LEGISLATIVE COUNCIL

SELECT COMMITTEE ON HEALTH SERVICES IN SOUTH AUSTRALIA

Old Parliament House Chamber, Old Parliament House, Adelaide

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WITNESSES

MEMBERS:

Hon. C. Bonaros MLC (Chairperson)
Hon. E.S. Bourke MLC
Hon. N.J. Centofanti MLC (via videoconferencing)
Hon. I. Pnevmatikos MLC
Hon. T.J. Stephens MLC

WITNESS:

SVIGOS, JOHN, Convenor, Women's and Children's Hospital Alliance

1193 The CHAIRPERSON: Professor Svigos, welcome to the meeting. Thank you for attending today. I will first read out some material that we need to provide you with. The Legislative Council has given authority for this committee to hold public meetings; however, due to the current situation concerning the COVID pandemic, the committee has resolved to exclude strangers from the gallery.

A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard, but the corrected transcript once received from you will replace the uncorrected transcript. I advise that your evidence today is being broadcast via the Parliament of South Australia website.

Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded that the same rules apply as with the reporting of parliament.

I also acknowledge that the land we meet on today is the traditional land of the Kaurna people and we respect their spiritual relationship with their country. We also acknowledge the Kaurna people as the traditional custodians of the Adelaide region. Their cultural and heritage beliefs are still as important to the living Kaurna people today. Professor Svigos, thank you again for appearing. I invite you first to make any opening remarks that you may have before we get into questions.

Prof. SVIGOS: Good morning, Ms Bonaros, thank you, and thank you for acknowledging the Kaurna people. Thank you for the opportunity to allow me to come before the select committee. May I introduce myself: I am Professor John Svigos. I continue to work in active clinical practice as an obstetrician and gynaecologist with SA Health since 1970; in private practice since 1978; as a consultant at the Women's and Children's Hospital in maternal foetal medicine until 2018; and, since then, working at the Lyell McEwin, Port Augusta and Gawler hospitals.

I am currently the Convenor of the Women's and Children's Hospital Alliance, which consists of a group of former senior consultants to the Women's and Children's Hospital with associated concerned professional bodies and concerned parents, who have joined together with Rachael Sporn as our champion since March of this year, in response to the courageous decision of 215 members of the medical staff of the Women's and Children's Hospital to go public in February with their professional, moral and ethical concerns of the depletion of resources and reduced staffing at the hospital, which is impacting on the care and services they provide for the women and children of South Australia.

The Women's and Children's Hospital Alliance would like to make comment on three areas of concern—which I guess is my opening statement—in our health and hospital system which we feel compelled to bring to your attention: governance and administration matters and how they relate to the Women's and Children's Hospital; secondly, specific and substantial clinical problems

currently being experienced at the Women's and Children's Hospital; and, thirdly, reservations and concern with regard to the planning of the new Women's and Children's Hospital. May I proceed further?

1194 The CHAIRPERSON: Yes, Professor.

Prof. SVIGOS: Firstly, with regard to governance and administration matters at the Women's and Children's Hospital, the Minister for Health, backed by the chief executive of South Australian Health, has developed a decentralised form of governance at the Women's and Children's Hospital in which the board of management, with advice and implementation by the CEO and its executive, is charged with, amongst other duties, making important and far-reaching decisions on clinical matters which, with due respect, they do not have the specific skill set or the budget to perform.

Without doubt, the board is comprised of respected individuals, but unfortunately there is not one member who is an active clinician at the hospital, which is now the norm for progressive contemporary national and international hospital boards, and thus it does not have the advantage of having the insight such clinicians can bring with their regular contact with patients, staff, facilities and visitors, as well as keeping abreast of current developments in the profession and other health institutions. I shall return to this critical limitation in a moment.

In the meantime, the CEO and the executive of the Women's and Children's Hospital have very recently expressed in their own words their lack of the skill set required to deal with an alleged budgetary overrun of $8 million, which has led to the rapid acquisition of the services of KPMG without tender and signed off on by the CE of SA Health for $1 million to $3 million to help with savings to correct this problem, principally by reducing nursing staff hours and to teach the incumbent administrative staff the required skill set over two to three years.

This $1 million to $3 million is sorely needed at the hospital for myriad resources and clinical services. To continue to support administrative staff who should have been employed with the required skill set is beyond comprehension, particularly as a number of board members have avowed skills in business management.

Let us now turn to the specific and substantial clinical problems being experienced at the Women's and Children's Hospital; firstly, provision of cardiac surgery and an extracorporeal membrane oxygenation (ECMO) support service. Adelaide is the only mainland state capital city that does not have this service available for babies and children in South Australia. A well prepared clinical and compelling business case, which would ultimately save SA Health $5 million per year for this capacity, was first presented 18 months ago by the Paediatric Intensive Care Unit to the CEO and the executive of the Women's and Children's Hospital.

A decision was delayed until finally a flawed independent review recommended that it should not go ahead on the basis of lack of numbers. We have 90 to 100 babies and children transferred to Melbourne for surgery each year which, once again, was an erroneous argument with the excellence centre in Perth and the second excellence centre in Sydney having the equivalent to even less numbers, as do other prestigious centres internationally.

Additionally, the review suggested without evidence and in the face of informed opinion to the contrary from international and national experts that perhaps a standalone ECMO or support service without a dedicated paediatric cardiac surgeon and cardiac unit might be entertained. This dangerous and uninformed proposal was rejected, quite rightly, by those proposing the service.

Twelve days ago, after considerable public pressure, the original proposal was requested by the Minister for Health to be put to the board of management of the Women's and Children's Hospital in person by the same group of proposers which includes cardiac surgeons from the Royal Adelaide Hospital along with a respected international paediatric surgeon with a team ready to take up the challenge in attendance by video. The board decided that, once again, the final decision should be delayed until opinions from three other specialists are received.

With a delay or no decision, there are consequences, particularly in our current COVID-19 situation where the usual process of referral to the Melbourne cardiac unit is no longer tenable and referral to Sydney is on a case-by-case basis. I have been given to understand that the Women's and Children's Hospital, sadly, has seen the death of three babies in the last four weeks

who were unable to be transferred and who almost certainly would have benefited from on-site cardiac surgery and an ECMO support system. Do you want me to repeat that, Ms Bonaros?

1195 The CHAIRPERSON: If you could, professor.

Prof. SVIGOS: With a delay or a decision there are consequences, particularly in our current COVID-19 situation where the usual process of referral to the Melbourne cardiac unit is no longer tenable and referral to Sydney is on a case-by-case basis. I have been given to understand that the Women's and Children's Hospital sadly has seen the death of three babies in the past four weeks who were unable to be transferred, who almost certainly would have benefited from onsite cardiac surgery and an ECMO support system.

Respectfully, I shall leave it to you to imagine the profound effect of these deaths on the parents, their families and the dedicated medical and nursing staff dealing with these tragedies. The Women's and Children's Hospital Alliance would humbly ask: how many more deaths of babies and young children will the community and the staff be forced to endure before the Minister for Health will cut across this unnecessary procrastination due to the in-built inability of the board and the CEO and executive to make definitive clinical decisions and move to solve this problem?

Let us now turn to the special care birthing unit, or SCBU as it's known (and I am sorry about using some of these abbreviations). As a response to the outbreak of a serratia infection in the smaller neonatal intensive care unit at Flinders Medical Centre, the ageing neonatal intensive care unit and the special care baby unit at the Women's and Children's Hospital were assessed and it was found that the Women's and Children's Hospital SCBU had significant limitations with regard to infection control.

The unit was redesigned and refurbished with adequate distancing and appropriate ventilation, and on 14 August with great fanfare it was opened by the Minister for Health and since then, for the last 10 weeks or more, at a cost of $5,000 per day, it has remained idle until, strangely enough, today it's open, which we are very happy about but—

1196 The CHAIRPERSON: It's open today, did you say?

Prof. SVIGOS: It just started, open today; yes, that's correct. I have had advice that it was opened today. With such delays, however, there are consequences. The staff have been forced to continue to manage small and at-risk babies in the infection-prone old SCBU and have already had to cope with the dangerous power failure in the unit. This in turn has meant the urgent work on the neonatal intensive care unit, which was supposed to start on 1 September, has had to be delayed until the new SCBU was operational.

