the estate service resulted from changes to the way that fittings, furnishings and equipment (**FF&E**) assets would be treated.[186]

Whatever the explanations for the changes to different versions of the PSC, our concern remains that many of the assumptions underpinning the earlier versions of the PSC were based on poorly scoped service specifications and therefore made it difficult for DoH to evaluate value for money as the process was progressing.

Finding 40

The accuracy of the raw costs included in all but the final public sector comparator appear to have been undermined by the use of poorly scoped service specifications.

Adjusting for risk

One of the key intellectual principles underpinning the use of PPP-type contracts is the notion that project risks can be transferred to parties best able to manage those risks. For many projects, the question as to whether or not the proposed PPP arrangement

185 Submission No. 38 from the Department of Health, 29 May 2012, p. 1.
186 Submission No. 38 from the Department of Health, 29 May 2012, p. 1.

will deliver value for money will be determined by the extent to which risk has been identified, valued and transferred from the public sector to the private sector provider.[187] As a result, the role of risk in investment decision making has taken on some controversy, particularly in the United Kingdom, where allegations have been made about deliberate manipulation of PSC results to ensure that private bid options are selected.

On the numbers presented, Serco's bid was cheaper than the PSC results on raw costs alone, without the benefit of risk adjustments. What the criticisms of the use of risk adjustments in the UK do highlight, however, is the fluidity of the numbers used in PSCs given that they are, essentially, a series of assumptions.

A total of 35 risks have been identified for the project

DoH's commercial advisors identified a total of 35 risks associated with the project. 13 of these risks were said to be retained by the State and 22 were said to have been transferred to Serco.[188] The transferred risks total $299.7 million, whilst the retained risks totalled $142.1 million. **Table 5.2** on the next page provides a breakdown of risks identified for the project.

Ensuring that risks stay transferred through the life of the contract

Identifying, valuing and then transferring risk to the private provider during the procurement and negotiation processes is one thing, but ensuring that the risk stays transferred during the life of the contract is another. Having structured a contract that transfers the provision of equipment maintenance to Serco, for example, it still remains DoH's responsibility to ensure that Serco provides the service to the standard established in the contract and that it does not seek financial relief from the State should the cost of providing maintenance prove to be more than anticipated. The $299 million of risk identified in the financial modelling as having been transferred will quickly evaporate if DoH fails to properly enforce its contract.

Enforcing contracts, and ensuring that risk stays transferred through the life of a contract, can be problematic due to what transaction cost economists call 'post-contractual lock-in'. This is a situation whereby the buyer is locked in to a single supplier once a contract has been signed.

187 Julie Froud, 'The Private Finance Initiative: risk, uncertainty and the state', *Accounting, Organizations and Society*, no. 28, 2003, p. 574.

188 Paxon Group, *Commercial and Financial Analysis*, July 2011, pp. 66–68; in Submission No. 27 from the Department of Health, 30 March 2012.

Table 5.2: Risks identified during the PSC development process[189]

Transferred Risks	Retained Risks
Changes to employment conditions	Changes in Federal Legislation
Design inefficiencies	Changes in Government Policy
Equipment maintenance risk	Change in State Legislation
Facilitation and management	Changes to health care operating standards
ICT Project delivery risk	Force majeure
Inability to attract sufficient staff	Foreign exchange risk
Inadequate and inefficient circulation routes	Maintenance and refurbishment risk – Site components
Inadequate briefing of Service Specifications	Price of asset risk
Industrial relations and civil commotion	Residual value risk
Lifecycle risk	Risk of material changes in inflation
Maintenance and refurbishment risk – Site Services	Risk of unexpectedly long lead times for equipment
Obsolescence risk	Specification risk
Operating costs are underestimated	Unexpected change in demand – variable services
Performance risk	
Price of asset risk	
Price risk – consumables	
Risk of third party negligence	
Specification risk	
Subcontractor performance risk	
Unexpected change in demand – fixed services	
Wear and tear – assets	
Wear and tear – services	
$299.7 million	**$142.1 million**

Often there are a number of reasons as to why this occurs, including:

- Problems of asset specificity, where the investments made in key aspects of the contract (for example, unique methods for delivering services), cannot be easily transferred to another supplier.[190]

- The costs of adjustment process, which might include the costs of switching from one supplier to another (i.e. searching the market, re-contracting and transition costs), but it might also include disruptions during the transition to the new provider.[191]

What this means, in effect, is that once a contract is operating, and the buyer becomes unhappy with the performance of the contractor, the buyer may feel that it is locked in to both the contract and contractor because the cost of doing anything about it (in

189 Paxon Group, Commercial and Financial Analysis, July 2011, pp. 66–68; in Submission No. 27 from the Department of Health, 30 March 2012.

190 Although, as we note in later chapters, the contract contains mechanisms to reduce this particular problem for the Department.

191 Lonsdale, Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy & Politics*, 35, 4, p. 684.

both economic and non-economic terms) is too great. In such a situation, the transferred risks identified and valued in the financial modelling may prove to be illusory.

This is not to say that we think this will happen with respect to the FMSC. In fact, as we explain in further detail in **chapter 6**, the contract signed with Serco contains a number of very useful mechanisms to limit the impact of post-contractual lock-in. Nonetheless, it is important to highlight the fact that the value of risk transfer identified in the PSC is simply a number calculated from a complex financial model. It will prove meaningless unless DoH assiduously enforces its contract. This is particularly so given experience in the UK, which indicates that FM providers engage in a sustained attempt to recover value from contracts once they are operating.[192]

Political risks cannot be transferred

By their own nature, large contracts like the FMSC deal with the provision of public services and frequently these public services are politically sensitive. Any risk that eventuates in a disturbance to the provision of the service will be a political risk. So, even when formally transferred to the private partner, the risk of service disruption or quality degradation is always a public partner risk. This is a view echoed by Mr Tim Marney, the Under Treasurer, when he observed:

> *In broad terms, the risk always is with the state because if something […] goes wrong, it is the state that is accountable, regardless of whether or not they have contracted out the actual delivery. Ultimately, if something goes wrong, it is a state contract for service; it is a state facility.*[193]

An example of this type of political risk has recently been provided by the Royal North Shore (**RNS**) Hospital in Sydney. Cleaning services are provided at the hospital by a facilities management provider as part of a 28-year PPP contract. The FM provider recently cut the number of cleaning staff as it argued that increases in hospital activity levels were not reflected in the level of payments it was receiving from the NSW Government. Initially, the government's position was to maintain that the contract contained provisions to meet the costs experienced by the FM provider arising from increased clinical demand. However, as the dispute continued, and media reports began to highlight the impact of the dispute upon the quality of healthcare received by

192 Lonsdale, Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy & Politics*, 35, 4, p. 684.

193 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 25 October 2011, p. 2.

patients, the NSW Government instructed the local health district to cover the cost of the private provider employing more staff.[194]

In the case of the RNS dispute, the NSW Government was clearly of the view that it had transferred the risk of unexpected increases in demand, and had therefore transferred the associated risk of increased cleaning costs. This probably explains the government's reluctance to renegotiate the contract. Enforcing a contract in the face of political and public pressure can, however, be a tough proposition.

As Mr Marney observed, FSH will remain a State facility, and the political risks associated with the operation of the facility will likely mean that the State's ability to effectively enforce contract provisions that shift risk will be weakened, particularly if—as in the case of RNS—enforcing the contract means also negatively impacting on patient experiences.

DoH insists that all ICT project delivery risks have been transferred to Serco

DoH has identified 'ICT project delivery risk'—which is said to be the risk that the ICT project is not on budget or on time—as a risk that has been entirely transferred to Serco.[195] We raised doubts about the ability of the Department to achieve this high level of risk transfer given the history of poor management of ICT projects in Australia and overseas. We also noted that Serco was being asked to integrate its software with a new version of its patient administration system (**PAS**) known as webPAS, which is only currently being subject to testing at Fremantle Hospital. Integrating two separate software systems being developed simultaneously by separate companies is undoubtedly an undertaking replete with risks.

In response to our doubts about whether these risks could be genuinely transferred, DoH advised that the contract places obligations on Serco to integrate its software system with whatever system DoH has is in place on the day that FSH is opened. This requirement for Serco to be prepared for a number of options with respect to webPAS was taken as evidence that the risk of ICT project delivery had been transferred in totality to Serco.[196]

One of the general principles of contracting is that the private sector will accept almost any risk, but that in doing so a price will be extracted in the form of a 'risk premium'.[197]

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194 ABC News, *Meeting to address staffing dispute at RNS*, 7 May 2012. Available at: http://www.abc.net.au/news/2012-05-07/meeting-to-address-staffing-dispute-at-rns/3995586?section=nsw. Accessed on 5 June 2012.

195 Paxon Group, Commercial and Financial Analysis, July 2011, pp. 66–68; in Submission No. 27 from the Department of Health, 30 March 2012.

196 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 21.

197 Rui Sousa Monteiro, 'Risk Management', in Graeme A. Hodge (ed.), *International Handbook on Public-Private Partnerships*, Edward Elgar, Cheltenham, 2010, p. 274.

In other words, the more risk that is transferred by government, the more it will have to pay to the private sector in exchange for taking on those risks.

The likelihood that problems with the ICT project will arise is not negligible. The history of successful delivery of ICT projects in Western Australia, and within DoH in particular, is not strong. Serco and its IT subcontractors are being asked to integrate their own software with a PAS software package developed by DoH. The Auditor General has previously found that PAS was poorly procured and planned.[198] In the United Kingdom, the procurement of large-scale ICT projects through the use of PPP-type contracts has been abandoned due to many notable cost over-runs and delays.[199]

The role of the ICT service contingency payment in managing the State's ICT risk

DoH has acknowledged that Serco's bid for the ICT components represented 'high-cost and high-risk',[200] but maintains that the contract contains 'mechanisms' to deal with the 'uncertainties of large ICT projects'.[201] One such mechanism is the ICT service contingency payment, which is 'capped to reduce risk but retain possibility of variation due to unforseen events'.[202] The value of the cap is approximately 5 per cent of the total value of the ICT components in the FMSC.[203] The contract contains a number of conditions for payments under the contingency, but in broad terms it appears to be structured in such a way as to provide compensation to Serco for:

> *1 the resolution of any issues on the ICT Compliance Document to the satisfaction of the Principal and reflected in the ICT Service Plan for which the Facilities Manager incurs costs in achieving that resolution; and*
>
> *2 the identification, management and resolution of any ICT Additional Risks for which the Facilities Manager incurs costs in identifying, managing and resolving those ICT Additional Risks*.[204]

198 Auditor General for Western Australia, *ICT Procurement in Health and Training*, October 2010, pp. 6–7.

199 Jean Shaoul, 'A Review of Transport Public-Private Partnerships in the UK, in Graeme A. Hodge (ed.), *International Handbook on Public-Private Partnerships*, Edward Elgar, Cheltenham, 2010, pp. 558–559.

200 Submission No. 35 from the Department of Health, 15 May 2012, p. 4.

201 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 24 April 2012, p. 9.

202 Submission No. 35 from the Department of Health, 15 May 2012, p. 4.

203 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 10.

204 Facilities Management Services Contract, Schedule 7, p. 25.

The contract provides a definition for an ICT additional risk:

> *a risk in respect of the performance of the ICT Service that a world class information technology provider, with access to information that was accessible to the Facilities Manager at the Effective Date, could not reasonably have anticipated as at the Effective Date.*[205]

The ICT compliance plan is a document appended to the ICT service specification that details how Serco's ICT solution materially departs from the range of documents establishing Serco's responsibilities with respect to the ICT components of the project. The contingency payment exists, therefore, to compensate Serco should it incur costs either arising from an additional risk, as defined above, or from implementing solutions to the material departures included in the ICT compliance document.

Should one of the conditions arise wherein Serco can request compensation from the ICT contingency, it must submit a request for the payment to DoH, which will then consider the request before agreeing to the payment. It is open to the Department not to make a payment; however, Serco can use the dispute resolutions mechanisms in the contract if it feels that DoH has erred by failing to agree to make a payment.

Finding 41

The Department of Health acknowledges that the information and communication technology components of the Facilities Management Services Contract are high-cost and high-risk.

Finding 42

The information and communication technology (ICT) service contingency payment has been designed to cap the financial impact of risks arising from the ICT components of the Facilities Management Services Contract, whilst retaining the possibility of variation due to unforseen events.

The contingency payment may not limit risk with respect to ICT delivery

Although the Department has strongly asserted that the ICT contingency payment caps its liability for delays and cost overruns on the delivery of the ICT components, it is not clear that the contingency completely limits Serco's ability to request variations to the contract should it need to do so when delivering the ICT components.

As noted above, the ICT contingency can be accessed by Serco in order to resolve issues detailed in the ICT compliance document. The compliance document provides four categories describing where the ICT solution departs from the requirements established in the various contract documents governing ICT.

205 Facilities Management Services Contract, Schedule 7, p. 24.

The two categories of interest are:

- Further design required – Serco describes 24 separate requirements that have not been included in the overall ICT solution because the information available to Serco was insufficient to design a solution. Both Serco and DoH have agreed that the 24 requirements are necessary for hospital operation and both parties have undertaken to work together to add the elements to the overall ICT solution. Serco has noted that where the completed integration design for these requirements require material changes to the ICT solution, these **will be the subject of a variation**.[206] (Emphasis added).

- Service scope boundary—Serco noted in the compliance document that the services covered under management services will continue to be developed post-contract award and that it had not been practical to commit to the inclusion of the ICT to support these services at the time the contract was developed. Any additional ICT required to support these Services will be included in the finalisation of the service design and **will be the subject of a variation**.[207] (Emphasis added).

The language used by Serco to describe how these departures from the contract requirements will be resolved is revealing. Rather than describing access to the ICT services contingency payment, Serco notes that should changes to the service specifications be required for either the management and integration service or the ICT service, a variation will be lodged. The contract provides for separate mechanisms for resolving payments for variations. We sought clarification from DoH as to whether these variations would be covered by the ICT contingency payment, and the following response was provided:

> *The ICT compliance summary is made up of a number of different sections (for example: further design required, aspirational requirements etc.) some of these items would fall under an ICT contingency event and others may constitute a Variation. Each would need to be addressed on a case by case basis at the time. Payment might be drawn from the ICT contingency pool or be subject to a Variation requiring Principal approval. They are mutually exclusive alternatives. It is envisaged that many of the compliance issues may be resolved with no requirement for additional funding. There will be some that will require further work and may trigger an ICT contingency event. For some other 'unknowns' they may be subject to Variation*

206 Serco Australia, *ICT Compliance Summary*, August 2011, p. 8; in Submission No. 34 from the Department of Health, 4 May 2012.

207 Serco Australia, *ICT Compliance Summary*, August 2011, p. 13; in Submission No. 34 from the Department of Health, 4 May 2012.

> *rather than an ICT contingency event. Where there is a 'material' change to the ICT Solution (i.e. the Principal elects to change the 'output requirements') this would constitute a Variation and would be done in accordance with section 26 of the FM Contract. Note also that the order of precedence within the contract is that the ICT contingency payment ranks before any potential variation.*[208]

Although we acknowledge DoH's view that most of the issues on the ICT compliance summary can be resolved without the need for additional funding, we note that Serco and DoH seem to have a different view as to when a variation might be necessary. DoH has stated that a variation might be necessary in response to a procurer (i.e. the Department) elected change, whereas Serco has stated in the compliance document that changes to the ICT solution to integrate the issues on the ICT compliance summary will be subject to a variation. This seems to be a fundamental divergence of views, and suggests that there may yet be negotiations between DoH and Serco to settle the true cost of implementing the ICT solution at FSH.

We note the experience in the UK, where many contract managers have described how contractors will use the variations process to extract additional money from the contract:

> *Without doubt, the private sector will try to come back for extra money for every risk they haven't thought of before and do so by trying to pass off that risk as something new. They will use everything to increase costs, in particular any ambiguities in the trust's requirements. It is like a game of chess and you need an experienced team who knows how to play the game in order to obtain value for money.*[209]

If Serco is able to use the variations process to resolve the issues on the ICT compliance document, then it suggests that DoH's risk with respect to ICT delivery has not been capped by the ICT contingency payment.

Finding 43

The State's exposure to the risk of cost escalation in the delivery of the information and communication technology (ICT) components of the project may not be capped, as the Department of Health states, if Serco requires variations to the contract in order to deliver the services identified on the ICT compliance document.