There are a number of individuals on the board of management who profess to have governance and risk management credentials and surely this crisis would fall within their remit. Additionally, the $350,000 lost thus far in keeping the unit ready for service would have employed, for one year, five nurses or three junior doctors who are all sorely needed at the hospital.

Thirdly, I turn to the surgical equipment replacement budget. Currently, there is an outstanding amount of $12.3 million required to replace outdated or repaired surgical equipment at the hospital. Thirty per cent of these items are well past the manufacturer's use-by date and include neonatal ventilators often repaired three and four times, oxygen monitors, operating laparoscopes and orthopaedic and neurosurgical drills, just to name a few. SA Health has made inadequate provision for this, with $800,000 per year for the next two years being made available in the hospital budget to deal with this problem of $12.3 million.

Once again, there are consequences of such inertia and procrastination as those same individuals sitting on the board of management with their credentials of governance and risk management would be aware that this aberration of using outdated equipment places the hospital in a precarious medico-legal risk situation, let alone the more significant potential human risk of harm to the women and children being treated at the hospital.

There are many other pressing and dire issues at the hospital involving staffing, resources, paediatric cancer treatment, epilepsy management, obstetric issues and computer problems to name just a few, but time constraints do not allow me to elaborate at the moment, although I am prepared to take questions.

However, before doing so, it is with great disappointment that I would like to draw your attention to the reservations and concerns of the planning of the new Women's and Children's Hospital. I shall put aside the general reservations already expressed at a number of other forums: a $1.9 billion build on a potentially contaminated and dimensionally inadequate site, with a reduced bed and service capacity, and inadequate staff and visitor parking and unmentioned parental accommodation facilities, all of which are waiting to be addressed.

As you are aware, the Minister for Health has made numerous references to the input of frontline clinicians, doctors, nurses and midwives into the planning of the new Women's and Children's Hospital in the hope that the design and commissioning errors of the Royal Adelaide Hospital would not be repeated.

Despite being granted only a token $600,000 of the estimated $2.4 million required to provide cover of patient services of the participating clinicians by other clinicians, nevertheless the medical and nursing staff have put this to one side and have thrown themselves enthusiastically, and often in their own time, into the 90 or more planning user groups and strategic user groups, only to be bewildered and demoralised by the clear ignoring of the previously decided process of acceptance and implementation of their input by the apparent medically inexperienced, bureaucratic coordinators of the process, Johnstaff.

There are no plans to work from but just concepts, and there is no acknowledgement of clinicians' suggestions and to whom these suggestions are reported to, nor is there information available regarding the overall context of the new hospital with community and state services, which would impact significantly on the planning of the new hospital. So we are planning blind.

Most participants and participating clinicians are of the opinion that the plans are already done and dusted and that their input will be ignored, as the Johnstaff participants continue to feed back to them that the central planning committee, whoever that might be, have already decided on such things as bed numbers, the provision of laboratory services off site and for open workspace areas.

With regard to the latter, with the contemporary design of buildings nowadays in the light of the COVID-19 pandemic, there will be a rejection of open space concept and separate offices, distancing, ventilation and separate entrances and exits would be required in the new hospital in order to keep patients and staff safe but clearly adding to the cost.

Once again, even in this early stage of planning, it's clear that clinician input, despite the strident denials of the Minister for Health and the CEO, is not welcome, and so I have reiterated there will be consequences of this rejection of consultation, with the ongoing problems at the Royal Adelaide Hospital now certainly being repeated again and most likely at great cost both financially but, more importantly, in human terms to the women and children of South Australia. That is the end of my presentation, Ms Bonaros.

1197 The CHAIRPERSON: Thank you, Professor Svigos, for that opening. Can I start by congratulating you on the work that you have done over five decades in this area. You are obviously well known and well regarded in this area. You have delivered, I imagine, many of our children as well.

Prof. SVIGOS: It's been an honour to have done so.

1198 The CHAIRPERSON: Wonderful. You obviously speak with a great deal of experience on behalf of clinicians who work in this area. Before turning to some of the issues that you have raised, can we just confirm for the record what prompted the Women's and Children's Hospital Alliance to be implemented?

Prof. SVIGOS: As I stated in February, 215 members of the staff decided to go public with their concerns, having previously brought it to the attention of the CEO and the executive in October last year. In response to their public show—a courageous show, I might add—of bringing forward these problems, a group of my fellow colleagues who used to work at the Women's and Children's Hospital, who only recently left the Women's and Children's Hospital or retired, decided that we would band together to be a voice for the staff because we knew fairly soon that they would be shut down.

They have been threatened with that at least on two occasions now in terms of not being able to speak up about what the problems are. Yet the Minister for Health said that that wasn't going to happen, that he accepted this. When he was the shadow minister for health previously he would listen to the concerns of the staff, but we had a notion that it probably wouldn't happen and that is why the alliance is there: to speak on behalf of the staff which we feel they will be constrained from doing.

1199 The CHAIRPERSON: It takes a great deal of courage for clinicians currently practising to come forward.

Prof. SVIGOS: It's the hardest thing to do. It's with great guilt that I have to profess my knowledge of what is going on with great disappointment. I have worked for 30 years at that institution and I'm proud of that institution. It hurts me to even mention that perhaps we can't give the quality care that we should be giving to the women and children of South Australia. It's a reflection on me, I feel—and my colleagues feel the same—and, similarly, the junior colleagues who are working at the hospital now feel that way.

1200 The CHAIRPERSON: Noting what you have just said, Professor Svigos, let's make this very clear: your evidence to this committee today is that in the past month three children have died as a result of not being able to access surgery here in South Australia and potentially not even interstate, so they have missed out on potentially life-saving—

Prof. SVIGOS: Exactly. I agree with what you have stated, yes.

1201 The CHAIRPERSON: What has been the toll, not just the unspeakable toll on those families—and I'm sure all members join me in extending our sincerest condolences to those families—but on the clinicians and those who work at the hospital?

Prof. SVIGOS: The clinicians are totally demoralised. They feel that they have let their patients down. It's very difficult for them to explain why this is so. It's very difficult to cope with that. We have what we call safety learning systems or SLSs and so forth for the executive to help them deal with this, but this time they have not received any response other than, 'I don't think you should be talking about this.'

1202 The CHAIRPERSON: To your knowledge, what, if any, explanation has been given to the families of those three children in relation to—

Prof. SVIGOS: I wasn't present at the time so I can't tell you totally. Mine would only be third-hand information, that they explained to the parents that these facilities were not available.

1203 The CHAIRPERSON: Just turning to those facilities then specifically, if a standalone ECMO is such a dangerous proposal, then why has it been suggested by the chairman of the board of management of the Women's and Children's Hospital for the clinicians to consider?

Prof. SVIGOS: I believe it's on the basis of a flawed notion of reduced cost of ECMO which could be used to keep a sick child alive in preparation for the child to be transferred interstate for surgery without the hospital having to bear the cost of a full cardiac surgery unit, the surgeon and set-up at the Woman's and Children's Hospital. I believe it's an erroneous decision made based on cost.

1204 The CHAIRPERSON: How much do we spend on transferring patients to Victoria at the moment?

Prof. SVIGOS: We spend $5 million a year transferring patients. The business case to set up a unit would be $6 million in the first instance and $1 million to continue it. Thereafter we would be saving at least $4 million a year to the South Australian health budget if we were able to do that, with the situation becoming cost neutral within two years.

1205 The CHAIRPERSON: Just be clear: for an additional up-front expenditure of—

Prof. SVIGOS: Of $6 million.

1206 The CHAIRPERSON: —yes, $6 million—$5 million is what we spend to send these children to Victoria for treatment.

Prof. SVIGOS: Correct, 90 to 100 children.

1207 The CHAIRPERSON: If we were to have that service here in South Australia over the long term, the cost each year would be?

Prof. SVIGOS: It would be $1 million.

1208 The CHAIRPERSON: And yet we spent $5 million per year to have them transferred to Victoria or elsewhere.

Prof. SVIGOS: Correct.

1209 The Hon. E.S. BOURKE: Can I just ask a supplementary on that point?

Prof. SVIGOS: Certainly.

1210 The Hon. E.S. BOURKE: Is anyone experienced in cardiac surgery who is able to perform those surgeries? Is there anyone who has expressed interest in coming to Adelaide to perform those surgeries?