208 Submission No. 38 from the Department of Health, 14 June 2012, p. 12.

209 Lonsdale, Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy & Politics*, 35, 4, p.684.

How PPPs theoretically allow optimal risk allocation and management

A traditional approach to the procurement of a hospital might require a government to issue separate contracts for the following stages:

- Designing the infrastructure
- Building the infrastructure
- Maintaining the infrastructure
- Operating the infrastructure[210]

PPP contracts, on the other hand, typically bundle each of the services above—plus financing—into a single contract let to a single entity, which is usually some form of special purpose vehicle (**SPV**) that brings together financiers, builders and FM specialists. The theoretical logic behind bundling services that might otherwise be separately procured is reasonably straight-forward. In traditionally procured projects, each contractor's involvement with the project is limited, and their interests in the project—and the incentives levied against them—extend only as far as their last payment. The benefit of bundling is that it ensures that if one company is assigned the responsibility to design, build, finance, maintain and operate an asset, then the incentives will have aligned on that company to increase the likelihood that the project has been optimised for long-term operation, because the entity will be involved in the hospital for a longer-term.[211]

Not all bundling is equally effective.

- Bundling design and construction creates incentives for 'cutting corners', reducing the quality of the infrastructure and its expected lifespan, because the incentives aligned on the entity responsible for design and construction end once construction has been completed.
- Bundling construction and maintenance allows contractors to link performance failures to design errors and so obtain compensation for increased cost.
- Bundling design, construction and maintenance and often operation (over an extended period, usually 20–35 years) creates incentives for efficient delivery of infrastructure, linking payment to the performance of infrastructure or to the effective delivery of services.[212]

The nature of the contract does not allow for optimal risk management

One of the critical theoretical benefits of PPP contracts is the realisation of efficiencies through the bundling of design, construction, finance, maintenance and operation of an asset. We examine the background to this theory in more detail below, but put simply efficiencies can be achieved by aligning incentives on a single entity to design,

210 Jean-Etienne de Bettignies and Thomas W. Ross, 'The economics of Public-Private Partnerships: some theoretical contributions', in Graeme A. Hodge (ed.), *International Handbook on Public-Private Partnerships*, Edward Elgar, Cheltenham, 2010, p. 131.

211 Private briefing.

212 Rui Sousa Monteiro, 'Risk Management', in Graeme A. Hodge (ed.), *International Handbook on Public-Private Partnerships*, Edward Elgar, Cheltenham, 2010, p. 261.

build and then operate an asset over an extended period.[213] These incentives allow for optimal risk allocation and the maximisation of cost efficiencies.

Because the FMSC covers only the maintenance and operation of the FSH, many of the benefits, particularly with respect to the management of risk, cannot be realised in the same way that they would be had a full PPP approach been adopted. For example, because Serco's input was not sought at the very early stages of the design process, its experience as an FM provider in hospitals could not be fully utilised when designing the Hospital, and so there remains a greater risk that the design may not have been optimised to reduce life-cycle costs had Serco been involved with the project from the beginning.

Competitive neutrality

According to the Productivity Commission, competitive neutrality policies aim to promote efficient competition between public and private businesses. Specifically, they seek to ensure that government businesses do not enjoy competitive advantages over their private sector competitors simply by virtue of their public sector ownership. All Federal, State and Territory Governments have agreed to implement competitive neutrality policies as part of the National Competition Policy reform package.

The principle of competitive neutrality does not extend to competitive advantages arising from factors such as business size, skills, location or customer loyalty.

The Western Australian policy on competitive neutrality provides the following examples of competitive advantages that may be enjoyed by government businesses:

- Exemption from taxes and charges. For example, government businesses may be exempt from Federal income and wholesale sales taxes, State taxes and local government rates;
- Exemption from Corporations Law reporting requirements;
- Explicit or implicit government guarantees on debts, which may permit government businesses to operate at a loss and with freedom from the threat of insolvency;
- The cost of capital may be lower for government businesses because of the lower risk of dealing with governments which have the power to tax;
- Government businesses may be able to purchase inputs provided by other government businesses at concessional prices relative to those charged to private firms;

213 Private Briefing.

- Government businesses are free from the threat of takeovers; and
- Government businesses may be immune from particular regulatory requirements.

DoH advised that the impact of payroll tax was the only competitive neutrality adjustment made to the PSC, and has valued it at $67.9 million. The $67.9 million figure would have been calculated on the basis of the statutory rate of 5.50 per cent and applied to the estimated operating costs involving labour costs.[214]

Finding 44

The only competitive neutrality calculation applied to the public sector comparator for the Facilities Management Services Contract related to the exemption from the payment of payroll taxes by State Government bodies.

The discount rate

The small quote which begins this chapter relates to the role of the discount rate in calculating whether a private sector bid represents value for money (**VfM**) when compared to a traditionally procured project. Discount rates are the final modification made to both the PSC and private sector bids in order to create cost figures that are directly comparable. The discount rate achieves this comparability by converting the projected cash flows of the project (for private bids and the PSC) over the project life into present monetary values—the net present cost of the project. This is necessary because the PSC and private bids will invariably have different cash flows over the project's life, meaning that a comparison of figures in anything but present dollar terms will not be meaningful, because in finance theory, the value of money decreases over time.

The calculation of the discount rate is a reasonably complex process, and has been summarised on page 91.

Our interest in the discount rate is two-fold: were the relevant guidelines followed, and were the series of assumptions that underpin the development of the discount rate credible? Paxon completed the development of the discount rate for DoH and it would seem that the relevant IA Guidelines were followed. There are, however, some inconsistencies in the approach adopted that require elaboration.

A different asset beta was used for PSCs in August 2010 and July 2011

DoH and its commercial advisors would appear to have followed the IA Guidelines and allocated asset betas using the standards established by Infrastructure Australia. Across a period of 12 months, however, they have been inconsistent with the value of the

214 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 25 October 2012, p. 19.

asset beta used and, perhaps most alarmingly, the asset beta shifted from low-risk to very low-risk, despite an increase in the risk profile of the project.

It is not uncommon for a number of PSCs to be developed during procurement processes because the nature of projects will change as they are refined, and the understanding of issues like risk will increase as familiarity with the project also increases. The IA Guidelines allow for these changes, although it is suggested that changes should be well-documented. As we have outlined in earlier parts of this chapter, we have received four different versions of the PSC from DoH. It is the two most recent PSCs that are of interest because they have been calculated using different asset betas.

Asset betas are used in some finance calculations as a measure of systematic risk and they are central to the development of the discount rate to be applied to the private sector bids.[215] Asset betas are defined in the IA Guidelines, which provides for a consistent approach to the application of systematic risk in PPPs in Australia. The asset beta defines asset types according to 'very low', 'low' or 'medium' risks. As **table 5.3** on page 93 details, social infrastructure projects tend to fall under the very low risk category whilst highly technical projects are classified as medium risk.

Between June and August of 2010, DoH evaluated the two bids received from the shortlisted respondents and, as part of that evaluation process, the project's commercial advisor further refined the PSC that had been completed in May. A number of services were excluded from the comparative analysis on the basis that bids had not been received for the services or on the basis that the scope for the services were, at the time, relatively unknown. As a result, the high-risk ICT services and the MES, and several other lower-risk services, were excluded from the calculation of the PSC.[216] The decision by the commercial advisor to exclude these services is not in doubt; however, the decision to allocate an asset beta of 0.5[217] to the project at this point would seem inconsistent with the risk profile of the project itself and also with the categorisation of systematic risk for hospital facilities established by Infrastructure Australia.

215 Significantly more information on systematic risks, asset betas and discount rates is contained in the text box below.

216 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions*, September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

217 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions*, September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

Calculating the discount rate (2)

Systematic Risk Type	Percentage of risk allocated to private sector	Actual risk transferred
Demand	15%	$0.15 \times 0.54 = 0.08\%$
Inflation	80%	$0.80 \times 0.72 = 0.58\%$
Residual Value	25%	$0.25 \times 0.18 = 0.04\%$
Increased Downturn	25%	$0.25 \times 0.36 = 0.09\%$
	Total	**0.79%**

Once the allocation of systematic risk is known, the PPP discount rate can be calculated using the following formula:

risk-free rate + allocated systematic risk premium = PPP discount rate

In Western Australia, the risk-free rate is generally equal to an average of the 10-year Government Bond rate and is provided by the Western Australian Treasury Corporation. For the purposes of this example, we have assumed that the risk-free rate is 5.30 per cent. Therefore, the PPP discount rate applied to the PPP bid for our example would be 6.09 per cent.

It is important to note that different discount rates are applied to the PSC and the PPP project proposals. Because no systematic risk is transferred to the private sector in a PSC, the risk-free rate is the discount rate used.

Another PSC was completed by the commercial advisor in July 2011. According to DoH, this PSC was 'amended and updated to reflect changes once negotiations with the preferred respondent had been completed'.[218] Once again, updating the PSC to reflect the contract as signed with the private provider is standard practice and endorsed in the IA Guidelines. Once negotiations with Serco were completed, all elements of the contract were incorporated into the PSC, including the ICT components and the MES contract signed with Siemens.

ICT contracts are generally considered to carry greater levels of risk than other types of infrastructure contracts and this is reflected in Infrastructure Australia's categorisation of systematic risks outlined in **table 5.3** below. ICT projects are categorised in the medium risk band and assigned an asset beta of 0.9.

In the PSC completed in August 2010, this significant element of the project and the risk carried with it would appear—quite appropriately—not to have been incorporated. However, when the ICT components were included in the PSC developed in July 2011, an asset beta of 0.3[219] was utilised indicating that the commercial advisors took the

218 Submission No. 20 from the Department of Health, 6 February 2012, p. 4.

219 Paxon Group, *Commercial and Financial Analysis,* July 2011*,* p. 79; in Submission No. 27 from the Department of Health, 30 March 2012.

Table 5.3: Asset betas established in the IA Guidelines[220]

Risk band	Project sectors and example projects	Asset beta	Real risk premium
Very low	**Accommodation and related services** Aged care housing Public Housing Hospital facilities Correctional facilities	0.3	1.8
Low	**Water, transport and energy** Wastewater treatment plants Water infrastructure Hospital car parking Hospital energy plants Road projects (non-toll)	0.5	3.0
Medium	**Telecommunications, media and technology** Entertainment Telecommunications and IT Knowledge economy	0.9	5.4

view that the systematic risk profile of the project had decreased despite the inclusion of the ICT components.

The risk profile of the project being modelled in the July 2011 PSC was evidently higher than the risk profile of the project modelled in the August 2010 PSC: the earlier PSC excluded ICT and MES, the latter PSC included them. Despite this, Paxon assessed the systematic risk of the project in July 2011 as being lower than the systematic risk for the project in August 2010. This is a counter-intuitive shift that is not supported by the evidence or the guidance contained in the IA Guidelines.

Finding 45

Two different measures of systematic risk were applied to the public sector comparators (PSCs) completed in August 2010 and July 2011.

- The information and communications technology (ICT) components of the project were excluded from the August 2010 PSC; however, they were included in the PSC developed in July 2011. ICT is generally considered to be a high-risk infrastructure type reflected in the risk-banding assigned by Infrastructure Australia (IA).
- ICT represents a significant proportion of the total cost of the Facilities Management Services Contract.
- The measure of systematic risk applied to the August 2010 PSC was greater than that assigned to the July 2011 PSC despite the exclusion of high-risk ICT from the earlier version.

220 Infrastructure Australia, *Discount Rate Methodology*, December 2008, p. 23.

- This is a counter-intuitive shift in measurement that is not supported by the evidence or the guidance contained in the IA Guidelines.

DoH could not adequately explain the changed asset beta

We asked DoH to account for what would appear to be counter-intuitive shifts in the risk ratings assigned to the project by the commercial advisor. DoH provided the following advice:

> *The asset beta was chosen to best align with advice provided by Infrastructure Australia in the National PPP Guidelines and analysis of appropriate Asset Beta for public hospital projects.*[221]

We also asked DoH what actions it had taken to satisfy itself that the change had been appropriate:

> *The Department of Health and the then Department of Treasury and Finance reviewed the asset beta scores and deemed them to be appropriate and in-line with Infrastructure Australia National PPP Guidelines.*[222]

This is a non-answer that failed to adequately explain why the asset beta was reduced at the same time that the risk profile of the project increased.

Finding 46

It seems likely that the Department of Health did not have sufficient understanding of the work of its commercial advisor to adequately scrutinise important assumptions that were being applied in the public sector comparator.

Recommendation 3

The Department of Treasury needs to apply a greater level of scrutiny to the work being carried out by commercial advisors on public private partnership (PPP) and PPP-type projects on behalf of State Government agencies.

The impact of ICT was not reflected in the calculation of systematic risk

The impacts of the risk of ICT components have been considered in the application of the appropriate risk beta in other Australian hospital projects. The commercial advisors on the Royal Adelaide Hospital, for example, noted that that project has a 'significant ICT component'—valued at approximately five per cent of the overall project—which includes a 'complex integration engine delivered by the private sector'.[223] The

221 Submission No. 35 from the Department of Health, 15 May 2012, p. 6.
222 Submission No. 35 from the Department of Health, 15 May 2012, p. 6.
223 Ernst & Young, *New Royal Adelaide Hospital: Systematic Risk Transfer and quantitative VfM analysis*, June 2011, p. 14

commercial advisors took the view that the ICT components of the South Australian Hospital added 0.03 to the project's asset beta.[224]

By way of contrast, the value of the ICT components in the contract signed with Serco is closer to 15 per cent (in NPC terms) of the overall project.[225]

Finding 47

Despite representing a significant proportion of the total cost of the Facilities Management Services Contract, and belonging to the higher risk band, the ICT components were not taken into account when calculating the discount rate used to analyse bids.

Recommendation 4

The Department of Treasury needs to ensure that the asset beta used for projects with significant information and communications technology (ICT) elements reflect the risk associated with ICT projects when calculating discount rates.

Changes to the asset beta values impact upon VfM calculations

As we have already outlined, the determination of VfM relies on discounting total dollar figures to NPC amounts. It is possible that the outcome of the VfM comparisons may change once the discounted figures have been calculated. In other words, a PSC might offer a lower cost solution when non-discounted figures are used; however, once discounted cash flow (**DCF**) analysis occurs, that result might change. Therefore, it is important to ensure the use of the right discount rate.

In the case of the August 2010 PSC, its non-risk adjusted, non-discounted value is approximately $115 million cheaper than the raw costs calculated for the provision of the services by Serco.[226] That is to say, before risk adjustments were made to the numbers and before DCF analysis was undertaken to calculate the net present cost of the two options, public sector delivery of the FMSC was calculated to provide the lower cost alternative. Once risk adjustments were made, the PSC's cost advantage was more than reversed.

When carrying out the DCF, the use of an asset beta of 0.5 rather than 0.3 meant that the discount rate applied to Serco's bid was much higher than the corresponding discount rate applied to the PSC. This meant that Serco's risk-adjusted bid went from

224 Ernst & Young, *New Royal Adelaide Hospital: Systematic Risk Transfer and quantitative VfM analysis*, June 2011, p. 14

225 Submission No. 27 from the Department of Health, 30 March 2012.

226 Department of Health, Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions, September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

being 8.3 per cent cheaper (in nominal terms) than the PSC to over 16 per cent cheaper once the values had been discounted.

The risk-free rate used is inconsistent with the IA Guidelines

The IA Guidelines require the use of jurisdiction specific government bond rates for determining the appropriate risk-free rate when calculating the discount rate.[227] In other words, the Western Australian Government's 10-year bond rate should be used, and not the equivalent Commonwealth bond rate. However, in the 'sources and assumptions' document Paxon notes that the risk-free rate has been determined by the use of the '10-year Commonwealth Government Bond Rate' as quoted by the Western Australian Treasury Corporation on 25 March 2011.[228] Paxon indicates that the bond rate (and therefore the risk-free rate) was 5.45 per cent. This corresponds to the Commonwealth 10-year bond rate on that day.

If the Western Australian 10-year bond rate had been used as required by the IA Guidelines, the risk-free rate would have been in the range of 5.92–5.935 per cent.[229]

Finding 48

The Department of Health's commercial advisor did not follow the Infrastructure Australia Guidelines when it used the 10-year Commonwealth Government bond rate, rather than the equivalent Western Australian bond rate, to determine the risk-free rate used during the calculation of the discount rate for the project.

Assumptions for assigning systematic risk lack fidelity

As detailed in the previous chapter, one of the crucial responsibilities of the commercial advisor is to determine the extent to which systematic risks have been transferred to the private sector. As each project is unique, commercial advisors are required to apply their experience to projects when carrying out this task.

Paxon determined that 87 per cent of the demand risk for the project had been transferred to Serco, because 87 per cent of the contract is fixed price.[230] In other words, if demand for hospital services increases, then the risk associated with that increase in demand sits with Serco, because a very high percentage of the contract is for a fixed price and therefore the price paid by the State is mostly immune to shifts in

227 Infrastructure Australia, *Discount Rate Methodology*, December 2008, p. 14.

228 Paxon Group, *Sources and Assumptions,* May 2011, p. 45; in Submission No. 31 from the Department of Health, 20 April 2012.

229 Mr Wayne Currie, Corporate Treasury, Western Australian Treasury Corporation, *Telephone Conversation*, 23 April 2012.

230 Paxon Group, *Sources and Assumptions,* May 2011, p. 45; in Submission No. 31 from the Department of Health, 20 April 2012; and Paxon Group, *Commercial and Financial Analysis*, July 2011, p. 81, in Submission No. 27, Department of Health, 30 March 2012.

that demand. In the absence of a better description, this is what we have called demand growth risk.

In considering the extent of this risk, it is important to evaluate the extent to which upside risk can be present in an operating hospital. DoH itself has acknowledged that occupancy rates for the hospital 'will quickly reach full operating capacity' and that infrastructure planning 'assumes a 90% occupancy for tertiary hospitals'.[231] Clearly, demand is constrained by the hospital's size. In other words, for demand to meaningfully exceed the limits of FSH—limits that are expected to be reached shortly after the hospital opens—an expansion of the physical asset would be required and any such expansion would be outside the scope of the FMSC.

Given this, there is very much an upper limit to the extent that demand can grow over the life of the contract and this upper limit reflects the operational capacity of the hospital. The suggestion, therefore, that 87 per cent of systematic demand risk has been transferred to Serco lacks fidelity and fails to take into account the possibility that demand will be less than anticipated. What this means is that there is a risk that the facility will be under-utilised and that DoH will continue to pay Serco 87 per cent of the contract by value regardless of whether FSH is under-utilised.

Can the PSC be used to determine whether the project represents value for money?

Any PSC completed for any project faces a number of limitations when it comes to attempts to try and definitively establish whether a project represents value for money. Firstly, and perhaps most significantly, the results of the PSC are simply the outcome of a series of financial models that provide a projection of the costs of a project that will probably never exist. The PSC is developed, after all, to provide no more than a comparison to the cost of a project that actually will be developed.

Furthermore, because the PSC is simply a financial model, it cannot provide any guidance on the question of value for money for the non-financial aspects of the project. It is possible, for example, for the more expensive option to provide superior value for money once non-cost factors are taken into account. A better project may be cheaper than alternatives, but overall value for money may point to a more expensive project.

Relying on the PSC and its emphasis on projected costs when attempting to determine value for money can be problematic for other reasons, too. As has been made clear throughout this chapter, the numbers used to calculate the PSC are little more than

231 Submission No. 36 from the Department of Health, 15 May 2012, p. 2.

assumptions, subject to the same variability of any estimate. As we have seen, assumptions are made about the:

- Raw costs used for inclusion in the PSC, including estimated savings derived from delivering these services in new facilities.
- Risk valuation and allocation.
- Discount rate applied to the private sector bid.

We have also seen how poorly scoped service specifications impacted upon the quality of the PSC results produced throughout the life of the procurement process. Once again, if the information going in to the PSC is not of sufficient quality, then the level of assurance that can be attached to the results of the PSC must surely be diminished.

Given the uncertainty associated with the calculations used in the PSC, it would be significant error to assume that a PSC result can definitively establish the relative value for money offered by a private bid compared to the public sector. The question of VfM can only be answered once the contract is operational, and the question of achieving VfM moves from the hypothetical to the practical. In order to achieve the savings projected as a result of the PSC process, DoH will need to manage its contract assiduously, ensure that risks that it has paid to transfer to Serco remain transferred, an enforce the quality provisions of the contract through the appropriate use of performance regimes and payment abatements.

It is in the operation of the contract that the definitive answer about value for money may be provided.

Chapter 6

The Contract in Operation

No monitoring; no value for money.[232]

Ensuring value for money

Given the extent of the services that Serco will be providing at the Fiona Stanley Hospital (**FSH**) it should come as little surprise that the Facilities Management Services Contract (**FMSC**) is a substantial document, running to eight volumes once its attachments, appendices and schedules are included.

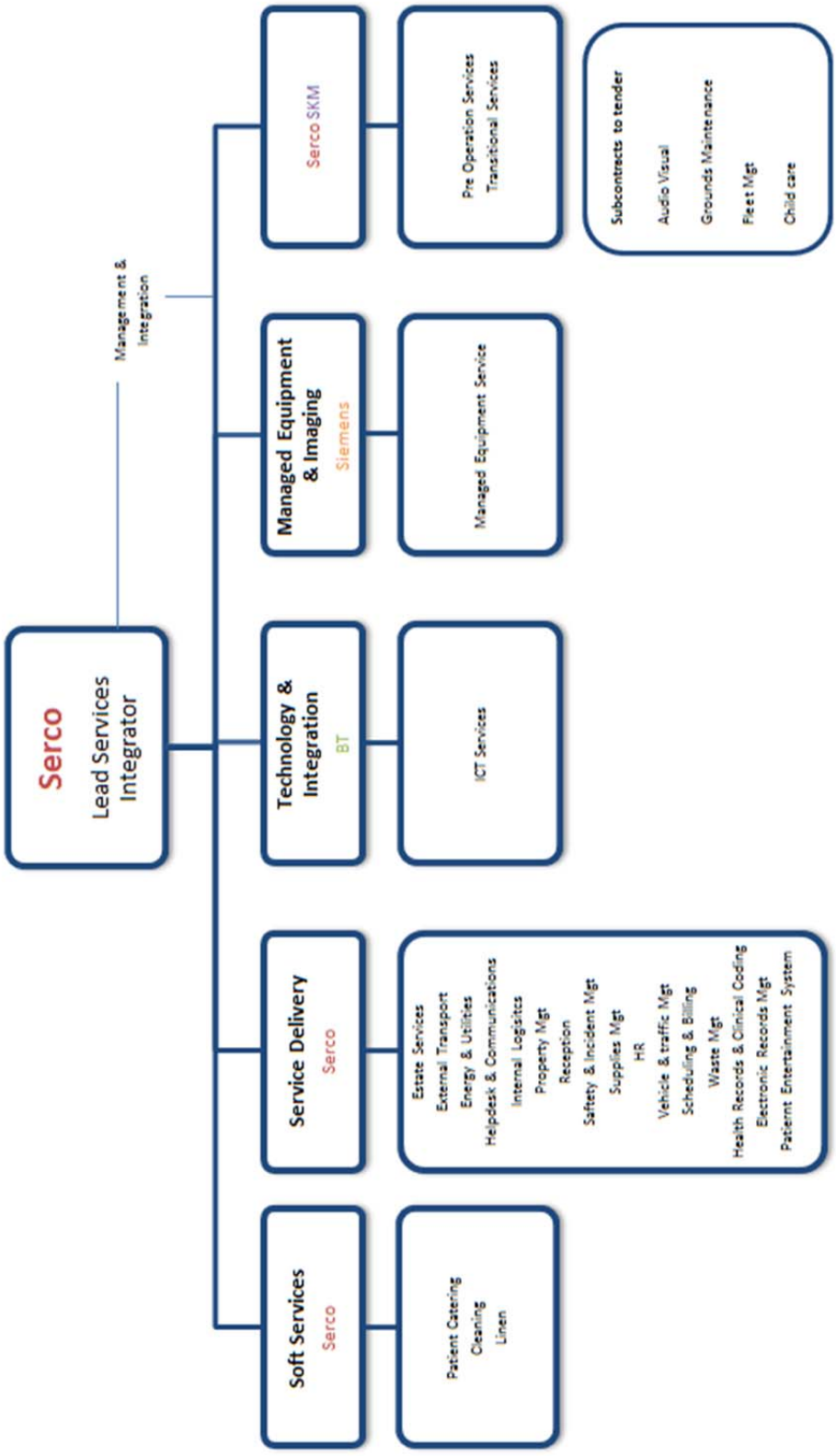
It is only once the hospital is operational, and the eight written volumes of the contract are used by the Department of Health (**DoH**) as the basis for the management of its relationship with Serco, that it will be possible to accurately get a sense of whether or not the contract is delivering value for money (**VfM**) for the State. Until the hospital is operational, questions of value for money will rely upon the series of models developed to support the procurement process. As we have outlined, these models are based upon a series of assumptions about the anticipated costs for the project, and the results can vary wildly depending upon the nature of those assumptions.

The question of value for money can therefore only really be settled once the contract is in operation and Serco is delivering the services in an operational environment. Once the contract is operating, the issue of value for money is influenced by a number of important factors, including:

- The extent to which Serco is delivering the services to the standards expected;
- How the contract empowers the State to ensure that Serco meets the standards required; and
- The willingness of the State to enforce the contract to ensure value for money.

Each of these issues is interlinked. The United Kingdom's National Audit Office (**UKNAO**) has noted that contractors will 'seek to pass risk back to the taxpayer if

232 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 694.


Serco
Lead Services Integrator
Management & Integration
Soft Services
Serco
Patient Catering
Cleaning
Linen
Service Delivery
Serco
Estate Services
External Transport
Energy & Utilities
Helpdesk & Communications
Internal Logistics
Property Mgt
Reception
Saftety & Incident Mgt
Supplies Mgt
HR
Vehicle & traffic Mgt
Scheduling & Billing
Waste Mgt
Health Records & Clinical Coding
Electronic Records Mgt
Patient Entertainment System
Technology & Integration
BT
ICT Services
Managed Equipment & Imaging
Siemens
Managed Equipment Service
Serco SKM
Pre Operation Services
Transitional Services
Subcontracts to tender
Audio Visual
Grounds Maintenance
Fleet Mgt
Child care

[agencies] do not meet their obligations or enforce the contract'.[233] In effect, this means that the State has paid Serco to both deliver services under the contract and to also accept risk that the State has sought to transfer. As we outline in this chapter, the FMSC contains many features that assist the Department to defend its position relative to Serco once the contract is operating. Those features will count for nothing—as the UKNAO noted—if DoH fails to effectively monitor Serco's performance and enforce the contract should the performance fall below the standards outlined in the contract.

Some important elements of the FMSC

The contract covers three distinct phases of the hospital's operational life

The contract acknowledges that in delivering services at FSH, Serco will be operating in three distinct phases of the life of the hospital:

- Pre-operations: covers the period from July 2011 to December 2013. During this time, Serco will conduct all planning and procurement required to establish the 28 services it is delivering, prior to practical completion of FSH.

- Transition: covers the period from December 2013 to April 2014. During this time, Serco will provide planning and service provision prior to commencement of operations.

- Operation: the period from April 2014 (when FSH opens) to the expiry of the term of the contract, including 2 five-year extension options.[234]

Serco must have management and service plans in place

During the pre-operations period, Serco must refine the service plans and management plans (henceforth, the facilities management plans (**FM Plans**)) into finalised documents. The FM plans were initially submitted by Serco as part of its response to the request for submissions (**RFS**). When the RFS was issued, DoH advised shortlisted respondents that the FM plans would be refined throughout the procurement process, including during negotiations with the preferred bidder and then refined further once the contract had been awarded.[235]

The FM plans contain two sub-categories: management plans and service plans. Both types of plans must 'fully describe the policies, procedures, protocols, method

233 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 29.

234 Department of Health, *Fiona Stanley Hospital: Facilities Management Services Project – Project Summary*, February 2012, p. 4.

235 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.

Table 6.1: Facilities Management Plans for FSH[236]

Service Plans	Management Plans
Audio Visual Service Plan	Acceptance Testing Plan
Cleaning Service Plan	Australian Industry Participation Plan
Electronic Records Management Service Plan	Authorisations Plan
Energy and Utilities Service Plan	Communication Plan
Estate Services Plan	Complaints Management Plan
External Transport Service Plan	Contract Management Plan
Fleet Management Service Plan	Emergency Management Plan
Grounds Maintenance Service Plan	Environmental Management Plan
Health Record Management and Clinical Coding Service Plan	Health and Safety Plan
Human Resource Management Service Plan	Human Resources and Learning and Development Plan
Information and Communications Technology Service Plan	Information and Communications Technology Management Plan
Internal Logistics Service Plan	Industrial Relations Plan
Linen Service Plan	Infection Control Plan
Managed Equipment Service Plan	Interface Management Plan
Management and Integration Service Plan	Managing Contractor Interface Plan
Patient Catering Service Plan	Quality Assurance Plan
Patient Entertainment Systems Service Plan	Risk Management Plan
Pest Control Service Plan	Security Management Plan
Pre Operational Service Plan	Service Improvement and Customer Service Plan
Property Management Service Plan	Site Access Plan
Reception Service Plan	Stakeholder Management Plan
Safety and Incident Management Service Plan	Termination Plan
Scheduling and Billing Service Plan	Transition Plan
Sterilisation Service Plan	
Supplies Management Service Plan	
Transitional Services Plan	
Vehicle and Traffic Management Service Plan	
Waste Management Service Plan	

statements and other requirements that fully describe the manner in which the Facilities Manager will perform its obligations under this Contract'.[237] The management plans are also required to outline the strategies and methodologies that Serco agrees to adopt in order to deliver the full range of services in an 'integrated and seamless fashion'[238] and must be 'developed to align and be consistent with the Management and Integration Service'.[239]

A service plan is required for each of the 28 individual services being procured through the FMSC. In addition to the service plans, 23 individual management plans must be provided. These are outlined in **table 6.1** above.

236 Facilities Management Services Contract, Schedule 1
237 Facilities Management Services Contract, Schedule 1, p. 3.
238 Department of Health, *Evaluation Report: Fiona Stanley Hospital – Facilities Management and Support Services Request for Submissions,* September 2010; in Submission No. 29 from the Department of Health, 3 April 2012.
239 Facilities Management Services Contract, Schedule 1, p. 3.

Table 6.2: Detail required in different levels of the FM Plans[240]

Level 1	Level 2	Level 3
The draft Service Plan should be in overview format providing sufficient detail to describe the solution, justify the proposed price and address: • resources required to deliver the solution; and • interaction with other systems.	The draft Service Plan should be in sufficient detail to fully describe the solutions, justify the proposed price and fully describe: • all functions and processes; • a detailed resourcing and rostering strategy; • all specific equipment required to provide the service at operational commencement; and • all of the systems, functional specifications and design components.	The Service Plan should be in a complete format and include all necessary detail required to support full operations including the following: • describe the work processes and procedures; • policies and operating manuals; and • a scheduling timeline including milestones.

Pre-operational milestones have been set for Serco

The contract sets milestones for when Serco must have completed its facilities management plans during the pre-operations period. Schedule 14 of the contract establishes pre-operational milestones that must be achieved by Serco by the prescribed date. The milestones require Serco to have completed all FM plans to the level of detail described under 'level 3' in **table 6.2** above before December 2012. At the time of writing this report, Serco had met the two pre-operational milestones that it had been obliged to deliver[241]—the first at the end of October 2011 and the other at the end of December of the same year.

Acceptance testing is central to the pre-operations and transitions periods

Serco must demonstrate that it can deliver each individual aspect of the 28 services it has been contracted to provide through a series of acceptance tests that must be held before the hospital opens. These are intended to test the performance of the services to the standards required in the contract within an operational hospital. Upon receiving the results of the acceptance tests, DoH will determine whether the acceptance tests have been passed. Should the Department determine that the tests have not been passed, Serco can be instructed to repeat the test.[242]

Facilities management plans were not finalised at contract closure

Prior to the execution of the contract, Serco was only required to have completed its service plans to the level of detail required in level 2 outlined in **table 6.2** above. This

240 Department of Health, *Request for Submissions for the provision of facilities management and support services for the Fiona Stanley Hospital*, February 2010, Schedule 2; in Submission No. 30 from Department of Health, 17 April 2012.

241 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 24 April 2012, p. 11.

242 Facilities Management Services Contract, Clause 14, p. 96.

has meant that important detail about how Serco intends to operate and deliver its services in the functioning hospital were not resolved at the time the contract was signed.

To the greatest extent possible, the parameters for how the services are to be delivered at FSH should have been finalised during the contract negotiation period. The UK National Audit Office has noted that outstanding issues at contract close should be kept to a minimum,[243] and although any changes that might be made to the FM Plans would seem unlikely to impact upon the cost to the State of delivering the services, there may be an impact on the quality of service provision.

Finding 49

Important details about how Serco would deliver the services at Fiona Stanley Hospital were not finalised at the time that the contract was signed with Serco. These details will continue to be refined in the lead-up to the commencement of operations at the hospital in April 2014.