Prof. SVIGOS: Yes, there is. There is an overseas, internationally-acclaimed surgeon whose wife is from Adelaide. They are anxious to come back to Adelaide if they can. He would be the ideal person to do this. He also has a team to help as well, and he appeared on video with a submission to the board just recently.

1211 The Hon. E.S. BOURKE: What's delaying that process at the moment? What would be stopping him from coming back to Adelaide, where his from, to provide this service?

Prof. SVIGOS: Because he would want to be able to take over a cardiac unit. He would want to set it up. He's been approached by several other hospitals all over the world to go there to set up their cardiac unit, but he's wanting to come back to Adelaide for personal reasons. He would like to come and set that up, but if there is no notion that this is going to go ahead, if the board have already made the decision that they don't want it to go ahead—they have already made it once—then there is no incentive for him to come.

1212 The Hon. E.S. BOURKE: Is it only the board that makes that decision, or is it the minister that makes that decision as well?

Prof. SVIGOS: That's the governance that's been set up by the Minister for Health and the Chief Executive of SA Health.

1213 The Hon. E.S. BOURKE: So the minister could use his position to—

Prof. SVIGOS: I do believe he could, and I wish he would.

1214 The CHAIRPERSON: To your knowledge, there have been three deaths that we have referred to over the last month.

Prof. SVIGOS: Yes.

1215 The CHAIRPERSON: Have there been previous deaths that you are aware of—

Prof. SVIGOS: Yes.

1216 The CHAIRPERSON: —that are attributable to the same lack of surgery here in South Australia?

Prof. SVIGOS: Yes; that is why this whole thing has been instituted 18 months ago.

1217 The CHAIRPERSON: Do we have any idea of the number of deaths that we may have that we may be dealing with?

Prof. SVIGOS: I don't know that, no.

1218 The CHAIRPERSON: But there may be clinicians who are aware or certainly the hospital should be aware of the number of deaths.

Prof. SVIGOS: They should be aware, yes, that's correct. No, I don't have that information.

1219 The CHAIRPERSON: Are you aware of any legal action that's being instigated by any of the parents?

Prof. SVIGOS: No, I don't believe so, but I don't know.

1220 The CHAIRPERSON: Do you think, in your opinion, that there may be grounds for liability on the part of the government in relation to some of those deaths?

Prof. SVIGOS: I'm not a lawyer, Ms Bonaros; I don't know.

1221 The Hon. E.S. BOURKE: Can I just have one supplementary? You've stated that you're not a lawyer and the minister has stated that he is not a medical professional, but he recently said on FIVEaa that he doesn't want to have an opinion on this. I will quote what he said:

> To be frank, I don't want to give you my personal opinion. I am a politician.

Do you think the minister should have an opinion on whether we do have cardiac surgery provided here in South Australia?

Prof. SVIGOS: Of course I do. He's in charge of the lot. It stays with him. This is something he contracted to do, to give the women and children of South Australia the best possible health we can give. We've got clinicians anxious to do that. We need the budget, of course, obviously, to do that, but we need the will first.

1222 The Hon. I. PNEVMATIKOS: You have identified already that a number of patients are suffering, and you've identified a health cardiac specialist who would be available in terms of our state. Are we losing skilled doctors?

Prof. SVIGOS: Yes. The whole notion of how we do our staffing has been that we have really got rid of a layer of what we call senior trainees. These senior trainees are no longer appointed at the hospital. These senior trainees were the lifeblood of the next group of consultants. They would go away and study overseas for two or three years, come back with new ideas and become the next lot of consultants.

At the moment, we've got a situation where we don't have any of those, or very few of those, senior registrars, so there are not people coming back with ideas; they are going elsewhere. So we are left with an ageing consultant workforce, with some very junior staff looking after the patients. This became evident with the COVID-19 epidemic, where the ageing consultants were considered at risk and had to go home and manage things from home, with the junior people on deck—a most unsatisfactory situation, you will agree. That's the consequence of this.

1223 The Hon. I. PNEVMATIKOS: How long would it take to remedy this sort of situation?

Prof. SVIGOS: It's going to take us at least two or three years, but that is well before we move to the scheduled move to the new hospital in 2026. I don't want people just going into neutral. This need is always going to be there and we need to really deal with it. If we don't deal with it and say, 'We are going to get a new build in 2026 but not a new service,' that's really defeating the purpose of having a world-class centre.

1224 The Hon. I. PNEVMATIKOS: You talked about how the alliance was formed. How rife is bullying behaviour within the Women's and Children's Hospital? What have you seen happening?

Prof. SVIGOS: Nothing really in terms of something tangible because I haven't actually stepped foot in the place for two years, but I am very well aware of it all, and I work in other hospitals as well. Apart from the question about there being an obvious suppression on being able to speak freely, which is part of the contract you sign when you become a doctor working at the hospital, that is the main area I consider to be bullying—to stop people from expressing their concerns. There may be other examples of that, but if you are asking me for specific things, I cannot give you that.

1225 The CHAIRPERSON: To your knowledge, in relation to that, whether implicit or explicit, doctors have been spoken to about speaking out on this particular issue?

Prof. SVIGOS: Correct.

1226 The CHAIRPERSON: Particularly in relation to deaths that have occurred at the hospital?

Prof. SVIGOS: Yes, at the moment.

1227 The CHAIRPERSON: And specific doctors who have singled out cases, to your knowledge, have been pulled aside and have been spoken to about the appropriateness of their behaviour?

Prof. SVIGOS: Yes, that is correct.

1228 The CHAIRPERSON: And those same doctors have taken an oath that says that their responsibility to their patient overrides any other responsibilities they have?

Prof. SVIGOS: That's correct; overrides everything else.

1229 The CHAIRPERSON: In terms of our global reputation as a medical hub—and I know you touched on this in terms of the brain drain—what does this do to our global reputation in this area?

Prof. SVIGOS: I was lucky enough to be at the Women's and Children's Hospital when it became a world-class, well regarded centre. I don't think we're there now. Things have been allowed to wind down so much that we are probably a bit second class now. The chief executive of SA Health mentioned that in this—I don't know whether it was in this room, but in this very house.

1230 The Hon. E.S. BOURKE: In regard to there being fewer professional and skilled people within these positions, and you have said that you feel like we have become a second-class health service—

Prof. SVIGOS: Yes, that's right.

1231 The Hon. E.S. BOURKE: —I guess that has consequences at another level where, if you have someone who is highly skilled at this level and they come to South Australia, will they feel like they have to carry the weight of the health system and that they will be relied on and solely be seen as the person they have to go to, so that is an additional burden for them? They might share that load with other highly skilled professionals.

Prof. SVIGOS: Perhaps I have it wrong, but if they are encouraged to come they would gladly wear that. We have been doing that for 20 or 30 years, because we know that at the end of it we are going to give the best possible care we can to the patients, but they have to be encouraged. If they are not encouraged and they are discouraged by staffing cuts, by no resources and so forth, then it is disheartening, particularly when other centres are offering you something better.

1232 The Hon. E.S. BOURKE: And who should be encouraging them to come?

Prof. SVIGOS: The Minister for Health, the executive of SA Health—everybody.

1233 The CHAIRPERSON: Professor Svigos, I think we could spend all afternoon on this topic—

Prof. SVIGOS: We could; that's why I didn't want to get into it.

1234 The CHAIRPERSON: —because I know that we all have a lot of questions on this, and we may forward additional questions to you in writing. I just want to touch on two things. You mentioned the equipment at the hospital, and there have been suggestions that we are at least 20 or 30 years behind the times in terms of where we are at with the equipment that doctors have to work with. Is that an accurate reflection, do you think, of where we are now?

Prof. SVIGOS: I don't know about 20 or 30 years behind, but I think it took about 10 years to develop into this situation. It can be cured pretty quickly with $12.3 million.

1235 The CHAIRPERSON: In relation specifically to the issue of doctors requiring this urgent treatment, what has been the impact of COVID-19? I know that you touched on this in your opening, but obviously we have an issue in Victoria, which is preventable.

Prof. SVIGOS: Yes, we can't transfer patients to Victoria to the cardiac unit as we used to. Sydney is a case-by-case situation, depending on what is going on with their COVID-19 situation. It is telling us that if we are not self-sufficient we are going to run into this problem again. It

would be crazy to think that this will be the last pandemic we are going to have. People say it's once in 100 years. We have no way of knowing that. We don't even know what we are doing next month.