In particular, we noted that in the current version of the cleaning service plan, Serco has undertaken to encourage hospital employees to 'approach the dedicated Cleaning Service Personnel directly to request cleaning tasks'.[244] However, the procedure that will deliver this level of flexibility will only be developed as part of the 'level 3 plan'. Similar interactions between clinical staff and service staff in similar contracts in the UK and elsewhere have historically been very different.[245] Generally, hospital employees have not been able to directly request the completion of certain tasks, including cleaning, because such direct interactions bypass the reporting mechanisms required for the service provider to report on performance, and also to calculate its monthly service charge. The ability of hospital employees to directly request cleaning tasks is, therefore, a significant contract element and one that provides a material contribution to the overall value for money offered by the contract. As a result, Serco's plan for how these direct interactions would be managed should have been provided in detail as part of the contract negotiation process.

The incomplete FM Plans also have an effect on the key performance indicators (**KPIs**) contained in the service specifications. To continue with the example from above, six of the 18 KPIs relating to cleaning require that cleaning be carried out in accordance with the cleaning service plan. Unfortunately, it will only be in the next version of the cleaning service plan that the 'processes for each type and level of cleaning required including Scheduled Cleaning, Isolation Cleaning, cleaning required for the discharge or

243 UK National Audit Office, *A Framework for evaluating the implementation of Private Finance Imitative projects: Volume 2*, May 2006, p. 24.

244 Serco Australia, *Cleaning Service Plan*, March 2011, p. 17. In Submission No. 34 from the Department of Health, 4 May 2012.

245 Private Briefing.

transfer of Patients, cleaning of specific wards and cleaning of departments' will be established.[246]

That the KPIs would be established and make specific reference to Serco's obligations under the cleaning service plan before those obligations had been agreed to in detail is less than ideal.

Finding 50

Many of the key performance indicators against which Serco's performance in delivering the services will be measured require Serco to perform tasks in accordance with detail contained in the service plans.

Finding 51

Many of the service plans, including the cleaning service plan, have not been completed to the level of detail where Serco has outlined how it will deliver the services. This means that the key performance indicators are making specific reference to Serco's obligations in the service plans before those obligations have been agreed to in detail.

The role of the Helpdesk

The Helpdesk serves as the first point of contact for hospital employees to log service requests or complaints. Once a request has been logged, the Helpdesk determines the appropriate task that is required, assigns a rectification time in compliance with the standards set in the KPIs and also determines the priority of the request. The processes for assigning priority will be finalised for incorporation in the level 3 Helpdesk and communications service plan when it is completed by the end of 2012.[247]

Once a task has been created it will be assigned by the Helpdesk to personnel via portable devices connected to the hospital's wireless network. Helpdesk operators will be trained to analyse service requests to determine the following:

- What trades or skills are required to complete the request;
- What priority is required to complete the request in accordance with the Department's priorities and timeframes;
- Who will be assigned the work based on trade, skill and geographical location; and

246 Serco Australia, *Cleaning Service Plan*, March 2011, p. 44. In Submission No. 34 from the Department of Health, 4 May 2012.

247 Serco Australia, *Helpdesk and Communications Service Plan*, March 2011, p. 16. In Submission No. 34 from the Department of Health, 4 May 2012.

- In the case of an estate services request, whether the estate service personnel's workload enables them to attend to the request within the attendance time or if work priorities need to be altered.[248]

Accurate record keeping by the Helpdesk will provide the most efficient way for the performance of Serco to be monitored. For example, calls received by the Helpdesk will be time logged, and the Helpdesk will be advised when a task is attended to and when it has been rectified. This performance information will be logged, and any non-compliance with KPIs will be used in the calculation of any monthly payment abatements.

This reliance upon data collected by the FM provider in the monitoring of performance is a common feature of similar contracts in Australia and internationally. Independently gathering the data required would probably require significant investment in resources and an unnecessary duplication of effort. Nonetheless, we would expect DoH to robustly and regularly audit the quality and accuracy of information being recorded by the Helpdesk in order to independently verify that the services are being delivered in accordance with the requirements established by the contract.

Finding 52

Information about the performance of Serco in delivering the services at Fiona Stanley Hospital will be recorded through the centralised Helpdesk, which is a service also provided by Serco.

Recommendation 5

The Department of Health needs to regularly audit the quality and accuracy of information being recorded by the Helpdesk in order to independently verify that the services are being delivered in accordance with the requirements established in the contract.

How the contract defends the State's position

The general principle that underpins the operation of contracts like the FMSC is the realisation of savings by transferring risk to the private provider during the life of the contract. As we noted in **chapter 5**, one of the key principles of these contracts is that the Department has paid a premium to Serco to ensure that this risk is transferred. If, during the operation of the contract, this risk is somehow shifted back on to the State, then the extent to which the contract is achieving value for money can be called into question.

248 Serco Australia, Estate Service Plan, April 2011, pp. 42–43. In Submission No. 34 from the Department of Health, 4 May 2012.

Once a contract is operating, the buyer—in this case the Department of Health—is vulnerable to inadequate realisation of risk transfers if post-contractual power relations favour the supplier.

The contract has a number of mechanisms that seek to balance the post-contractual power relationship and minimise the impact of post-contractual lock-in whilst ensuring that the State has a relatively strong position to defend the value for money offered by the contract once it is operating.

The contract establishes the level of performance expected of Serco

The contract establishes what the State expects Serco to do and the quality that it must deliver when doing it. It does this through the service specifications, which DoH describes as containing a 'front end', specifying the relevant service, and a 'back end', containing the performance regime for that service.

Serco's performance when delivering the FMSC is assessed against these service specifications, which contain failure points that accrue in response to service failures. Should too many failure points accrue, Serco may face the possibility of defaulting on the contract or of being issued with a 'take out' notice by the State, which would then result in the individual service being removed from Serco.

The accrual of failure points also has an impact on the payments made to Serco, which is explained in further detail in the next section.

Payments to Serco are subject to 100 per cent abatement

One hundred per cent of Serco's monthly service payment is at jeopardy due to performance failures.

The contract recognises two types of service failure:

- Performance failures: faults relating to a particular KPI which are not rectified within the required time.
- Availability failures: faults that cause parts of the hospital to be unavailable which are not rectified within the required time.

The use of failure points to measure any potential shortcomings in the performance of Serco allows the State to allocate points that reflect the consequences of the various failures that may occur. As we have already noted, it is Serco's responsibility to report on the number of failure points accrued during each month.[249] Failure points have a direct relationship to the total value of the monthly service abatement amount, as each

249 Facilities Management Services Contract, Schedule 16.

failure point has been given a particular financial value.[250] The formula below outlines how the monthly service abatement is calculated:

$$(\$)\ \textbf{Monthly Service Abatement} = \textbf{Failure Points} \times (\$)\textbf{Failure Point Value}$$

It is quite common for many PPP-type contracts to include a cap on the level of abatements that can be incurred during a single month. This often arises from restrictions on the level of abatement that project financiers are willing to accept – excessive abatements might jeopardise the ability of the project companies to repay debt, so finance is often contingent upon the existence of 'light-touch' abatement regimes. For example, in the case of the Royal North Shore Hospital in Sydney, an abatement cap of 50 per cent has been negotiated for the hard facilities management

What the contract says about 'availability'[251]

The contract provides the following definition for 'available':

A Functional Unit being available for the use intended by the Principal (as discerned by reference to the department, room number and room name of the Functional Unit), having regard to:

1. **(accessibility)** whether a person who is entitled to enter, occupy, or use the relevant area is able to enter and leave safely and conveniently using normal access routes;

2. **(safety)** whether the Functional Unit is in a state or condition such that a person who can be reasonably expected to require to enter, leave, occupy, or use the Functional Unit is able to do so safely, including compliance with relevant Health Policies and Workplace Health and Safety Laws;

3. **(prescribed functional use)** whether the Functional Unit is in a state or condition such that the area may be used for the use intended by the Principal (as discerned by reference to the department, room number and room name of the Functional Unit), utilising generally accepted clinical and other operational practices, without interference to Patient Outcomes or unacceptable discomfort or inconvenience to Patients or other Hospital Users due to any Prescribed Functional Use Parameter not being met; and

4. **(equipment)** whether the equipment maintained by the Facilities Manager and located within that Functional Unit to enable the Functional Unit to be used for the use intended by the Principal (as discerned by reference to the department, room number and room name of the Functional Unit) and that is required for the performance of the Health Functions intended to be performed in that Functional Unit and, is available for use or operation by Hospital Employees unless such equipment is not available due to Planned Maintenance being performed in accordance with or contemplated by the Estate Service Specification,

and **Availability** has the corresponding meaning.

250 Paxon Group Commercial and Financial Analysis, July 2011; in Submission No. 27 from the Department of Health, 30 March 2012.

251 Facilities Management Services Contract, p. 4.

services and a cap of 33 per cent has been negotiated for the soft FM services.[252] Given that the capital component of the FMSC is comparatively small, objections from financiers would appear not to have been an issue during the negotiation of the contract, as the full services component of the fee payable to Serco can be abated. This means that should Serco's performance be consistently below the standards established in the KPI regime, 100 per cent of the monthly payments made to Serco may be abated. This would potentially result in Serco receiving no payment for the month during which the poor performance occurred.

Finding 53

If Serco's performance across the range of services is sufficiently below standard in any given month, it is possible that 100 per cent of its monthly payments could be abated as a result of the performance failures.

Service failure can lead to contract termination or removal of individual services

In addition to imposing financial penalties as a result of poor performance, DoH may also terminate the contract in its entirety, or individual services provided by Serco, should consistent service failure be recorded.

The State can terminate the contract in the case of an event of default arising from total service failure. An event of default occurs if, during any rolling three month period, the number of failure points accumulated for all services exceeds the Failure Point Default Threshold, an upper limit on the number of failure points which can be accrued by Serco.

If an event of default occurs, Serco is required to demonstrate that process improvements and/or preventative measures have been taken to address the failures and to ensure that future performance will comply with the standards required in the service specifications. These proposed improvements to service delivery are required to be contained in a Remedy Plan. If the Department is not satisfied with Serco's measures to improve its performance, then it may elect to terminate the contract. If it accepts the measures put in place by Serco, then a six month probationary period will commence during which time DoH may terminate the contract if it feels that Serco is not complying or is unlikely to comply with the Remedy Plan.

Similarly, if during any rolling three month period, the number of failure points accumulated for any individual service exceeds the failure point default threshold, the provision of that service by Serco can be terminated. However, such termination is only

252 ABN AMRA Investments Australia Limited, *ABN AMRA Social Infrastructure Trust: Information Memorandum*, 5 November 2008, p. 17. Available at: http://www.nab.com.au/wps/wcm/connect/5b1aa9804c4be001baeffbef56a82861/ASIT_IM.pdf?MOD=AJPERES&CACHEID=5b1aa9804c4be001baeffbef56a82861

permissible after Serco has failed to deliver against a service remedy plan agreed between the parties. If this occurs, the Department can issue a takeout notice for the service that it is removing from Serco.

Finding 54

The contract with Serco can be terminated by the State if, during any rolling three month period, the number of failure points accumulated for all services exceeds an amount established in the contract.

The contract transfers the State's 'costs of switching' individual services

One of the factors that shifts the power balance of an operational contract away from the customer and toward the buyer is the costs associated with switching from the supplier should its performance be consistently below standard. These costs often act as a brake on the willingness of customers to terminate contracts.

In the case of the FMSC, the contract includes mechanisms for transferring the State's exposure to this so-called 'cost of switching'—at least in the case of removing individual services from Serco due to poor performance—to Serco. The contract provides that the State can recover any loss incurred in connection with exercising a takeout notice, including any additional costs that it incurs in doing so.[253]

For example, if DoH terminated Serco's provision of patient catering services due to performance failure, the Department could recover the costs associated with finding a new provider to provide the service or, alternatively, of bringing the service back 'in house'. Furthermore, the contract requires Serco to develop a detailed termination management plan in which it is required to outline how it would handle either the termination of the entirety of the contract or individual takeout events. The termination plan describes how Serco will:

> *transition the relevant Facilities Manager's Obligations on a temporary or permanent basis to a New Service Provider to ensure uninterrupted provision of the Services and the transfer of Personnel, knowledge, records, equipment, any relevant IP and other assets, or removal of assets or other equipment as required.*[254]

In the event of termination of the contract arising from total service failure, the State will have reason to call upon the performance security provided by Serco in the form of bank guarantees and insurance bonds.

253 Facilities Management Services Contract, Schedule 6.

254 Serco Australia, Termination Plan, April 2011, p. 5. In Submission No. 34 from the Department of Health, 4 May 2012.

Performance security provisions are sound, but some aspects are not ideal

As we have noted already, one of the key mechanisms open to the State for enforcing the performance of Serco in its delivery under the contract is abatement regime that places up to 100 per cent of payments to Serco at risk for poor performance. The performance security provisions, or surety, are another mechanism through which the State can defend its relative position once the contract is in operation. The exact detail of the provisions falls under the definition of facilities manager confidential information established in the contract, and we have agreed to respect the confidentiality of specific elements relating to the performance security provisions.

Nonetheless, there are some general comments that can be made about the performance security contained in the FMSC.

The performance security required by the FMSC is unconditional and must be paid upon demand if a number of pre-conditions are met, including non-performance by Serco.[255] Infrastructure Australia expresses a strong preference for performance securities to be in the form of bank guarantees; however, in the case of the FMSC, the performance security is split between insurance bonds and bank guarantees, with a significant majority of the security being offered in the form of insurance bonds. The Department of Treasury (**DoT**) offered advice to DoH on the suitability of the use of insurance bonds. [256]

Bank guarantees offering a greater degree of certainty should be used whenever possible, although we understand that following the global financial crisis access to these guarantees has proven more difficult. In assessing the relative merits of bank guarantees, KPMG has noted the following about banks and their willingness to unconditionally pay guarantees when called:

> *Banks do not wish to be drawn into disputes arising from the performance or otherwise of the underlying contract. Their reputations depend on strict compliance of their obligations.*[257]

We note that in the past insurance companies have proven more willing to dispute the validity of a claim, even where the bonds provided by the insurance company have been unconditional. We also note that the Western Australian Government's Centre for Excellence and Innovation in Infrastructure Delivery has reported that there 'is a higher

255 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 10.

256 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 11.

257 Australian Constructors Association, *Bonding Issues Faced by Construction Companies in Australia*, KPMG Corporate Finance (Aust.), October 2009, Available at: http://www.constructors.com.au/publications/bonding-issues-faced/Bonding-Issues-Faced-by-Construction-Companies-in-Australia.pdf

risk that insurers will not handover a call on an insurance bond, and in the past, their solvency has been more questionable'.[258]

Finding 55

There is a general preference for bank guarantees to be used rather than insurance bonds for the purposes of performance security on infrastructure projects. Despite this, the significant majority of the performance security offered by Serco is in the form of insurance bonds.

Expressed as a percentage of the overall value of the FMSC, the value of the performance security offered by Serco is quite low. We note, however, the requirement for Serco to 'top-up' the performance security should DoH call upon any amount of it. For example, if the Department calls upon $200,000 from the security, Serco is obligated to replace it 'on the same terms as the performance security that was called by the procurer so that the total amount of the performance security held by the procurer at any time is in the amount required [in the contract]'.[259]

Minimising pricing risks associated with long-term contracts

A contract extending for 20 years, as in the case of the FMSC, is making a series of assumptions about technologies and methodologies used in the delivery of the contracted services. Should technology or methods change that result in considerable efficiencies and cost-savings, significant pricing risks will emerge and negatively impact upon the value for money achievable by the State.

In order to address this potential shortcoming, the contract allows for benchmarking and market testing to occur at semi-regular intervals. Benchmarking is a process whereby Serco will be required to compare its own costs, or the costs of its subcontractors, against the market price of equivalent services. If Serco's provision of the services is higher than market prices, then a reduction in the price charged to the State should be made. There is the risk, however, that payments to Serco increase should Serco's costs be lower than market prices.

The contract requires that both Serco and DoH agree on the identity of the organisation that will carry out the benchmarking exercise and also the aspects of each servicer that will be subject to the benchmarking process. At a minimum, the process must include both the pricing and KPI aspects of the services.[260]

258 Centre for Excellence and Innovation in Infrastructure Delivery, Performance Securities for Construction Contracts: Practice Note, State Solicitors Office, March 2011, Available at: http://www.ceiid.wa.gov.au/Docs/Performance_Securities_Practice_Note.pdf

259 Facilities Management Services Contract, Clause 11, p. 88.

260 Facilities Management Services Contract, Schedule 17.

Market testing will require Serco to effectively re-tender the relevant service so that DoH can test the value for money of that service in the market. The Department may also opt to provide an in-house bid for the service in order to confirm that private provision of the service remains the best means for attaining value for money. Market testing is applied to services that can be isolated from the overall contract and includes:

- Pest control
- Car parking and traffic management
- Cleaning
- Security
- Catering
- Linen
- Waste management[261]

The pressure that can be maintained on Serco through benchmarking and market testing is a crucial means through which value for money can continue to be realised through the life of the contract. It is a mechanism for overcoming the problem of post-contractual lock-in and re-addressing power balances between the two parties once the contract is in operation. In the UK, it has been noted that implementing benchmarking processes can be difficult, although there are examples of where it has been done well and found to have delivered agencies real value for money.[262]

The contract encourages Serco to find efficiencies

The contract encourages Serco to find efficiencies in the delivery of the services, therefore reducing the cost of the contract to the State.

Under the contract, Serco is required to submit an annual service plan in which it must provide forecasted volumes for catering, sterilisation and waste over the coming year. It must also forecast the overall health function activity levels for the hospital, including admitted and non-admitted patient figures.[263] Serco may propose a reduction in the service levels arising from the forecasts contained in the annual service plan. In that

261 Paxon Group Commercial and Financial Analysis, July 2011; in Submission No. 27 from Department of Health, 30 March 2012.

262 UK National Audit Office, *PPP in practice: National Savings and Investments' deal with Siemens Business Services, four years on*, May 2003, p. 5

263 Facilities Management Services Contract, p. 102.

case, if DoH accepts the proposal, the Department will receive 100 per cent of the benefit of the resulting reduction in service cost.[264]

In addition to reducing service levels in response to anticipated reductions in volumes, Serco may also achieve efficiencies by proposing alternative forms of delivery for the services. If the proposal is accepted, then both Serco and DoH must negotiate any amendments required to the contract to implement the proposal. An incentivisation fee will then be payable to Serco; however, Serco's share of the savings derived from the increased efficiency would appear to be capped at 25 per cent.

If, after 12 months, the Department is not satisfied with the alternative form of delivery as implemented by Serco, DoH can instruct the company to revert to the previous arrangement for the delivery of the service.[265]

DoH is not obliged to use Serco for variations

The Department retains flexibility with respect to the selection of sub-contractors to carry out variation works.

If DoH is not satisfied with the price offered by Serco to fill a variation request, then the Department can require Serco to return to test the market and find another sub-contractor to perform the service. The contract also establishes a distinction between variations and directions (a direction being an instruction from a DoH employee to complete work) and acknowledges that there may be some disagreement between the Department and Serco regarding whether a direction ordered by DoH may in fact constitute a variation. In situations such as these, assiduous contract management and good will between both parties is required. Resolution of disputes such as a dispute regarding variation versus direction can take time, and can be subject to hold-up, whereby the contractor deliberately slows the resolution process in order to strengthen its own position as pressure to resolve issues mounts on the Department.

Assiduous contract management remains critical

The UK National Audit Office has noted that contractors will 'seek to pass risk back to the taxpayer if [agencies] do not meet their obligations or enforce the contract'.[266] A contract manager for a hospital in the UK has also observed that:

264 Paxon Group Commercial and Financial Analysis, July 2011, p. 48; in Submission No. 27 from Department of Health, 30 March 2012.

265 Paxon Group Commercial and Financial Analysis, July 2011, p. 48; in Submission No. 27 from Department of Health, 30 March 2012.

266 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 29.

> *No monitoring; no value for money. [The supplier] will chip away at the deal struck. You have to investigate, you have to check, you have to be firm.*[267]

It is quite clear, then, that deriving value for money from contracts requires more than simply a 'good' contract with strong protections for the procuring agency. It also requires the agency to actively enforce the provisions of the contract, to monitor the performance of the contractor and to apply payment abatements when performance is below the accepted standards. The experience in the UK, however, indicates that monitoring of contracts can be difficult and enforcing standards can also prove to be challenging, particularly where those standards rely upon subjective measures.

As we have discussed in earlier parts of this report, contract enforcement can also prove politically difficult. The problems encountered by the New South Wales Government when attempting to enforce contracted cleaning standards at the Royal North Shore Hospital demonstrates the reality that political risk is impossible to transfer.

Less observable to the public, but equally important, is the issue of payment abatements for poor performance. In the UK, the National Audit Office (**UKNAO**) has found examples where the level of abatement levied did not reflect the seriousness of the performance shortcoming.[268] On the other hand, it has also found examples where the abatements levied were too high, which led to problems with relationships with contractors, thus reducing the likelihood that the agency and contractor could work together to overcome the problems.[269]

Finding the right balance in managing the contract can therefore be seen to be something of a difficult proposition. Nonetheless, it is critical if a contract is to deliver value for money to the State over its operational life.

DoH must monitor its performance management system

The UKNAO identified six key objectives of a good performance management system:

- Provides timely reports;
- Ensures problems are dealt with;

267 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 694.

268 UK National Audit Office, *Darent Valley Hospital: The PFI contract in action*, February 2005, pp. 16–17

269 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 17.

- Identifies actions to improve performance;
- Identifies deductions;
- Identifies performance; and
- Reports problems.[270]

In the UK, a number of different hospitals were then asked to judge their own performance management systems against these criteria. Through their responses, it emerged that most hospital operators were only moderately satisfied with the quality of their performance management systems.[271] This finding reinforced an earlier report from the UKNAO which found that problems with performance management processes had negatively impacted upon relationships between hospitals and contractors.[272]

The UKNAO has also found that the level of deductions levied against contractors can be too low to provide the incentive for improved performance they are designed to achieve.

The experience in the United Kingdom suggests that departmental contract managers should assess the effectiveness of the performance management regime once it is operational, because the transition from the theoretical to the operational can expose flaws in the systems.

Recommendation 6

The Department of Health will need to closely monitor the effectiveness of the performance measurement regime in use at Fiona Stanley Hospital and be prepared to negotiate changes with Serco should it prove not to provide the level of performance assurance required.

Self-monitoring by Serco of its own performance may cause problems

As we have noted in earlier parts of this report, it is common for contractors to self-monitor performance and report to the responsible agency at the end of each month. Although this arrangement is generally considered to be optimal, it has caused problems in the United Kingdom in the past, particularly with respect to information asymmetries between the contracting parties.[273]

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270 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 33.

271 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 33.

272 UK National Audit Office, *Darent Valley Hospital: The PFI contract in action*, February 2005, p. 18.

273 Pamela Stapleton, Anne Stafford and Jean Shaoul, ' NHS Capital Investment and PFI: From Central Responsibility to Local Affordability ', *Financial Accountability and Management*, vol. 27, no. 1, February 2011, p. 7.

In one case, for example, the service provider was providing information to the responsible agency that, whilst deemed accurate, was in a form that made it difficult for the performance data to be used to actually measure the provider's performance. Resolving the matter required many months of negotiations.[274] Part of the settlement involved the agency itself becoming more closely involved in the monitoring process.[275] The UK's National Audit Office has noted that a similar requirement to duplicate performance monitoring has led to conflicts between the responsible agency and the contractor in other hospitals.[276]

The intellectual underpinning of self-monitoring of performance arises from the notion that PPP-type contracts (like the FMSC) are relational in nature and replace the adversarial tone of more traditional contracts. One of the alleged benefits of these relational contracts is the efficiency that can be achieved by relying upon the contractor to self-monitor. What often happens, however, is the need for the responsible agency to monitor in tandem with the contractor in order to ensure that performance is being measured and reported accurately. In the process, one of the efficiency gains anticipated by using a contract like the FMSC is undermined. Difficulties in the relationship between the contractor and customer may also arise.

We're all contract monitors now

In order to ensure that Serco is delivering the quality of the services required by the contract, DoH will need to rely upon its clinical staff to report faults and service failures in an accurate and timely fashion. This will require clinical staff to be familiar with the contract and Serco's obligations. DoH is paying for the delivery of services to a certain standard, and if Serco fails to deliver that quality then DoH will be accepting risks that it has paid to transfer to Serco. In order to ensure that Serco both carries out its functions and is penalised if it fails to do so, DoH will need its staff to be actively engaged in the contract management process.

In the UK, hospitals have developed simplified versions of contractual metrics, including those relating to penalty schemes, in order to educate staff members about the contract.[277] This has been viewed as a reasonably successful way to provide staff with the knowledge necessary to contribute to the enforcement of the contract.

274 Pamela Stapleton, Anne Stafford and Jean Shaoul, ' NHS Capital Investment and PFI: From Central Responsibility to Local Affordability ', *Financial Accountability and Management*, vol. 27, no. 1, February 2011, p. 7.

275 Private Briefing.

276 UK National Audit Office, *Darent Valley Hospital: The PFI contract in action*, February 2005, p. 17

277 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 694.

Recommendation 7

The Department of Health needs to:

- develop education packages for clinical staff to ensure that they are aware of the performance requirements of Serco under the contract; and
- actively engage clinical staff in the monitoring of Serco's performance of its contracted responsibilities.

Subjectivity is a problem for all performance measurement regimes

The UK National Audit Office has previously reported on the problems of performance measurement regimes relying upon subjective judgements. The measurement of service quality is generally considered to be made difficult by the fact that, although service quality might be identified in terms of performance characteristics, their measurement requires the application of subjective judgement.

Cleaning has been highlighted as an example of the problem of subjectivity: the only way this can be measured is through personal observation, and what constitutes a high standard of cleanliness may vary from one observer to another.

In the UK, disagreements between contractors and responsible agencies have arisen due to the reliance upon subjective measures of performance.[278] We note that the KPIs in place for the FMSC seek to minimise reliance upon subjective measurements, but they cannot be eliminated entirely. It is reasonable to expect, particularly in the early stages of the operation of the hospital, for disagreements between DoH and Serco to arise regarding some measures of Serco's performance.

Managing these disagreements will be a critical early test for both parties and will no doubt set the tone for the how the two parties approach the contract over its operational life.

The risk of quality shading

Quality shading arises when a contractor attempts to extract maximum returns from a contract by reducing the quality of the inputs used when delivering the contract. Quality shading is thought to be most common in fixed fee contracts, as contractors will have limited other options for recovering margins should the cost of delivering the contract increase.

One contract manager from the NHS in the UK noted the following about quality shading:

278 UK National Audit Office, *Darent Valley Hospital: The PFI contract in action*, February 2005, p. 17.

> *The contractor will, of course, try to increase its profits through quality shading. It will substitute materials or products, while still formally meeting the specification, and it will sub-contract if it can to firms with cheaper staff'.* [279]

It has also been reported, again in the UK, that contractors will act strategically when it comes to quality shading. For example, they might reduce the quality of inputs in areas where they do not expect to be detected or will select areas that are viewed as not impacting upon the performance measures in the contract. Contractors have also been reported as exploiting ambiguous language used in some contracts, including words like 'clean' and 'quality' or 'high quality'.[280]

Interestingly, the catering service specifications require Serco to deliver a 'high-quality and nutritious catering service to all Patients'.[281] This specification is a succinct embodiment of the problems associated with enforcing a contract against the risk of quality shading. The nutritional content of a meal can, for example, be measured, and a contract can specify a requirement for a contractor to deliver a variety of meal types over a set period of days (as the FMSC does). It is significantly more difficult, however, to ensure that a contractor delivers a 'high-quality' service and it is also a difficult requirement to enforce through monitoring and measurement of the contractor's performance.

Preventative maintenance in an operational hospital

Perhaps unsurprisingly, the level of clinical activity in a hospital can impact upon the ability of contractors to undertake some preventative maintenance.[282] The Fiona Stanley Hospital, for example, is anticipated to 'quickly reach full operating capacity' and DoH has noted that infrastructure planning 'assumes a 90% occupancy for tertiary hospitals'.[283]

If preventative maintenance does not occur as a result of high-levels of hospital occupancy, then the Department is in effect accepting risk that it has paid to transfer to Serco.

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279 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 694.

280 Chris Lonsdale and Glyn Watson, 'Managing contracts under the UK's Private Finance Initiative: evidence from the National Health Service', *Policy and Politics*, vol. 35, no. 4, January 2007, p. 694.

281 Department of Health, *Service Specifications – Patient Catering*, July 2011, p. 2, in Submission No. 20 from Department of Health, 6 February 2012.

282 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 29.

283 Submission No. 35 from the Department of Health, 15 May 2012, p. 2.

Serco's performance should be disclosed each quarter

The FSMC signed with Serco provides DoH with the opportunity to disclose the following information about Serco's performance:

- The quantum of failure points incurred by Serco;
- Monthly service abatement amounts; and
- Any liquidated damages incurred.

Ensuring that information about the performance of Serco is made publicly available is an important element of ensuring that both Serco and the Department are subject to the type of public scrutiny that contributes to improved performance at the Hospital.

Recommendation 8

The Department of Health should be required to publicly report, on a quarterly basis:

- The quantum of failure points incurred by Serco;
- The specific performance failures that led to Serco incurring those failure points; and
- The monthly service abatement amounts.

Goodwill between the parties is a critical element

Despite being a comprehensive document that seeks to maximise certainty, like all contracts the FMSC is 'incomplete'. No contract can ever cover the multitude of variables that might arise over a 20-year life. This simple fact will require Serco and DoH to work closely together over the next 20 years to ensure the cost-effective and efficient operation of the hospital. To a very large degree, the smooth operation of the contract will rely upon a spirit of cooperation and goodwill between Serco and the State.

During our visit to the United Kingdom, many of the people we spoke to with direct experience in the management of complex hospital contracts reported that goodwill between all parties was essential to providing an environment in which unexpected events or simple changes could be managed in a successful way. One example involved the cleaning of artwork donated to a particular hospital. The FM provider agreed to clean the artwork at no extra cost but insisted that this additional cleaning be reflected in the contract via the variations process. This was designed to ensure that the contract reflected the tasks that the provider was carrying out and to also protect the FM provider's position in future benchmarking exercises.

The hospital also agreed to consult with the FM provider before selecting artworks. It was noted, for example, that a painting on the wall was easier to clean than a sculpture hanging from the ceiling. The consultative process was used as a means for providing additional services to the hospital whilst protecting the financial position of the FM provider.

In this chapter, we have looked at some of the elements contained within the contract as signed with Serco and found them to have addressed many of the earlier criticisms of these types of contracting arrangements in the UK, including:

- The abatement regime;
- The termination provisions;
- The performance security; and
- The reduction in the costs of switching should the State choose to terminate individual services arising from poor performance.

In many instances, these features would only be required if significant problems arose with Serco or its delivery of individual services. Day-to-day occurrences—like the installation and cleaning of new artworks—will rely less upon the provisions of the contract and more upon the willingness of both parties to work together and to compromise.

Finding 56

- The delivery of non-clinical services at Fiona Stanley Hospital will in all matters need to conform to the signed contract between Serco and the Department of Health.
- All such contracts are incomplete inasmuch as they are incapable of covering every eventuality that may arise in a contract which is likely to last 20 years.
- The success of this contract with Serco will rest on both the details of the contract and the quality of the working relationship between the contract partners.

Chapter 7

Value for Money?

What is value for money?

It should hardly be surprising that value for money (**VfM**) is a concept that has appeared frequently in this report, as it is central to the intellectual arguments that underpin contracts like the Facilities Management Services Contract (**FMSC**).

VfM is not simply limited to a consideration of cost; there are many other factors that contribute to a determination as to whether a project represents good value. The Victorian Department of Treasury and Finance has a particularly instructive definition that encompasses the various elements that constitute VfM:

> *Value for money denotes, broadly, a balanced benefit measure covering quality levels, performance standards, risk exposure, other policy or special interest measures (e.g. environmental impacts), as well as price [of inputs and outputs]. Generally, Value for Money is assessed on a "whole of life" or "total cost or ownership" basis, which includes the transitioning-in, contract period and transitioning-out phases of a contractual relationship. It is often used in the sense of the "long-term sustainability of Value for Money", denoting that the state focuses on choices that ensure Value for Money outcomes are promoted and protected in successive anticipated contracts.*[284]

As we can see, in this definition of VfM there are numerous individual components most of which are not directly related to the financial cost of a proposed project, including:

- Quality
- Performance
- Risk exposure
- Special interest measures

In considering the question of VfM in the context of the FMSC, it should be obvious that questions about quality, performance and risk exposures will only be answerable once the contract is actually in operation. There is no academic or industry data that

284 Department of Treasury and Finance, Victoria, *Strategic Sourcing Policy*, June 2006, Available at: http://www.vgpb.vic.gov.au/CA2575BA0001417C/pages/procurement-practitioners-stage-1---planning-step-3---develop-the-procurement-strategy-strategic-sourcing-policy

could give any confidence that an evaluation of this stage of the development of the project could give any level of certainty regarding the achievement of VfM. This means that absolute statements about the contract providing VfM cannot be based on 'actual' experience and would appear at this stage to rest on financial modelling and assumptions about what the contract is supposed to deliver.