1236 The Hon. I. PNEVMATIKOS: I want to go back to the special care baby unit. You indicated that it's operational from today.

Prof. SVIGOS: Yes, from today. This morning I got a phone call.

1237 The Hon. I. PNEVMATIKOS: What do you think of the issues that left this unit idle for so long and babies being looked after in the old space?

Prof. SVIGOS: It was a reflection of, unfortunately, the executive and the chief operational officer, who forgot to factor into the planning that extra staffing would be required. I think the minister said it was a union dispute. It was a planning problem, where they weren't factored into it. You need more nursing staff, because you are broadening the size of the nursery in order to have distancing, and they came in and said, 'Look, this is a new form of teaching and we have to teach these people how to do this. They need extra resources like personal protective equipment.'

These things weren't available at the time, or weren't made provision for, and we've had a 10½ week delay. As I said, it is $350,000 worth.

1238 The Hon. I. PNEVMATIKOS: Turning to another related issue, nine emergency department pod spaces were built at the hospital earlier this year. Are those pods now fully operational or are they idle?

Prof. SVIGOS: No, they have the potential to be there. They have been lying empty. They are sitting on the footpath, ready for a crane to fall on them or a car to run into them. They are sitting there empty, ready to go if needed, so we can't complain about that, because we don't know, but there's no staffing for it. There's no staffing available for it. I think the Hon. Ms Bonaros brought this up some time ago.

1239 The Hon. N.J. CENTOFANTI: I am Nicola Centofanti. I just want thank you, Professor Svigos, for your service and commitment to women and children around the state, as a recipient of the services of the Women's and Children's Hospital on the birth of my twins. I can certainly personally attest to the exceptional care, so thank you, first and foremost.

I have a question in relation to the surgical equipment replacement. How often, in your opinion, does clinical equipment, on average, need replacement? You mentioned that you felt the budget this year was inadequate for equipment replacement. Do you know what has been the previous budget for this, annually, over the last 10 years?

Prof. SVIGOS: It's been gradually wound down, it would be fair to say, but $800,000 per year for two years is not going to catch up the $12.3 million worth of equipment. Generally, the turnover time is about five years, if I may say. A number of our items, 30 per cent of them, are well past that five-year mark in terms of their use-by date, and the manufacturers who won't stand by them now. If you are talking about risk, we are running a huge risk.

1240 The Hon. N.J. CENTOFANTI: Could you take on notice what that budget has been?

Prof. SVIGOS: Previously? No, I don't have the figures on that. I am terribly sorry. I would have to investigate that.

1241 The Hon. N.J. CENTOFANTI: I am happy for you to take that on notice.

Prof. SVIGOS: It's an accumulative thing, though, to get to $12.3 million.

1242 The CHAIRPERSON: Before I go to the Hon. Ms Bourke, we talked about the SCBU, which coincidentally has opened today, but has been closed.

Prof. SVIGOS: Yes, isn't that wonderful?

1243 The CHAIRPERSON: It is absolutely wonderful.

Prof. SVIGOS: Is the minister going back to open it, is what I am going to ask?

1244 The CHAIRPERSON: I am not sure, but I am sure we can ask that question. The minister did indicate, to a question that was asked of him, that the reason for the delay in the opening

was a union dispute by the Australian Nursing and Midwifery Federation with the hospital. Do you care to comment on that?

Prof. SVIGOS: Yes, I think I already have. The problem was that it wasn't planned for in the first instance, so the union was obliged to look after their members and the babies by insisting on training and education, the correct number of staff and also additional resources, such as personal protective equipment.

1245 The CHAIRPERSON: Do you think it's reasonable in any sense that the minister would blame, effectively, a union?

Prof. SVIGOS: I think he has probably just shifted the blame a little bit because the blame actually sits with the executive.

1246 The Hon. E.S. BOURKE: It was quite a scene in the chamber, wasn't it, about the union's fault?

1247 The CHAIRPERSON: It was quite a scene.

1248 The Hon. E.S. BOURKE: I would like to go to the consultation that has been undertaken by KPMG. They have engaged in consultation to consider efficiency measures at the hospital. What are your thoughts about this consultancy? What are they trying to achieve by efficiency measures, in your view?

Prof. SVIGOS: Firstly, they are doing the job of people who are already appointed there who are getting paid to do this job, so I can't work that out. In private business, wouldn't they be let go? That's one thing. They are replacing people's duties for people who should be able to do those duties. The way they have already announced that they are going to make up the $8 million budget shortfall is by reducing nursing hours.

1249 The Hon. E.S. BOURKE: That was my next question.

Prof. SVIGOS: If that is so, the service has to suffer as a result of that, so I can't agree with them having to do that. They are also going to spend some money teaching the incumbent staff how to implement these budget savings. The Women's and Babies' Division—that is, the obstetric and baby side of the hospital—is being charged with making $4,300-a-day savings. This is in the light of being overworked, not having enough staff and not even being able to be sure that they are going to have enough staff on weekends. They are under-resourced. The equipment, as I have already mentioned, is not up to scratch, and all of those sort of things, and then heaped on top of that they say, 'Okay, we want you to save $4,300 per day, please' and that is left to a clinician to do.

As we get back to whose job is whose, I understood that the executive and SA Health provide doctors with resources so they can do their job well. The understanding is that you all will work with it to try to make it efficient, but the understanding is that the resources come from them and the doctors do the work. Is that clear?

1250 The Hon. E.S. BOURKE: Yes, that's great, thank you.

1251 The Hon. I. PNEVMATIKOS: I want to move to considering how babies and children are affected by all of this, particularly in terms of mental health and the services that are provided, as well as outpatient services generally.

Prof. SVIGOS: If I would say to you that the mental health facilities at the Women's and Children's Hospital on the women's and babies' side of the hospital have been depleted, I would guess that you would not be surprised. We can barely find a social worker, psychiatrist, mental health worker and so forth. The minister has committed some money to building a new mental health ward and so forth, but I don't think he really knows the costs of that because you need a consultant to run the service, we need registrars and we need nursing staff, all of which we don't have at the moment. Is that answering the question?

1252 The Hon. I. PNEVMATIKOS: Yes. Are there delays in terms of outpatient appointments?

Prof. SVIGOS: Yes.

1253 The Hon. I. PNEVMATIKOS: How significant are those delays?

Prof. SVIGOS: I think that, in terms of mental health, they are very significant. I don't think it would take much imagination to understand that, if you are waiting for a long time to get an appointment in when you have a mental health issue, that will just worsen the situation. General practitioners admirably try to fill the void, but they want experienced people to deal with these problems and they are longstanding and then they have an impact on the pregnancy, they have an impact on the child, they have an impact on the bonding of the mother and the child, and all those sort of things, which you have obviously heard in this house many times before in terms of child protection, so, yes, it has a huge impact on us.

Our domiciliary care service, for example, where midwives go out to the house after they are discharged home after 24 hours, apart from perhaps on one or two occasions if they happen to live close to the hospital, has been gradually cut down, so now we have reduced numbers of midwives going out to look after these patients in their homes and identifying which ones potentially have a mental health issue, apart from breastfeeding and all that sort of thing.

1254 The Hon. I. PNEVMATIKOS: Do the reductions in terms of staffing, programs and facilities also apply to obstetrics and epilepsy services?

Prof. SVIGOS: Yes. At the moment for epilepsy, for example, there is a one-year wait for a new patient to get in to be assessed by a neurologist. They can barely keep up with the workload. They are not doing any research and they are not doing any of the new surgical ways of dealing with epilepsy that overseas centres can do. They just don't have enough staff or enough time to be able to do this. They are just too busy working with the clinical load and have been working with at least one or two consultants short for at least the last 10 years.

1255 The CHAIRPERSON: Can I ask a question in relation to something you referred to in your opening, which is equally as alarming. You mentioned that there were issues in regard to the treatment of children with cancer at our hospital.

Prof. SVIGOS: Yes.

1256 The CHAIRPERSON: Can you elaborate on that further in terms of the seriousness?

Prof. SVIGOS: Yes, certainly. I hope that I can make it short, but I probably can't. Over the passage of five years, the Michael Rice haematology and paediatric cancer unit has been allowed to become understaffed at both a senior medical and experienced nursing level and under-resourced, particularly in terms of ancillary staff and equipment. A review conducted in 2018 found that the formerly prestigious unit required an additional three senior staff consultants and four senior registrars just to deal with the delays in treatment, the clinical load and to meet the national average for the appropriate staffing of such a unit.

This was not acceptable to the Women's and Children's Hospital executive and they employed KPMG in 2019, who specified that one additional senior consultant and one additional senior registrar was all that was required, unfortunately using flawed data and a lack of knowledge of the multidisciplinary style of care required for such patients.

Despite much staff agitation, the one senior consultant and the one senior registrar appointments were made, which really trivialised this crucially important service for the children of South Australia with cancer by not meeting the national average requirement based on activity data, thus leaving this vitally important unit critically understaffed and under-resourced.

As previously stated, inevitably there will be human consequences of a clinical service decision being made without the significant input of responsible clinicians but instead by hired consultants and bureaucrats working to an unrealistic financial agenda. I don't think I need to elaborate any further on that.

1257 The CHAIRPERSON: I don't think you do. Basically we have been ignored in terms of recommendations that are made as to the number of individuals that we need to undertake those services.

Prof. SVIGOS: Yes.

1258 The CHAIRPERSON: Given everything that you have said today and given the reliance by parents like me and others in this room on the Women's and Children's Hospital—we go there when our children are sick—

Prof. SVIGOS: We have an assumption that you are going to get the best possible treatment and that there shouldn't be any problem with it.

1259 The CHAIRPERSON: Is it your view today that, given what you said at the outset about the make-up of the board, where we don't have clinicians involved in that decision-making process, that budgetary measures are being put ahead of children's lives in this jurisdiction?

Prof. SVIGOS: I am going to have to admit that. I don't want to, but I'm going to have to admit that.

1260 The CHAIRPERSON: Thank you.

1261 The Hon. E.S. BOURKE: That was a concerning point to end on. Just to go back to the statement that you were making before about understaffing and under-resources, does it concern you, and you touched on this, that KPMG staff and consultants are being paid $3,700 per day and we are in desperate need of finding the required staff?

Prof. SVIGOS: We want that money, yes. We are telling the obstetricians to save $4,300 a day for the budget and yet we are paying that to KPMG.

1262 The Hon. E.S. BOURKE: Did it concern you that there was no tender process to find KPMG to be the consultancy?

Prof. SVIGOS: Absolutely. The rigmarole that we are forced to go into just to make a case for a piece of equipment would be much more than what KPMG went through to be able to tender a service for $1 million to $3 million.

1263 The Hon. E.S. BOURKE: Going back to your very concerning point that you made earlier in your statement that we should always be thinking of the cost of health of our women and children when thinking of this hospital, what needs to change to make sure that they are getting the best service when going to that hospital, as we all think we are. Is it the budget requirements?

Prof. SVIGOS: Yes. I will tell you something: I would love to have Professor Spurrier's budget. If the hospital had Professor's Spurriers budget—which is limitless, as I understand—to protect the people of South Australia and so forth, I think this is equally as important. And, yes, the budget is the problem. I feel sorry for the people who are administering the budget and all that sort of thing, but I feel even more sorry for my patients and my colleagues.

1264 The CHAIRPERSON: By the same token, when the minister claims that clinicians are being involved in all these decisions that you are talking about, but a lot of them—

Prof. SVIGOS: I have given you an example of how they are not.

1265 The CHAIRPERSON: Well, you have given us plenty of examples of how they are not, but is it your understanding that $600,000 is what the minister has set aside for clinician involvement in the new Women's and Children's Hospital?

Prof. SVIGOS: That's right, yes.

1266 The CHAIRPERSON: What will $600,000 get you?

Prof. SVIGOS: It would give us about enough for clinician involvement for about three or four weeks. They are taken out of their duties to do this planning for two to four hours, so someone has to cover their duties—if they can find someone to cover it, firstly, because the service has been cut down so much. So they have to have somebody covering their services so that the patients are still looked after while they are off doing the thing.

If they get into a situation where, when the funds have run out and they have to make a decision, 'Which one will I go to: the planning committee or look after patients?', I reckon you know my answer. They are going to go and look after the patients and forget the planning committee.

1267 The CHAIRPERSON: Do you think that the government and the minister were genuine in their wanting to involve clinicians in the design and implementation of the new hospital?

Prof. SVIGOS: I think they have paid lip service to it, Ms Bonaros.

1268 The CHAIRPERSON: Thank you. Any more questions from any of the members? Professor Svigos, thank you very much for your evidence today. I'm sure that there are going to be more questions that will be forwarded to you.

Prof. SVIGOS: Thank you. I will be happy to answer them if I can.

1269 The CHAIRPERSON: Wonderful. I'm just sorry for the state of affairs. You have painted a very bleak picture of our current state of affairs involving our most vulnerable.

Prof. SVIGOS: I wish I could be more encouraging. It hurts me to even talk about this. As I said before, and as Ms Centofanti would know, this would hurt me considerably to have to even admit that there is a problem and that I'm part of that problem, and that I was part of that problem and still am.

1270 The CHAIRPERSON: We thank you for your frankness and your honesty today.

Prof. SVIGOS: Thank you.

THE WITNESS WITHDREW

WITNESS:

MULHOLLAND, BERNADETTE, Chief Industrial Officer, South Australian Salaried Medical Officers Association

1271 The CHAIRPERSON: Ms Mulholland, thank you for joining us today, and welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings; however, due to the current situation concerning the COVID-19 pandemic, the committee has resolved to exclude strangers from the gallery.

A transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. The uncorrected transcript of your evidence today will be published immediately upon receipt from Hansard but the corrected transcript, once received from you, will replace the uncorrected transcript. I advise that your evidence today is being broadcast via the Parliament of South Australia website. Should you wish at any time to present confidential evidence to the committee please indicate and the committee will consider your request.

Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament. Before we get into questions, I invite you to make any opening remarks that you may have.

Ms MULHOLLAND: Thank you, Ms Bonaros. My name is Bernadette Mulholland. I am the Chief Industrial Officer of the South Australian Salaried Medical Officers Association. Because of my position, I have the unique ability to speak with doctors in the public sector working right across the state, from the most junior intern to the most senior clinical academic. About 12 months ago, SASMOA was contacted by a number of members within the Women's and Children's Hospital and the Medical Staff Society.

For those of you who do not know what the Medical Staff Society is, it is a large group of doctors. In fact, it includes all doctors at the Women's and Children's Hospital. All doctors can be a member of the Medical Staff Society. They regularly gather, approximately once a month, to discuss issues that pertain to them and their services. From that discussion, there is an executive who will then take that information through to the WCH executive, and they will either do that in a written or verbal format.

Normally, the Medical Staff Society take the running of everyday—both clinical and industrial—matters without the assistance of SASMOA. It is only with reluctance, I felt, probably predating that 12 months, that they come to us for assistance and help. Leading up to the Medical Staff Society's request for us to actually attend one of their meetings, we were aware of ever-increasing concerns from different units that were coming to us about resourcing of their particular service.

In particular, junior medical officers had come to us that they were, in one particular situation, sleeping on the floor because of the lack of resources that were available to the service and the ability to sub in, if you like, other trainee medical officers to do that work. That raised red flags with SASMOA and it also started to raise red flags with the medical staff that worked in that particular area. After a lot of work, we were able to obtain the necessary resources for that particular unit.

That then, I guess, created a discussion between us and the Medical Staff Society, so in about September last year myself and a colleague were called to a meeting about the lack of resources right across the Women's and Children's Hospital. We are talking medical staff resources. We were also told about burnout and fatigue.

We saw very demoralised doctors not knowing what to do, doctors who were always of the view that if they put forward a logical, clinical argument to the employer that was in order to protect the patients that they served, then common sense would prevail. What they were actually

seeing was that common sense wasn't prevailing, that there was certainly a new broom in town that was putting finances before the care of patients, and patients were suffering.

Initially, it was a tentative step towards SASMOA. Their first initiative a year ago was to write to the executive about all the concerns they have, and I have a copy of that letter with me here today if that would assist you all in relation to that, but they were very extreme—

1272 The CHAIRPERSON: Can we table that letter, Ms Mulholland?

Ms MULHOLLAND: I certainly will. I have done packs, in the neatness of what I do, so if I could just table that. There is one extra for the person on Zoom but I am not sure how you will get that.