Value for money and the FMSC

At present, the judgement as to whether or not the FMSC represents VfM for the State relies upon the series of assumptions and calculations made in the development of the public sector comparator (**PSC**). The Department of Health (**DoH**) has noted in the *Fiona Stanley Hospital Facilities Management Services Contract Project Summary* that:

> *The extensive and detailed evaluation process – which included assessment of service solutions, commercial issues, and financial modelling – concluded that the proposal from Serco represented the best option for service delivery and the lowest price and, therefore, the best value-for-money for the State.*[285]

At this stage of the life of the project, the conclusion reached in the quote above relies exclusively on the PSC results and the evaluations made during the procurement process. The Hospital has not yet been built, and Serco has yet to commence delivering services in an operational environment (although it is now delivering some pre-operational services), which means that it is not possible to genuinely assess VfM because we cannot assess the:

- Quality of the services being delivered;
- Hospital's operational performance; and
- Extent to which risk allocated to Serco has effectively been transferred.

This has not stopped DoH from making definitive statements about the VfM offered by the deal with Serco:

> *[…] the FM Contract represents a cost saving of $515.6 million compared to the PSC, or 18% of the cost under the PSC.*
>
> *As such, a contracted method for providing the Project (via Serco) demonstrates the better value-for-money to the State.*[286]

285 Department of Health, *Fiona Stanley Hospital Facilities Management Services Project: Project Summary*, February 2012, p. 9.

286 Department of Health, *Fiona Stanley Hospital Facilities Management Services Project: Project Summary*, February 2012, p. 13.

In our view, relying on the PSC to make these types of definitive statements about VfM is problematic because the PSC cannot be used as a mechanism for the non-financial elements of VfM.

Relying on PSC results to describe VfM is problematic

The PSC is, after all, just a model. It might be a sophisticated model, but as we examined in **chapter 5** it rests upon an extraordinarily large number of assumptions. In the case of the FMSC, for example, there were a substantial number of assumptions made for each of the 28 services being provided by Serco, in addition to the series of assumptions that overlay the PSC as a whole (i.e. the discount rate or specific project risk calculations).

The United Kingdom National Audit Office (**UKNAO**) has noted that PSCs are 'prone to error' and that the complexity of the models used in the development of the PSC makes it difficult to detect and eliminate those errors.[287] This was a view that was elaborated upon by Mr Gary Sturgess, the former head of the Serco Institute, who explained that procuring authorities in the UK moved:

> *[…] away from the public sector comparator because the feeling was that it just did not mean anything. Certainly, in the conversations I had with Treasury, the feeling was that the numbers that were being generated did not meaningfully reflect the true-cost of in-house delivery.*[288]

While decision makers may find a PSC useful in making procurement and investment decisions, to rely upon it as an arbiter of VfM is inherently problematic.

The data from the UK experience is inconclusive

We spoke to the UKNAO about findings from their reviews of hospital 'PFI contracts'. PFI contracts are the name given to PPPs in the UK, and they share many similarities with the FMSC, including long contract lives, private provision of services and risk transfers. The UKNAO has found that, for the most part, the data about the cost and performance of these contracts in the UK is inconclusive. Generally, most service providers are meeting hospitals' expectations, but it was also noted that there was no difference in measured performance between PFI and non-PFI hospitals in independent assessments of environment and catering.[289] In other words, PFI hospitals were not

287 UK National Audit Office, *The use of PSC in decisions on PFI deals*, 2003. Available at: http://www.publications.parliament.uk/pa/cm200203/cmselect/cmpubacc/764/764w02.htm

288 Mr Gary Sturgess, Australia and New Zealand School of Government, *Briefing*, 21 March 2012, p. 9.

289 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, pp. 16–17.

performing significantly better or significantly worse (with respect to these two elements) than other hospitals.

The UKNAO made similar findings with respect to the costs of operational PFI hospitals. Against five types of facilities management services—maintenance, catering, portering, cleaning and laundry—the UKNAO noted that, for the most part, the difference between the cost of delivering the services in PFI and non-PFI hospitals was not statistically significant.[290]

We also met with a team of academics from University College London who have for the past several years been attempting to compare the cost and performance of PFI hospitals in the UK against non-PFI hospitals. This team's conclusions are slightly different than those of the UKNAO; they find that PFI hospitals tend to have 'higher performance in aspects of patient environment, cleanliness and to some extent catering, at seemingly no higher costs'.[291] They go on to note something the UKNAO also noted in discussions with us: making conclusions about the performance and cost of PFI versus non-PFI hospitals is significantly hindered by the lack of solid data, particularly with respect to so-called Hard FM services relating to the maintenance of the building assets.[292]

It is concerning to note the rush to these types of contracts without solid empirical data demonstrating their superiority in operational environments.

Fittings, furnishings and equipment costs

Questions about VfM provided by these types of contracts can be illustrated by the arrangement used by DoH to fund the fittings, furnishings and equipment (**FF&E**) required for operations to commence at the hospital. The FF&E includes medical and ICT equipment in addition to patient and audio visual equipment and also general hospital equipment. This is the one part of the FMSC which most resembles a traditional PPP because Serco will be required to organise its own finance to pay for the assets. In the UK, questions have been asked, including by several Parliamentary committees, about the VfM of deals where the private provider must borrow in order to fund the construction or purchase of an asset. Many critics note that governments are able to borrow at significantly cheaper rates than private organisations. Information provided to the Committee by the Department of Treasury, and reproduced below in **table 7.1**, illustrates the difference in borrowing costs for the State Government and private sector organisations.

290 UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 23.

291 Ive, G., Murray, A., Edkins, A., Rintala, K., 'Cost and Performance Comparison of PFI and Non-PFI Healthcare Infrastructure in England', Conference Paper.

292 Private briefing.

Table 7.1: WA Government borrowing rates vs private sector borrowing rates (at 7 Nov 2011) [293]

Term	WATC	AAA-rated companies	AA-rated companies	A-rated companies	BBB-rated companies
4 years	4.17%	4.81% to 6.86%	5.44% to 5.60%	5.50% to 8.20%	6.06% to 7.20%
9/10 years	4.65%	5.47% to 5.89%	6.57%	6.66%	7.14%

If the provision of the FF&E by Serco via the lease arrangement is to provide better VfM for the State, it will need to overcome the extra cost built into the arrangement arising from Serco's borrowing costs and any leasing fees payable by the State to Serco. In nominal terms—that is, before the application of discounted cash flow analysis—the arrangement with Serco is actually more expensive and results in DoH paying approximately $170 million more for the provision of the assets than the estimated actual value of those assets. Once the values are discounted, however, and risks valued and transferred to Serco, the arrangement with Serco has been valued by the Department as between approximately $10 million and $30 million cheaper than traditional procurement.

A break-down of the anticipated repayments over the 10-year life of the FF&E components of the contract is provided in **table 7.2** below:

Table 7.2: Annual payments for FF&E (nominal values)[294]

Year	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
$M	76.2	76.2	76.4	76.4	76.0	54.9	41.5	40.2	38.7	11.9

The repayments decrease in value over time because the contract with Serco covers only a single lifecycle for each asset type. As individual assets reach the ends of their useful lives, DoH will have the option of extending the life of the asset, replacing it under the leasing arrangement, or directly purchasing a replacement asset. The reduced repayments in later years also reflect a decrease in interest payments as capital is repaid during the course of the contract.

One aspect of the leasing arrangement appeared in the 2011–12 Government Mid-year Financial Projection Statement, reflecting changes to anticipated operating expenses and capital outlays. DoH provided the following explanation for those changes:

> *[…] over the forward estimates period, there is a net increase of $151.9 million in expenses with a corresponding off-set reduction of $161.2 million in capital expenditure over the same period. This reflects the decision to transfer responsibility of facility-related assets under the asset solution component of the FMSC to Serco. Procurement of these*

293 Submission No. 11 from the Department of Treasury, 16 November 2011, p. 6.
294 Submission No. 37 from the Department of Health, 29 May 2012, p. 3.

> *assets had originally been scoped as capital expenditure within the estimated total cost of the FSH project budget.*[295]

The contracting arrangement has a $380 million net debt impact over the period to 30 June 2015. This recognises the full lease obligation of the State for furniture, fittings, medical equipment and ICT assets procured as part of the hospital set-up by the contractor, the cost of which will be paid over the lease term.

The information about the FF&E arrangement was provided late in the course of the Inquiry, and the Committee has not had sufficient time to fully review or form a judgement on the arrangement.

Value for money may rely on Serco and its performance

If it is not possible to rely upon the PSC to establish that the FMSC provides VfM, and operational experience for similar contracts in the UK is inconclusive, then it seems obvious that the VfM potentially on offer through the FMSC will only be measurable once the contract has been operating. In other words, the proof of the concept will have to be provided from the operation of the hospital itself.

Even taking into consideration the laudable safeguards included in the contract (and examined in **chapter 6**), it does seem like a significant risk to partner with the private sector for the most expensive contract ever signed in Western Australia without really having proved the concept.

To some extent, given the nature of contracting, this is unavoidable, and the risk to the State can be minimised if the State effectively manages the contract. Unfortunately, on that front, the history of contract management by the Western Australian Department of Health has proven to be less than satisfactory.

295 Submission No. 20 from the Department of Health, 6 February 2012, p. 1.

Appendix One

Changes to key performance indicators

The service specifications are a key element of the Facilities Management Services Contract (**FMSC**) as they are the mechanism by which the Department details what is required of Serco over the life of the contract, and the consequences for Serco if it fails to meet these obligations. The details of the performance regimes are critical to the State's ability to enforce the content of the service specification.

DoH provided the Committee with two different copies of the service specifications. The first, dated April 2010, was the version used to construct the public sector comparator (**PSC**) completed in May 2010. It corresponds to the version of the document provided to respondents when the Department issued its request for submissions (**RFS**). The second version, dated July 2011, is the complete set of specifications included in the final contract signed with Serco. A comparison of the two versions reveals that a number of significant changes were made to the performance regime sections, in particular the key performance indicators (**KPIs**).[296]

According to Mr Sebbes, the Executive Director of Fiona Stanley Hospital (**FSH**), any changes made to the service specifications during the contract negotiation period were either to clarify definitions and tighten language or were in the Department's favour.[297] The Committee accepts that aspects of the service specifications relating to the content of the individual services were not substantially changed. It is clear, however, that the elements of the specifications relating to the performance regime—the KPIs—were significantly altered during contract negotiations.

To illustrate the extent of the changes made to the KPIs, we have analysed in some detail the following services:

- Cleaning;
- Estates management;
- Managed equipment service; and
- Management and integration service.

296 The information in this appendix is sourced from the following: Department of Health, *Service Specifications – Cleaning, Estate, Managed Equipment, Management and Integration*, April 2010 and July 2011, p. 3, in Submission No. 20 from the Department of Health, 6 February 2012.

297 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 24 April 2012, p. 27.

A clear majority of the changes made to the KPIs for these services represent a lessening of the standards required from Serco and are therefore not in the State's favour.

It is important to note that the Committee was not able to conduct a full comparative analysis of all the service specifications. It should also be noted that while a large number of changes were made to the KPIs, most of the KPIs remained unchanged or changed in only minor ways. A small number of KPIs were altered to the benefit of the State, but these are outweighed by the changes in Serco's favour.

The tables on the following pages are set out to clearly demonstrate the degree to which each KPI changed. It is important that we establish some methodological foundations:

- For each of the four services, the performance parameters for each KPI have been reproduced as they are in the service specification documentation.
- The other components of the KPIs (see list below) are only represented by the amount they changed during the contract negotiation period.
- A number of the changes are not easily represented in a tabular summary; they have been recorded as 'changed'.

Below are brief descriptions of the categories that are referred to in the KPIs and in the tables below. There are also examples of what changes to each category will mean in effect.

Cleaning service

An efficient cleaning service is critical to the safe operation of the hospital and for the care and safety of all hospital users. The objective of the cleaning service is to provide and maintain a clean, safe, tidy and infection-free environment for all hospital users. The service provides a core function which enables other services to run efficiently and safely.

Cleaning tasks will be grouped into two categories, namely what the contract calls: scheduled clean and reactive clean. Scheduled clean are tasks around the hospital that can be foreseen and scheduled ahead of time such as changing privacy curtains and blinds. The cleaning of clinical areas such as operating theatres and peri-operative areas will be scheduled according to patterns of use and activity of the area in order to minimise disruptions and meet hospital users' needs.

Reactive cleaning tasks will generally be logged with the Helpdesk and will be allocated to the closest available cleaning service personnel. Tasks will be categorised and prioritised to enable work to be managed efficiently and the most urgent tasks will be

dealt with in a timely manner. Rectification times will be captured and monitored by the helpdesk to measure performance and to provide feedback to enable continuous improvement.[298]

Estate service

These services encompass the operation, maintenance, breakdown, repair and refurbishment services associated with FSH facilities including:

- Central plant operation/maintenance and energy management;
- First response team for immediate faults, repairs and minor works;
- Mechanical, electrical and hydraulic services;
- Fire systems, lifts and ground maintenance;
- Window and external fabric cleaning hoists;
- Security systems, nurse call, pneumatic tube systems; and
- Managing communications infrastructure.[299]

Managed equipment service

Siemens will provide the managed equipment service (**MES**) on behalf of Serco. Siemens will procure and install MES equipment as set out in the contract, and will include on-site biomedical service to be established in the pre-operational phase. A dedicated team of MES biomedical personnel will provide technical service for lower level technology items, and where their involvement does not cause disruption to health functions, provide first response for MES functions as defined in levels 1 and 2 faults. The configuration of the MES equipment provided will provide for approximately 99% of routine clinical diagnostics conducted at the hospital, and is capable of supporting substantially more clinical diagnostics with minimal reconfiguration.[300]

Management and integration services

The management and integration service (**MIS**) requires Serco to provide services at FSH in a manner that ensures all elements of each service are fully integrated and interoperable and are delivered as a seamless single service. The contract requires that

298 Serco Australia, *Cleaning Service Plan*, March 2011, in Submission No. 34 from the Department of Health, 4 May 2012.

299 Department of Health, *Facilities Management and Support Services at Fiona Stanley Hospital*, November 2009, p. 1.

300 Serco Australia, *Managed Equipment Service Plan*, April 2011, p. 8, in Submission No. 34 from the Department of Health, 4 May 2012.

Serco ensures that it delivers its services in such a way that patients can access the services easily and simply without needing to understand Serco's internal resourcing or allocations of responsibility. Furthermore, the MIS specifications require Serco to ensure that there is an effective alignment between all of the elements of each of the services, ensuring that there are no overlaps or gaps between the performance of each of the services.[301]

301 Serco Australia, *Management and Integration Service Plan*, May 2011, in Submission No. 34 from the Department of Health, 4 May 2012.

A Glossary of selected terms contained in the KPI tables on the following pages

The **performance parameter** outlines exactly what is required from Serco in delivering the service. Many of the changes to this category clarified definitions or meanings. Some changes were more significant, but are difficult to represent in the tables on the following pages. A common alteration made to the performance parameter was to change 'at all times' to 'for 99% of the time'. Effectively, this change lessens the likelihood that the FM will incur abatements for a particular failure.

In the overwhelming majority of service specifications we examined, the performance parameter for the continuous improvement indicators (**CIIs**) was relaxed. For every service, the KPI regarding the CIIs was altered from requiring that 'green range' is achieved for each CII, to 'amber or green range' is achieved. This represents a lessening of the standard level of improvement required by the FM. It should be noted, however, that the change from 'green' to 'amber or green' range always accompanied an increase in the number of failure points that were accrued if the FM failed to meet that standard.

Failure Points are the points incurred by Serco when its performance falls below the standards established in the service specifications and KPIs. Failure points also contain a monetary value and are used to calculate the value of any service payment abatements that might be incurred following substandard performance. If the number of failure points has increased, this means that Serco will incur more points for any failure to meet the standard set out in the performance parameter. If the number of failure points has decreased, the FM will incur fewer points for any failure to meet this standard. An explanation regarding how these points relate to abatement is in **chapter 6**.

An increase in the **failure period** grants Serco extra time to correct failures before penalties are incurred.