1273 The CHAIRPERSON: Thank you. Sorry for the interruption.

Ms MULHOLLAND: No, that's fine. In your pack you will see correspondence to the current chief executive officer, Ms Lindsey Gough, outlining a number of concerns from the Medical Staff Society. That letter was delivered to Lindsey Gough under the covering letter from SASMOA. At that stage, doctors were particularly concerned that they would be targeted as individuals for raising concerns within their hospital.

Having an initial view of that hospital and starting to see things that were actually happening with that hospital, I realised that concern for those doctors; 215 doctors signed the letter dated 24 October 2019. They wished to make known to the employer the concerns about the financial consequences and cost saving exercise that they were placing on patients, but also issues around equipment and resourcing, also around leadership and decision-making, concerns about contractors, issues about accessing the existing risk register in particular.

A number of doctors had said that they had attempted to put serious concerns on the Women's and Children's Hospital risk register and had been unable to access that register. That will be a matter I will turn to when I speak more about the Paediatric Intensive Care Unit (PICU) area. SASMOA has now sought, under FOI, to access that risk register. We have been unable to do it as an association—indeed, under any health and safety provisions—although we have now called for it given the inspection that we have done of the Paediatric Intensive Care Unit last week.

There were also concerns identified about gaps in staffing. We were very much aware of medical officers in the peak of their careers leaving the Women's and Children's Hospital, and it was incredibly concerning. Following the letter that was sent to the Women's and Children's Hospital, there were many attempts by doctors to meet with the chief executive officer. Up until this stage, the doctors referred to her almost as a ghost. They never saw her. They never spoke with her. There was a complete barricade for doctors to be able to raise their clinical concerns with the Women's and Children's CEO and the executive.

Our view was that the medical management system that had been provided was outdated. The doctors advised of a number of business cases they had provided directly to their line managers over a period of 12 years, which came to light a bit later on, which the executive denied seeing. We FOI'd those business cases—indeed, we had those business cases sitting on our desk—which the employer then, through FOI, denied having.

One particular group, neurology, had had a business case in for 12 years because of the lack of resourcing that they had for the service and that they were having a great deal of difficulty providing the necessary support and care to the patient demands and are still having problems. I am aware that they have attempted to put that matter onto the risk register. But simply, there is not enough staff, not enough medical resourcing, not enough allied health to run many of the services in paediatric medicine in this state.

The letter also looked at the future direction of the Women's and Children's Hospital. There was real concern that there had not been any attention turned to succession planning for the hospital. We were seeing an ageing medical workforce and we weren't also employing advanced trainees nor could advanced trainees be employed because there wasn't the ability to train over a period of time. So any advanced trainees we may be training have to go interstate to finish their training. They do not come back. It is a very specialised service and a very in-demand service.

So what we will be seeing over the next few years is an inability to recruit to the Women's and Children's Hospital in some particular areas because we aren't appropriately looking at the future needs of this particular hospital. Indeed, we now meet with the Medical Staff Society and our members on a fortnightly basis. They are incredibly concerned about what the future actually holds for them, for their junior medical officers and for the patients of this state.

They are struggling to understand the logic in the cost-saving exercises, the lack of replacement for equipment, and the danger that poses for babies and women of this state using this particular hospital. What they see is the once great name that was attached to the Women's and Children's Hospital that they actually want restored. It is very concerning that we are almost seeing the throes of the Women's and Children's Hospital, and if something is not done about it—and you've heard from Professor Svigos today—then the legacy that this will create for the women and children of this state will unfortunately be very grim. It's a very important issue to have a look at.

You will also note that when we did speak with the Medical Staff Society and our members, a number of issues have been raised by them, which I'm happy to touch on. But there are so many issues it's actually very difficult to know where to start and what actually has a priority. You have heard about the equipment register which has $12 million in equipment that is necessary to be upgraded or updated.

The Women's and Children's Hospital network has been provided by the Department (and let's remember that the department is the one that provides the money) $1 million roughly—and I am being generous: it's about $900,000—for replacement equipment, knowing that the $12 million cannot be replaced on the budget that they are actually providing. That includes any new equipment that might be required in that particular year or any emergency equipment that might be provided in that particular year.

There are a number of business cases that have been submitted that have either not reached the executive office, but if they have reached the executive office have been denied being received. Those business cases include staffing, equipment, allied health and anything else that is necessary to actually run a particular unit. There are issues around health and safety—not only the health and safety of the patients but the health and safety of our clinicians, particularly the mental distress this is all causing doctors.

I do not speak on behalf of other clinicians, but I'm very much aware that this is not specific for doctors; there is mental stress right across this particular hospital. We have been called in in probably the last two months and we have met with our members on workloads. Within our enterprise agreements there is a job planning exercise. That job planning—or what we fondly refer to as 'job sizing'—should enable an employer to determine how many doctors they need in the service.

Even ICAC in their report, Troubling Ambiguity, raised about job planning because it wasn't being done. I have travelled and traversed all the LHNs to look at job planning and many questions have been asked about it and it has now been finalised in many of the adult services. But in Women's and Children's it is not finalised. It's not finalised, we believe, because if they do the job planning exercises and they do what the ICAC requested in Troubling Ambiguity they will find that there is an amazing shortage of doctors.

In terms of haematology oncology, when we reviewed that before KPMG stepped in, the clinicians sat with the human resources people and worked out they needed an additional seven consultants just to meet the industrial requirements and the clinical requirements of that particular service.

We have an amazing round—and it always surprises me; I don't know why it does—of external consultants we pay a fortune for to find cost savings. I don't understand it. I don't understand their role and neither do the clinicians. In Women's and Children's in particular we have KPMG and Studer Group. We have many more that are actually in there at the moment. Either they are there for the current Women's and Children's or the new Women's and Children's Hospital.

The minister in his defence and, indeed, I believe, the department chief executive have said there have been 100 extra staff put into the Women's and Children's Hospital. When we have asked the question of the Women's and Children's Hospital now on several occasions, they

said, 'We don't know where those 100 staff are. We have no idea what they are talking about. They are probably across the road.' Across the road is where the new Women's and Children's Hospital project group sit, so I can only assume those 100 people are sitting in there.

When we have asked for more clarification, and we are a bit painful in this way, they said, 'Well, our definition of what 100 extra staff and FTE are may be different from what the department's definition is.' So we are always bemused and we still cannot find where these 100 additional staff are that both the minister and the chief executive have claimed have now been added to the Women's and Children's Hospital.

There are a number of services that are struggling. The PICU, which is probably the biggest at the moment in regard to cardiology, is struggling in terms of resourcing and providing the best care to Women's and Children's Hospital patients, in particular babies and mothers. Haematology and oncology I have already mentioned. Neurology has had a business case in for 12 months, and that matter has desperately been tried to get onto the risk register. We have met with the general medicine paediatric group. Renal, rheumatology, you name it and we have sat with them.

The other concern is now about the new Women's and Children's Hospital. Clinicians would like to see, and their slogan now—and I am glad to see there is still a little pep left in them—is 'Improve before we move'. If we don't improve before we move, we might not have the services that we expect to have at the new Women's and Children's Hospital.

One of the critical areas—and we saw this with Dr Spurrier—is the need to engage with clinicians. This government came into power expressing concern that in health we did not do enough engaging with our clinicians. I can say that's still not happening. There may be the theatre and the smoke and mirrors of engagement with clinicians, but they are certainly not listening to them, and they are certainly not applying what they are actually stating. Decisions in regard to the new Women's and Children's Hospital are already made. For a very intelligent group of clinicians, to hear 'You're the ones leading the answers for the new Women's and Children's,' is not only demoralising but just silly.

There is no discussion about the RAH integration and how the Royal Adelaide Hospital and the Women's and Children's Hospital will fit, although we are very clearly aware that the Royal Adelaide Hospital and a number of executives are working to determine what services will be moved across to the Royal Adelaide Hospital.

We have also become aware, as many of you have, of the car parking. It was one of our big issues, as it was at the new Royal Adelaide Hospital. Everyone needs a car park, coming to the new Women's and Children's Hospital. Indeed, the old Women's and Children's Hospital struggles. They have about 800 car parks at the present time, and that doesn't include the car parking that is able to be had on the street.

We were told that there has been no decision made on car parking, and you will see that in the presentation that we eventually did for the Women's and Children's executive. In two or three meetings they looked us in the eye and said, 'No decision has been made on car parking,' until we saw those documents that were obtained by FOI by the opposition, which quite clearly articulated 600 car parks.

We have also met with consumer groups who have approached the department, who have verified that information. We are concerned, as are consumer groups, that taking the tram with two or three children, one of whom may be very sick or, indeed, yourself, is not good clinical care. In fact, it's appalling that that has even been suggested.

We're concerned about the ability to backfill doctors and clinicians generally to participate in what are called PUGs—project user groups—of which there are 93. They go for many hours, and a report is meant to be tabled for sign-off by the clinicians participating. There are no terms of reference put into that governance document. There are no minutes. There is no sign-off, and there is no ability to escalate any concerns that they might have with the eventual document that comes back from the contractors from Johnstaff.

The doctors who are sitting—and we forced and pressured the executive to place doctors on higher-up committees—have said that they are not listening to them, decisions are already made, and we will get a hospital that is not commensurate with what is deemed to be

world-class, state-of-the-art promised by this government. It simply won't be. We have written to the government to ask what is world-class, state-of-the-art, and we received a page document, which I'm happy to share with you when I get back to my office. It is lengthy, it doesn't go to the heart of what is world-class, state-of-the-art, and it hasn't come from government.

There are many matters of concern. In particular, last week, as many of you know, we undertook an inspection. You wouldn't have known this, but we were called in by the doctors in the paediatric intensive care unit. It was a struggle on Thursday to go in because we were very much aware of the ability of the doctors trying to raise concerns with the government, the board, and the Women's and Children's executive about what was happening.

It culminated last week in the death of a third baby in about three weeks. The issue in regard to the death of the three babies was a need for ECMO and the need for a paediatric cardiac surgeon, but it wasn't simply the fact that we don't provide that service in this state. The issue was bigger than that. The issue was also about the COVID restrictions that had been imposed on Victoria which created an inability to transfer these very sick babies—and in one case, mother—to the Royal Children's Hospital.

The formal agreement with the Royal Children's Hospital for the provision of the service is funded. In the event of life-saving surgery there is a requirement to get that child incredibly quickly to the Royal Children's Hospital. There is not the ability at the moment to be able to do that. In fact, I'm very surprised that the focus was not just only on the fact that if we had that service here in South Australia it would prevent—and this is the clinicians' view—the deaths of some of those children.

Unfortunately, we had a fourth death, only on Friday, the day after I visited the PICU with my colleague. This morning we served the inspection report to the Women and Children's Hospital. We will do it with the board. We sent it to the minister and we sent it to the chief executive officer. I brought copies today and I'm are happy for you to have a read through it.

But it was incredibly distressing because what appears to have happened is that there was no alternative provided for these babies to be transferred except for Westmead in Sydney. Westmead's Children's Hospital was not a formal agreement. It's not a formal arrangement. Therefore, it is an ad hoc arrangement and it requires—goodwill is probably not a good word—but it does require the ability of those paediatric cardiac surgeons in Sydney to have the space, to have the ability, to have the staff to enable the transfer of sick babies over to Westmead Hospital.

That means that there isn't equity in care, and that was borne out on Thursday for the babies of this state who may have severe cardiac problems who need that assistance. If we were to go anywhere else in mainland Australia—anywhere—then they would have equity of care in those states. If you are in Newcastle, you would fly that child through to Westmead. Same for Victoria; same, even, for Western Australia. The significant mental distress that this not only has caused the doctors but the clinicians generally in that unit is indescribable. They are now beside themselves because they believe, in their view, they have done everything to raise this with all levels of the bureaucracy.

Where do they go from here in relation to PICU? They know that long-term it's going to be cheaper to provide that service here. They also know that there are surgeons available. They can be hired. They are willing and able to come to South Australia to run that service, and it is being rejected. It's being rejected at the cost of children's lives in this state. It should be a priority. It was horrendous listening to the doctors on Thursday and even more horrendous to hear of a fourth death on Friday. It is inexcusable.

The SLS reports that have been put in initially have been rejected. They have been rejected on the basis that we do not have an ECMO service here in South Australia and, therefore, they can be rejected. That advice was given to them by the Royal Children's Hospital in Melbourne after they did a review—conflict of interest, one might argue, in terms of them reviewing what does and does not go on our Safety Learning System. This is after the review of chemotherapy, a very similar situation, where we were told that a review of the Safety Learning System would be conducted.

We are still to hear, since February, when that started, what the outcome of that review was. What we fear is happening is a repeat of what happened in those situations: known deaths and an inability to be able to access a system to record those deaths, to record the process that is providing an inability to transfer babies interstate quickly, and an inability, which is the SLS system to do, to be able to record the mental distress that this is causing clinicians at the worksite.

1274 The CHAIRPERSON: Ms Mulholland, I'm at a loss in terms of the evidence you have just provided. Can I just start by passing on my respects to those families who have lost those children and also, of course, to those clinicians and frontline staff, including yourself, who are put in that unspeakable position of having to front those families and explain to them why it is that their child is no longer alive.

Just in relation to—and we have canvassed a lot of issues, but I just want to focus on those deaths for a moment. You have said that the chief executive has been almost a ghost in terms of their involvement with clinicians. I think you have already answered the question that clinicians simply do not have any involvement at any level of the decision-making process. What has been the response from the minister in relation to what has been said today?

Ms MULHOLLAND: I terms of when this happened in October, the initial letter went to the medical staff society and the minister did meet, and it was appreciated, with a number of medical officers, potentially more about the new Women's and Children's Hospital rather than the resourcing of the old Women's and Children's Hospital. Since that time the minister has not been part of the discussions moving forward. I tend to write to ministers, but I have not heard anything in relation to the correspondence.

1275 The CHAIRPERSON: Just to be clear: four children have died in the last month, including one as recently as last Friday, and to your knowledge has there been any discussion between those clinicians and the minister directly pertaining to those deaths?

Ms MULHOLLAND: My understanding is that one of the doctors forwarded an email, I think on Thursday.

1276 The CHAIRPERSON: To alert the minister?

Ms MULHOLLAND: To alert the minister.

1277 The CHAIRPERSON: Do we know what the board did to alert the minister of any of this?

Ms MULHOLLAND: Certainly I know that the same doctor advised the board, and one of the responses was—and I have not spoken to the minister about this—that it is preferred that you contact the board not the minister. That is mentioned in my report.

1278 The CHAIRPERSON: Given the current situation that we're in, and the fact that we have had more deaths, what if anything is in place to ensure that this does not happen this Friday, next Friday and the Friday after that in relation to any other family who has a child in the same situation as were those four young children?

Ms MULHOLLAND: I am not aware of anything.

1279 The CHAIRPERSON: So, presently speaking, we are in the exact same situation as we were last Friday? Nothing has been done that can address any of the issues you have raised today, or that Professor Svigos has raised today, in relation to the death of those children?

Ms MULHOLLAND: I understand that there has been a meeting with the Flinders Medical Centre in the hope that they might be able to provide the ECMO service, but I am unaware of any firm plans to do that.

1280 The CHAIRPERSON: Ms Bourke, do you have any questions?

1281 The Hon. E.S. BOURKE: Yes. And I would also like to share in the Hon. Ms Bonaros's condolences. I am also not sure where to take this, to be honest. You made a statement that you feel there is a grim legacy being created for the Women's and Children's Hospital. What actions need to be taken immediately to overturn this 'grim legacy'?

Ms MULHOLLAND: One of the issues in the medical officers' view that is creating a great deal of havoc is the time lines. The time lines that have been imposed almost makes it a mantra for those who have been imposed on—in this case we only see the Women's and Children's executive—that: 'It must be done by a particular time, we don't care about your workload, we need to get this done.' So, one of the issues is the time line that has been imposed for getting the planning done. I don't know what is behind that, I don't know why.