The **remedial period** serves as a type of credit that is immediately applied to the calculation of failure points in the event of a performance failure. When the remedial period is increased, this means that Serco has additional time to attend or rectify faults before it is penalised for any performance failure. When the remedial period is decreased, this means that it has less time before failure points are accrued for any performance failure.

A **repeated failure** is the occurrence of the number of performance failures within a specified period (measured on a rolling basis) which, in DoH's reasonable opinion, has arisen due to the same underlying cause. If the repeated failure for a KPI has been changed from 10 instances in one month to 20 instances in one month, this will be represented in the table below as a 100% increase. Repeated failures may be subject to higher levels of service payment abatement, meaning that financial consequences of repeated failures are more significant than for non-repeated failures.

In the tables below, cells have been highlighted in blue to represent that a change has been made to that element of a KPI. For all but the changes to performance failure points, an **increase** is a move in Serco's favour, and a **decrease** is a move in the State's favour. For performance failure points, the opposite is true.

In the case of a change to a performance parameter, details are provided in the footnotes.

Cleaning Service KPIs

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
1	Cleaning Equipment and Cleaning Consumables are provided, maintained, cleaned, stored and replaced in accordance with the relevant manufacturer's requirements and Good Industry Practice.	Changed.[301]	Changed.	Changed.	Changed.	No change.	400% increase.
2	Scheduled Cleaning is only performed during the relevant Access Time for that area, unless otherwise agreed with the Principal in writing.	No change.	No change.	No change.	No change.	No change.	400% increase.
3	Scheduled Cleaning in Critically Important Functional Areas is completed in accordance with the Cleaning Service Plan and in accordance with the Cleaning Standards.	No change.	No change.	100% increase.	No change.	No change.	No change
4	Scheduled Cleaning in Highly Important Functional Areas is completed in accordance with the Cleaning Service Plan and in accordance with the Cleaning Standards.	No change.	No change.	75% increase.	No change.	No change.	100% increase.
5	Scheduled Cleaning in Very Important Functional Areas is completed in accordance with the Cleaning Service Plan and in accordance with the Cleaning Standards.	No change.	No change.	33% increase.	No change.	No change.	100% increase.
6	Scheduled Cleaning in Important Functional Areas is completed in accordance with the Cleaning Service Plan and in accordance with the Cleaning Standards.	No change.	No change.	No change.	No change.	No change.	344% increase.
7	Isolation Cleans are attended to within the Attendance Time when requested in accordance with paragraph 2.2(a)(3) of this Specific Service Specification.[302]	No change.	No change.	No change.	No change.	No change.	No change.
8	Emergency Faults are Attended to within the relevant Attendance Time.	No change.	No change.	No change.	No change.	No change.	No change.
9	Reactive Cleans are completed in respect of Emergency Faults within the relevant Rectification Time.	No change.	No change.	No change.	No change.	No change.	No change.
10	Urgent Faults are Attended to within the relevant Attendance Time.	No change.	No change.	No change.	No change.	No change.	No change.
11	Reactive Cleans are completed in respect of Urgent Faults within the relevant Rectification Time.	No change.	No change.	No change.	No change.	No change.	No change.

302 Changed from weekly failure period to per instance failure.
303 Clarification.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
12	Non-Urgent Faults are Attended to within the relevant Attendance Time.	No change.	No change.	No change.	No change.	No change.	No change.
13	Reactive Cleans are completed in respect of Non-Urgent Faults within the relevant Rectification Time.	No change.	No change.	No change.	No change.	No change.	No change.
14	All Hospital beds are cleaned and made up with clean linen to meet the Cleaning Standards and at frequencies requested by Hospital Employees in accordance with the process stated in the Cleaning Service Plan.	No change.	No change.	No change.	No change.	No change.	No change.
15	All privacy curtains and blinds are present and clean in accordance with the Cleaning Standards.	Changed.[303]	Changed.	100% increase.	No change.	No change.	No change.
16	Facilities Manager performs regular inspections of each Functional Area at times and frequencies specified in the Cleaning Service Plan to ensure each Functional Area is in a state of cleanliness compliant with the Cleaning Standards.	No change.	No change.	No change.	No change.	No change.	No change.
17	Facilities Manager develops and maintains methods and procedures to respond to an Outbreak.	No change.	No change.	No change.	No change.	No change.	No change.
18	Amber or Green range is achieved for all Continuous Improvement Indicators on an annual basis.[304]	135% increase.	No change.	No change.	No change.	No change.	No change.

304 Changed from monthly failure period to per instance failure.
305 Clarification.

Estate Service KPIs

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
	KPI #1 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
1	Accurate records of the cost of undertaking Additional Works and forecast costs of Additional Works within the Annual Services Plan are maintained at all times.	No change.	No change.	No change.	No change.	No change.	No change.
2	All Programmed Maintenance is carried out and completed by the agreed scheduled time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[307]	No change.	No change.	No change.	No change.	No change.	No change.
3	No Programmed Maintenance is carried out outside the times specified in paragraph 2.3 of this Specific Service Specification unless otherwise agreed with the Principal.[308]	No change.	No change.	No change.	No change.	No change.	No change.
4	Other than in respect of the Facilities Manager's Equipment, all Emergency Faults are Attended to within the relevant Attendance Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[309]	No change.	No change.	100% increase.	No change.	No change.	100% increase.
5	Reactive Maintenance is completed in respect of all Emergency Faults related to Building and Site Service Assets within the relevant Rectification Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[310]	No change.	No change.	1100% increase.	No change.	No change.	No change.
6	Other than in respect of the Facilities Manager's Equipment, all Urgent Faults are Attended to within the relevant Attendance Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[311]	No change.	No change.	No change.	No change.	No change.	No change.

306 Improved standard.

307 Changed to include the opportunity to introduce a new standard, if agreed to by the principal.

308 Changed to specify equipment that is not Serco's.

309 Improved standard.

310 Changed to specify equipment that is not Serco's.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
7	Reactive Maintenance is completed in respect of all Urgent Faults related to Building and Site Service Assets within the relevant Rectification Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[317]	No change.	No change.	No change.	No change.	No change.	150% increase
8	Other than in respect of the Facilities Manager's Equipment, all Non-Urgent Faults are Attended to within the relevant Attendance Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[318]	No change.	No change.	No change.	No change.	No change.	No change.
9	Reactive Maintenance is completed in respect of all Non-Urgent Faults related to Building and Site Service Assets within the relevant Rectification Time and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[319]	No change.	No change.	No change.	No change.	No change.	No change.
10	Faults related to Building and Site Components and Principal's Equipment are rectified and Reactive Maintenance is completed within the time period agreed with the Principal and in accordance with the operational method statements contained in the Estate Service Plan and all other relevant Facilities Management Plans.[320]	No change.	No change.	No change.	No change.	No change.	No change.
11	The Principal is notified, within the timeframes stated in paragraph 2.2(d)(4)(B) of this Specific Service Specification, of the cost of undertaking the relevant works.	No change.	No change.	No change.	No change.	No change.	No change.
12	All additional plant and equipment are commissioned in accordance with paragraph 2.2(i) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
13	The procedure established under paragraph 2.2(o) of this Specific Service Specification is implemented and complied with by the Facilities Manager.	No change.	No change.	No change.	No change.	No change.	No change.

311 Improved standard.

312 Changed to specify equipment that is not Serco's.

313 Improved standard.

314 Improved standard.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
14	Appropriate Permits to Work are obtained and adhered to by the Facilities Manager and the Personnel in accordance with the process agreed by the Principal as required by paragraph 2.3(g) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
15	The Planning and Briefing Support Service is provided in accordance with the program agreed with the Principal as required by paragraph 2.2(n) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
16	The Facilities Manager completes all requests for Minor Works within the time agreed with the Principal.	No change.	No change.	No change.	No change.	No change.	No change.
17	All Additional Works are completed within the time agreed with the Principal and set out in the Estate Service Plan.[325]	No change.	No change.	Changed.[326]	No change.	No change.	No change.
18	All Upgrade Works are completed within the timeframes agreed with the Principal and set out in the Estate Service Plan. [327]	No change.	No change.	Changed.[328]	No change.	No change.	No change.
19	The Facilities Manager complies with paragraph 2.2(h)(1) of this Specific Service Specification.	50% decrease.	100% increase.	No change.	No change.	No change.	No change.
20	The Facilities Manager complies with paragraph 2.2(h)(2) of this Specific Service Specification.	50% decrease.	100% increase.	No change.	No change.	No change.	No change.
21	The Facilities Manager complies with paragraph 2.2(h)(3) of this Specific Service Specification.	63% decrease.	100% increase.	No change.	No change.	No change.	No change.
22	The Facilities Manager complies with paragraph 2.2(h)(4) of this Specific Service Specification.	50% decrease.	100% increase.	No change.	No change.	No change.	No change.
23	The Facilities Manager complies with paragraph 2.2(l) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
	KPI #24 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
24	The Facilities Manager complies with paragraph 2.2(i) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.

315 Changed to refer to Estate Service Plan.
316 Changed to refer to Estate Service Plan.
317 Changed to refer to Estate Service Plan.
318 Changed to refer to Estate Service Plan.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
25	Window cleaning is undertaken so that, at point of cleaning, glazed surfaces are visibly clean and smear free with no blood or body substances, dust, dirt, debris, adhesive tape and spillages visibly present and have a uniformly shiny appearance.	No change.	No change.	No change.	No change.	No change.	No change.
26	Graffiti is removed from any part of the Site within 48 hours of notification to the Helpdesk.	No change.	No change.	No change.	No change.	No change.	No change.
27	All emergency systems within the Site, in the event that any electrical, water, gas or other Utility supplies to the Site are not available, operate correctly.	No change.	No change.	No change.	No change.	No change.	No change.
28	Records in respect of the Estate Service, as detailed in paragraph 2.2(k) of this Specific Service Specification, are provided to the Principal within 5 days of the request being made.	No change.	No change.	No change.	No change.	No change.	No change.
29	Each lift achieves 99% Lift Availability (as defined below) for each week, as measured by the formula outlined below. In respect of each lift, the availability of the lift (Lift Availability) is calculated in accordance with the following formula: Lift Availability (%) = ((Total Time – Down Time) x 100) / Total Time where: 'Down Time' means the aggregate of the periods (in hours) during which the relevant lift was unavailable for normal use: if the relevant lift is not a Critical Care Lift, during Peak Operating Hours during the relevant week; or if the relevant lift is a Critical Care Lift, during the relevant week, in each case, excluding any period of unavailability due to the performance of Planned Maintenance, and 'Total Time' means: in respect of a lift which is not a Critical Care Lift, the number of Peak Operating Hours during the relevant week; or in respect of a Critical Care Lift, 168.	No change.	No change.	No change.	No change.	No change.	No change.
30	Each bank of two or more lifts (Lift Bank) achieves 99.5% Lift Bank Availability (as defined below) each week, as measured by the formula outlined below.	No change.	No change.	No change.	No change.	No change.	No change.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
	In respect of each Lift Bank, the availability of the Lift Bank (Lift Bank Availability) is calculated in accordance with the following formula: Lift Bank Availability (%) = ((Total Time – Down Time) x 100) / Total Time where: 'Down Time' means the aggregate of the periods (in hours) during which each lift within the relevant Lift Bank was: for each lift within the relevant Lift Bank that is not a Critical Care Lift, unavailable for normal use during Peak Operating Hours; and for each lift within the relevant Lift Bank that is a Critical Care Lift, unavailable for normal use during the relevant week, in each case, excluding any period of unavailability due to the performance of Planned Maintenance, and 'Total Time' means: the number of lifts within the relevant Lift Bank which are not Critical Care Lifts multiplied by the number of Peak Operating Hours during the relevant week; plus the number of lifts within the relevant Lift Bank which are Critical Care Lifts multiplied by 168.						
31	Amber or Green range is achieved for all Continuous Improvement Indicators on an annual basis.[319]	125% increase.	No change.	No change.	No change.	No change.	17% decrease.

319 Standard changed from green range achievement only to amber or green range.

Managed Equipment Service KPIs

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
1	The Facilities Manager establishes and maintains a Clinical Products Review Committee with membership approved by the Principal.	No change.	No change.	No change.	No change.	No change.	No change.
2	MES Equipment excluding Low Value Items and its associated service history are traceable by the Asset Management System for 99% of the time.[323]	Changed.	Changed.	No change.	No change.	No change.	No change.
3	Each item of MES Equipment, as selected and directed by the Principal, is procured in accordance with the procurement process in paragraph 2.4 of this Specific Service Specification.	40% decrease.	No change.	No change.	Changed.	No change.	No change.
4	All MES Equipment is adequately licensed and meets the requirements of the Therapeutic Goods Administration at all times.	No change.	No change.	No change.	No change.	No change.	No change.
5	MES Equipment is installed and commissioned in accordance with manufacturer instructions and guidelines.	52% decrease.	No change.	No change.	No change.	No change.	100% increase.
6	All installed MES Equipment is tested and certified in accordance with all Laws prior to commissioning.	44% decrease.	No change.	No change.	No change.	No change.	100% increase.
7	Manufacturer's claimed performance is achieved on the date of planned commissioning, and is verified in writing by a Hospital Employee designated by the Principal.	50% decrease.	No change.	No change.	No change.	No change.	100% increase.
8	Scheduled Maintenance is carried out at the times detailed in the Managed Equipment Service Plan.	78% decrease.	No change.	100% increase.	No change.	No change.	100% increase.
9	Emergency Faults in respect of Group A MES Equipment are Attended to within the Attendance Times (or any other standard accepted by the Principal under a Non Compliant Proposal).[324]	71% decrease.	100% increase.	71% decrease.	No change.	No change.	67% increase.
10	Urgent Faults in respect of Group A MES Equipment are Attended to within the Attendance Times (or any other standard accepted by the Principal under a Non Compliant Proposal).	No change.	No change.	No change.	No change.	No change.	108% increase.

320 Changed from all the time to for 99% of the time.

321 Changed to include new Group A classification, and the opportunity to introduce a new standard, if agreed to by the principal.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
11	Non-Urgent Faults in respect of Group A MES Equipment are Attended to within the Attendance Times (or any other standard accepted by the Principal under a Non Compliant Proposal).	No change.	Changed.[325]	No change.	No change.	No change.	67% increase.
12	Reactive Maintenance Activity in respect of Group A MES Equipment for each Emergency Fault is completed within the Rectification Times (or any other standard accepted by the Principal under a Non Compliant Proposal).	94% decrease.	700% increase.	200% increase.	No change.	No change.	No change.
13	Reactive Maintenance Activity in respect of Group A MES Equipment for each Level 1 Fault which is Urgent is completed within the Rectification Times (or any other standard accepted by the Principal under a Non Compliant Proposal).[325]	83% decrease.	300% increase.	500% increase.	No change.	No change.	108% increase.
14	Reactive Maintenance Activity in respect of Group A MES Equipment for each Level 2 Fault which is Urgent is completed within the Rectification Times (or any other standard accepted by the Principal under a Non Compliant Proposal).	94% decrease.	700% increase.	1100% increase.	No change.	No change.	108% increase.
15	Reactive Maintenance Activity in respect of Group A MES Equipment for each Non-Urgent Fault is completed within the Rectification Times (or any other standard accepted by the Principal under a Non Compliant Proposal).[327]	No change.	No change.	No change.	No change.	No change.	
16	Regular inspections of the Hospital and quality audits of MES Equipment are conducted in accordance with paragraph 2.9(d) of this Specific Service Specification.	66% decrease.	No change.	No change.	No change.	No change.	No change.
17	Product training is provided in accordance with paragraph 2.10 of this Specific Service Specification and the Managed Equipment Service Plan.	78% decrease.	No change.	No change.	No change.	No change.	No change.
18	80% of the number of Low Value Items as stated in Appendix E of this Specific Service Specification are available for use.[328]	N/A	N/A	N/A	N/A	N/A	N/A

322 Changed from two hours to one business day.

323 Ref. 13 and 14 are being compared against the same 2010 KPI – they were split into two according to Level 1 and Level 2 classification.

324 New reference to Group A.

325 New KPI.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
19	Each item of Group B MES Equipment with an annual maintenance value of less than $31,000 (Indexed) has an Uptime Percentage in any Quarter of greater than the relevant Quarterly Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal).[329]	N/A	N/A	N/A	N/A	N/A	N/A
20	Each item of Group B MES Equipment with a an annual maintenance value of less than $31,000 (Indexed) has an Uptime Percentage in any Contract Year of greater than or equal to the relevant Annual Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal).[330]	N/A	N/A	N/A	N/A	N/A	N/A
21	Each item of Group B MES Equipment with an annual maintenance value of between $31,000 and $102,000 (Indexed) has an Uptime Percentage in any Quarter of greater than or equal to the relevant Quarterly Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal).[331]	N/A	N/A	N/A	N/A	N/A	N/A
22	Each item of Group B MES Equipment with an annual maintenance value of between $31,000 and $102,000 (Indexed) has an Uptime Percentage in any Contract Year of greater than or equal to the relevant Annual Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal).[332]	N/A	N/A	N/A	N/A	N/A	N/A
23	Each item of Group B MES Equipment with an annual maintenance value of greater than $102,000 (Indexed) has an Uptime Percentage in any Quarter of greater than or equal to the relevant Quarterly Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal).[333]	N/A	N/A	N/A	N/A	N/A	N/A

326 New KPI.
327 New KPI.
328 New KPI.
329 New KPI.
330 New KPI.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
24	Each item of Group B MES Equipment with a an annual maintenance value of greater than $102,000 (Indexed has an Uptime Percentage in any Contract Year of greater than or equal to the relevant Annual Uptime Percentage Target (or any other standard accepted by the Principal under a Non Compliant Proposal). [339]	N/A	N/A	N/A	N/A	N/A	N/A
25	Amber or Green range is achieved for all Continuous Improvement Indicators on an annual basis. [340]	No change.	No change.	No change.	No change.	No change.	No change.

331 New KPI.

332 Standard changed from green range achievement only to amber or green range.

Management and Integration Services KPIs

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
1	The Performance Monitoring Plan, as detailed in paragraph 2.1(h) of this Specific Service Specification, is accurate, accessible and verifiable by the Principal at all times.	50% decrease.	No change.	No change.	No change.	No change.	No change.
2	The Principal is advised within one hour of any breaches of Laws or Authorisations as required by paragraph 2.1(i) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
3	An accurate organisation structure chart, as described in paragraph 2.2(b) of this Specific Service Specification, is maintained and provided (within 1 day of a change) to the Principal.	No change.	No change.	No change.	No change.	No change.	No change.
4	Personnel or delegates (authorised by the Principal) attend meetings called with at least 1 week's notice as requested by the Principal or authorised Hospital Employees in accordance with paragraph 2.2(d) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
5	Governance frameworks are maintained in accordance with the requirements in paragraph 2.3 of this Specific Service Specification and provided to the Principal at the end of each month.	No change.	No change.	No change.	No change.	No change.	No change.
6	The Facilities Manager provides to the Principal the recommendations of regular expert and quality reviews of the performance of each of the Services as required by paragraph 2.3(b)(2) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	65% decrease.[330]
7	The Facilities Manager provides to the Principal an annual independent expert review of the performance of all Services planning and delivery, as required by paragraph 2.3(b)(3) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	65% decrease.[331]
	KPI #8 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #9 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #10 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A

333 Increase in the period of time that defines a repeated failure.

334 Increase in the period of time that defines a repeated failure.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
8	The Business Continuity Plan is certified by an appropriately qualified external reviewer as required by paragraph 2.3(f) of this Specific Service Specification on an annual basis.	No change.	No change.	No change.	No change.	No change.	92% decrease.[334]
9	Each Service Level agreed with the Principal in accordance with paragraph 2.4(g) of this Specific Service Specification, is achieved in any month.	51% decrease.	No change.	No change.	No change.	No change.	No change.
10	Information or draft responses are provided to the Principal in accordance with paragraphs 2.6(d) and 2.6(e) of this Specific Service Specification and in the timeframe required.	No change.	No change.	No change.	No change.	No change.	150% increase.
11	All electronic data is treated in accordance with paragraph 2.6(f) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
12	A computer model in respect of the provision of all Services, as specified in paragraph 2.7 of this Specific Service Specification, is accurate, up to date and accessible by the Principal at all times.	No change.	No change.	No change.	No change.	No change.	No change.
	KPI #13 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #14 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #15 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #16 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
	KPI #17 of 2010 deleted.	N/A	N/A	N/A	N/A	N/A	N/A
13	The Principal is advised within one hour of any media enquiries made to any Personnel as required by paragraph 2.10(a) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
14	The Facilities Manager complies with paragraph 2.10(b) of this Specific Service Specification.	No change.	No change.	No change.	No change.	No change.	No change.
15	An integrated Site-wide Asset Management System, as detailed in paragraphs 2.11(a) and 2.11(d) of this Specific Service Specification, is maintained and operational at all times.	No change.	No change.	No change.	No change.	No change.	No change.
16	The Asset Management System is accessible at all times in accordance with paragraphs 2.11(b) and 2.11(c) of this Specific Service Specification.	No change.	No change.	100% increase.	No change.	No change.	No change.

335 Increase in the period of time that defines a repeated failure.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
17	An Inventory Management System, as detailed in paragraph 2.11(e) of this Specific Service Specification, is maintained and operational at all times.	No change.	No change.	No change.	No change.	No change.	No change.
18	The Facilities Manager holds a valid ISO 9001 accreditation as required by paragraph 2.12(c) of this Specific Service Specification, at all times.	No change.	No change.	No change.	No change.	No change.	No change.
19	Compliance with the Australian Council on Healthcare Standards standards is maintained as required by paragraph 2.12(c) of this Specific Service Specification, at all times.	No change.	No change.	No change.	No change.	No change.	No change.
20	Customer satisfaction surveys are conducted and information provided to the Principal in accordance with paragraph 2.12(e) of this Specific Service Specification.	45% decrease.	No change.	No change.	No change.	No change.	No change.
21	Risk documentation is updated every 3 months, as required by paragraph 2.13(c) of this Specific Service Specification, and submitted to the Principal.	No change.	No change.	No change.	No change.	Changed.	No change.
22	Principal Personnel and officers and employees of WA Health are not approached or communicated with in regards of employment opportunities as required by clause 6.1(h) of the Contract.[336]	No change.	No change.	No change.	No change.	No change.	No change.
23	There is a Facilities Manager's Representative at all times who is appropriately qualified in accordance with clause 6.4(a) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
24	The Principal is notified at least 5 Business Days before changing the Facilities Manager's Representative as specified in clause 6.4(b) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
25	Each of the Facilities Manager's representatives attend meetings of the Facilities Management Advisory Group as per clause 6.5 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
26	Weekly facilities management meetings are convened and chaired by the Facilities Manager and address the requirements as set out in clause 6.6 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
27	The Facilities Manager attends meetings in accordance with clause 6.7 of the Contract, when requested with at least 2 days notice by the Principal.	No change.	No change.	No change.	No change.	No change.	No change.

336 Removed prohibition of approaching consultants.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
28	Each Key Personnel is engaged, assigned and experienced as required by clause 6.8 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
29	Prior approval from the Principal is obtained before replacing Key Personnel as required by clause 6.9 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
30	The Principal is notified within 5 Business Days of the Facilities Manager becoming aware of changes in relation to Subcontractors as specified in clause 6.9(b) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
31	Each Personnel is suitably clothed and equipped with the appropriate safety equipment at all times in accordance with clause 6.10(a) of the Contract for 98% of the time in any month.[338]	Changed.	No change.	No change.	No change.	No change.	150% increase.
32	The Facilities Manager complies with clause 6.12(a) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
33	The Principal is notified as soon as practicable of any event that has occurred in relation to any Personnel as set out in clause 6.12(d) of the Contract.	No change.	No change.	No change.	Changed.	No change.	No change.
34	Each proposed Services Subcontract is tendered in accordance with clause 7.3(a) of the Contract.	73% decrease.	No change.	No change.	No change.	No change.	No change.
35	Information relating to proposed or existing Subcontractors, as specified in clause 7.5 of the Contract, is provided to the Principal within the timeframes requested.	No change.	No change.	No change.	No change.	No change.	No change.
36	The Principal is notified of any meeting or discussion with a stakeholder (as defined in the Stakeholder Management Plan) as required by clause 8.3(b) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
37	A register of consultation with stakeholders (as defined in the Stakeholder Management Plan) is maintained as set out in clause 8.3(d) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
38	Assistance is given to, and Records are made available to each of the persons listed in clause 9.2(a) of the Contract for the purposes specified under clause 9 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.

337 Changed from all the time to for 98% of the time.

Ref	Performance parameters	Performance failure points	Failure period	Remedial period	Concluded / Rectified	Monitoring method	Repeated failure
39	Access to the Facilities Manager's Personnel and facilities is provided to each of the persons listed in clause 9.2(a) of the Contract for the purposes specified under clause 9 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
40	The Annual Service Plan is prepared and provided to the Principal in accordance with the requirements set out in clause 15.6 of the Contract.	54% decrease.	600% increase.	600% increase.	No change.	No change.	No change.
41	The Principal is notified within 24 hours of any accident, incident, injury or property damage as specified in clauses 23.3(a) and 23.3(b) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
42	A written report is provided to the Principal on any incident specified in clause 23.3 of the Contract, within 2 days, in accordance with clause 23.3(c) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
43	All reportable situations are reported and the Facilities Manager complies with all other obligations under the Dangerous Goods Safety Act 2004 (WA) as required by clause 23.4 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
44	The Facilities Manager complies with clause 25.4(a) of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
45	Notify the Principal within 5 Business Days of becoming aware of any incident involving Confidential Information as specified in clause 34.2 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
46	Each Facility Management Plan is provided to the Principal and reviewed and updated in the timeframes required in accordance with Schedule 1 of the Contract.	No change.	600% increase	600% increase.	No change.	No change.	No change.
47	The Service Report is provided to the Principal on a monthly basis in accordance with the requirements of Schedule 16 of the Contract.	No change.	No change.	No change.	No change.	No change.	No change.
48	No Personnel smoke anywhere on the Site.	Changed.	215,900% increase	No change.	No change.	No change.	No change.
49	Amber or Green range is achieved for all Continuous Improvement Indicators on an annual basis.[340]	195% increase.	No change.	No change.	No change.	No change.	No change.

338 Standard changed from green range achievement only to amber or green range.

Appendix Two

Inquiry Terms of Reference

That the Public Accounts Committee inquire into and report on the processes utilised and outcomes reached in awarding Serco Australia the contract for the provision of non-clinical services at Fiona Stanley Hospital. In particular, the Committee is to examine the:

1. project definition processes undertaken to identify both the services required at the hospital and which of those services are to be provided by Serco Australia;

2. procurement plan, including the public sector comparator, endorsing the private sector delivery of non-clinical services at Fiona Stanley Hospital;

3. risk management planning undertaken;

4. compliance management arrangements for the contract; and

5. objectives, including service quality and value for money, and the extent to which the contract as signed is likely to meet those objectives.

Appendix Three

Committee's functions and powers

The Public Accounts Committee inquires into and reports to the Legislative Assembly on any proposal, matter or thing it considers necessary, connected with the receipt and expenditure of public moneys, including moneys allocated under the annual Appropriation bills and Loan Fund. Standing Order 286 of the Legislative Assembly states that:

The Committee may —

1. Examine the financial affairs and accounts of government agencies of the State which includes any statutory board, commission, authority, committee, or trust established or appointed pursuant to any rule, regulation, by-law, order, order in Council, proclamation, ministerial direction or any other like means.

2. Inquire into and report to the Assembly on any question which —

a) it deems necessary to investigate;

b) (Deleted V. & P. p. 225, 18 June 2008)

c) is referred to it by a Minister; or

d) is referred to it by the Auditor General.

3. Consider any papers on public expenditure presented to the Assembly and such of the expenditure as it sees fit to examine.

4. Consider whether the objectives of public expenditure are being achieved, or may be achieved more economically.

5. The Committee will investigate any matter which is referred to it by resolution of the Legislative Assembly.

Appendix Four

Submissions received

Name	Position	Organisation
Peter Whitelaw	Private citizen	
Michael Barnes	Acting Under Treasurer	Department of Treasury
John Gourley	Private citizen	
Closed evidence		Department of Health
Dr Michael Stanford	Group CEO	St John of God Health Care
Colin Penter	Convenor	Serco Watch
Toni Walkington	Branch Secretary	Community and Public Sector Union Civil Service Association of WA
Dan Hill	Secretary	Health Services Union of WA
Dave Kelly	Secretary	United Voice WA
Jonathan Kennedy	National Manager, Policy	Infrastructure Partnerships Australia
Timothy Marney	Under Treasurer	Department of Treasury
Closed evidence		Department of Health
Tim Evans	Communications Manager	Serco Australia
Closed evidence		Department of Health
Timothy Marney	Under Treasurer	Department of Treasury
Closed evidence		Serco Australia
Closed evidence		Department of Treasury
Closed evidence		Department of Health
Closed evidence		Paxon Group
Closed evidence		Department of Health
Timothy Marney	Under Treasurer	Department of Treasury
Timothy Marney	Under Treasurer	Department of Treasury
Anne Nolan	Director General	Department of Finance
Closed evidence		Paxon Group
Kim Snowball	Director General	Department of Health
Closed evidence		Department of Treasury
Closed evidence		Department of Health
Tim Evans	Communications Manager WA	Serco Asia Pacific
Closed evidence		Department of Health
Closed evidence		Department of Health
Closed evidence		Department of Health
Closed evidence		Department of Health
Closed evidence		Department of Health
Anne Nolan	Director General	Department of Finance
Kim Snowball	Director General	Department of Health

Closed evidence		Department of Health
Kim Snowball	Director General	Department of Health
Closed evidence		Department of Health
Anne Nolan	Director General	Department of Finance

Appendix Five

Hearings

Date	Name	Position	Organisation
25 October 2011	Mr Timothy Marney	Under Treasurer	Department of Treasury
25 October 2011	Mr Kim Snowball	Director General	Department of Health
	Ms Nicole Feely	Chief Executive, South Metropolitan Area Health Service	
	Mr Andrew Joseph	Director, Financial Policy Framework	
	Mr Wayne Salvage	Executive Director, Resource Strategy and Infrastructure	
	Mr Brad Sebbes	Executive Director, Fiona Stanley Hospital	
30 November 2011	Mr David Campbell	Chief Executive Officer	Serco Australia
	Mr Timothy Catterall	Director, Strategy and Business Development	
	Mr Ian Quarrie	Director, Strategy and Business Development	
	Mr Andrew Prince	Director	Serco Healthcare Consulting, United Kingdom
12 January 2012	Mr Wayne Salvage	Acting Executive Director, Resource Strategy and Infrastructure	Department of Health
	Mr Andrew Joseph	Director, Financial Policy Framework	
	Mr Brad Sebbes	Executive Director, Fiona Stanley Hospital	
3 April 2012	Mr Kim Snowball	Director General	Department of Health
	Mr Brad Sebbes	Executive Director, Fiona Stanley Hospital	

	Mr Wayne Salvage	Acting Executive Director, Resource Strategy and Infrastructure	
	Mr Andrew Joseph	Acting Director, Budget Strategy	
24 April 2012	Mr Kim Snowball	Director General	Department of Health
	Mr Brad Sebbes	Executive Director, Fiona Stanley Hospital	
	Mr Wayne Salvage	Acting Executive Director, Resource Strategy and Infrastructure	
	Mr Andrew Joseph	Acting Director, Budget Strategy and Management	
24 April 2012	Ms Anne Nolan	Director General	Department of Finance
	Mr Rodney Alderton	Executive Director, Government Procurement	
	Mr Graeme McLean	General Manager Planning and Practice, Building Management and Works	

Appendix Six

Acronyms

AGV	Automatic Guided Vehicle
ASFAP	Audit Services and Financial Advice Panel
AV	Audio Visual
BMW	Building Management and Works
BT	British Telecom
CBA	Commonwealth Bank of Australia
DCF	Discounted Cash Flow
DoF	Department of Finance
DoH	Department of Health
DoT	Department of Treasury
EOI	Expressions of Interest
ERMS	Electronic Records Management Service
FF&E	Furnishings, Fittings and Equipment
FSH	Fiona Stanley Hospital
FM	Facilities Management
FM Plans	Facilities Management Plans
FMSC	Facilities Management Services Contract
IA	Infrastructure Australia
IA Guidelines	Infrastructure Australia National PPP Guidelines
ICT	Information and Communications Technology
IT	Information Technology
KPI	Key Performance Indicator
MES	Managed Equipment Service
Mgt	Management
MHC	Midland Health Campus
MHISC	Major Health Infrastructure Steering Committee
NPC	Net Present Cost
NSW	New South Wales
PAS	Patient Administration System
PSC	Public Sector Comparator
PPP	Public Private Partnership
QE2	Queen Elizabeth II
RFS	Request for Submissions
RPM	Retail Property Management
RNS	Royal North Shore Hospital
SPV	Special Purpose Vehicle
SSO	State Solicitor's Office
UK	United Kingdom
UKNAO	United Kingdom National Audit Office

VfM	Value for Money
WA	Western Australia