The other issue is about clinical leadership. We all know after watching COVID that clinical leadership plays a really important part. In fact, after seeing how South Australia has had the ability to put in place good outcomes through clinical leadership, they need to start listening to their doctors—not just their doctors but also their nurses, allied health and administration. When I say 'administration', I am talking about your ASO-1s your 2s, your 3s. If that is not done, we will move down the path that we will not be able to move back from and we will not have a hospital that people actually want or need.

1282 The Hon. E.S. BOURKE: In regard to cardiac surgery, the minister has stated on FIVEaa—I said this to the previous witness—'To be frank, I don't want to give you my personal opinion. I am a politician,' in regard to attracting a cardiac surgeon here. Do you think the minister should have an opinion on this, and does it come back to the minister whether this is a service that we provide in this state? Or who does it come back to?

Ms MULHOLLAND: Ultimately, it's a discussion, is it not, between the minster and those who elect him. It's the community and it is the minister who need to make this decision—and the government. The rest, I think, must implement it, but if this government decides this is what we actually need to have, then that should be implemented.

If the community decides that that's what needs to be done for the sake of the future children of this state, then I think it's incumbent on any politician to listen to what the community actually wants and, indeed, what the clinicians actually want. We can't sit in isolation, and that's a problem in health. We all must work together for the betterment of the community, of the people who actually use the health system, and it's simply not happening.

1283 The Hon. E.S. BOURKE: At a personal level, I have to say, I have seen firsthand the stress and emotions at a physical, mental and every other level possible. My niece has to go to Melbourne to have one of these surgeries. To be confronted with this during COVID adds another level of complexity. Is this what other families are also experiencing? This is usually a stressful situation, but then to be confronted with COVID and the situation that is occurring in Melbourne, what complexities is that having?

Ms MULHOLLAND: Indeed, you may have in the past brought with you family, friends and support. My understanding is that there is now difficulty in allowing that to happen. There are now many not necessarily barriers but requirements that need to be gone through. Up until, I think, the last couple of days, even if you had family that may have been within Melbourne, it would be very difficult even to rely on them for a support base.

1284 The CHAIRPERSON: By way of supplementary in relation to that, do we have any sort of pandemic planning in this area? Up until now, have our hospitals had any planning for this sort of situation?

Ms MULHOLLAND: It's interesting. I reflected on that when I was writing the report. This should be something, you would think, that would have a priority, and I am unclear, even in conversations with the doctors, whether it had got to the department stage, or whoever does that, to look at the pandemic planning for children who may need these services.

I simply don't know, and that surprised me, because you would think, as your question would indicate, that this would be looked at and supported and done, but here we are with very sad outcomes over the last month, and it would suggest to me that this hasn't been elevated to the necessary level that it should be.

1285 The CHAIRPERSON: These cases have occurred over the last month during COVID.

Ms MULHOLLAND: Correct.

1286 The CHAIRPERSON: Can you confirm whether it's your understanding that prior to COVID, or prior to now, there haven't been other deaths that are also attributable to the fact that we don't have those services here in SA?

Ms MULHOLLAND: My understanding, in discussion with the doctors that I have spoken to, is that there are, but this is unusual.

1287 The CHAIRPERSON: Can you elaborate any further on the situation that occurred on Friday? Are you able to do that?

Ms MULHOLLAND: No. I only became aware of it last night and early this morning.

1288 The CHAIRPERSON: Understood.

1289 The Hon. I. PNEVMATIKOS: It seems a bit futile asking any questions after your outline, but in any event, there are some issues that I would like to clarify. Your organisation talks about incredible workload stress and burnout and at the same time a requirement by hospital admin and the structures within the hospital to undertake various activities that have no bearing on their work. Would you be able to outline the sorts of activities that you are talking about?

Ms MULHOLLAND: I can give you one clear example that springs to mind. We saw an update that came out only the other week, after raising on numerous occasions about workloads and this additional responsibility, to be advised that Sunrise, or the former EPAS, was about to be implemented into the Women's and Children's. It was brought forward because, we understand and we were advised, Southern Adelaide Local Health Network clinicians had such a workload that they were moving it forward into the Women's and Children's. That will be the straw that breaks the camel's back. They just do not have time or capacity to do that additional work.

There is also a group called Studer. Studer have introduced an accountability framework. I would need to get more information this, but that was meant to be implemented. It is about culture and driving a change in culture. No-one understands it very much, but we were advised by some doctors that was an additional 120 meetings they would have to attend in the year.

When they asked the question, 'Where has it been used anywhere else in the country?' to the chief executive officer, they were advised they didn't know. Then the doctors dug in and simply said, 'We are not doing it,' so they have postponed it for a couple of months. That was another example of the issues.

The PUGs, or project user groups, that they sit on take up quite a deal of time—two to three hours in addition to their work. Many of them don't get time, even though it's a requirement, to do their non-clinical work. That is work like providing and supervising trainees and attending to quality and safety. That is all done at home in their houses. They fill in their time sheets with outrageous hours for the consultants. It's easy for the employer to do it, should it choose to review the workload and fatigue and the problems that are associated. My view is that they know, therefore they won't.

1290 The Hon. I. PNEVMATIKOS: I want to turn to multidisciplinary care. There has been a reduction in focus in terms of providing multidisciplinary care. Is that reflected from a policy philosophical perspective and/or a reduction in staffing as well?

Ms MULHOLLAND: It's certainly not a philosophical opposition from medical workforce because they consistently say that the way forward in the Women's and Children's Hospital is a multidisciplinary workforce. One can only assume that it's because there is not the staff in the allied health and elsewhere to be able to provide that multidisciplinary policy or model of care.

1291 The Hon. I. PNEVMATIKOS: In terms of pathology services, where is it being moved off site and what impact does that have on the hospital?

Ms MULHOLLAND: There are two parts to that question. I understand there is a business case that has been put in place to have SA Pathology or a new build down there at the, for want of a better word, medical site, but there will still be—and I'm not clinician—a wet lab within the Women's and Children's Hospital. This is, again, the problem that we actually have: we simply don't know the answers.

You will be told that on one hand and then I will sit in a meeting, as I did yesterday, and they will say, 'That's not the case. We are doing this.' It's that shifting sands that everyone is having some difficulty with and that transparency over these statewide services as to where they are going to land within the hospital and what space is going to be needed for that.

1292 The Hon. E.S. BOURKE: As a supplementary to that: what other shared services at the new site are you aware of or that you can see could be an issue going forward?

Ms MULHOLLAND: Certainly, there is radiology (SAMI) services—we still haven't been advised about that—pharmaceutical and SA Pathology. They are the statewide services. Then you would need clarity around women's services. The network will be right next to the Royal Adelaide Hospital, which also provides women's services, and then you will have The QEH, which also provides women's services. We are told there's yet to be discussion on it, but then I will go to a Central Adelaide Local Health Network (CALHN) ILF who are told, 'No, we are working very closely with the executive about what those services will be co-joined with,' but no-one is actually verbally saying that publicly.

1293 The Hon. E.S. BOURKE: Are you suggesting that there could be a double up almost of the services for women at the Women's and Children's Hospital and then also at the RAH?

Ms MULHOLLAND: That's a possibility, or there could be a variety of acuities. I don't think that's been worked through to that degree yet.

1294 The Hon. N.J. CENTOFANTI: Thank you, Ms Mulholland for your time and evidence here this morning. Can you please elaborate more widely on your concerns about the consultation process and in particular about the 94 project user groups and the seven advisory groups that have been established and why you feel that they're not being listened to?

Ms MULHOLLAND: I feel that they're not being listened to because our medical officers are telling us that they are not being listened to. We are just simply the face of the clinicians who work within the system. They are becoming distressed that comments made and discussions had are not reflected in the written documentation that they receive and that they are aware of decisions at higher levels that are already made that they have had no input into or haven't agreed with.

An example recently of that is the accommodation that would be applied over at the new Women's and Children's Hospital. I understand that the infectious diseases doctor and specialist at the Women's and Children's gave a very good presentation about the impact of COVID now and the impact of COVID in the future if we didn't find a vaccine and talking about spaces not just for doctors to be able to do their responsibilities but also having individual offices to prevent COVID spreading in the back of a hospital area.

Our understanding so far of that is that doctors are being told at the project user groups that they won't be getting individual offices. In one situation we were advised that the way to address the COVID issue in the future is to have COVID testing on a regular basis for those clinicians who work within the hospital, which seems to defeat the whole purpose of trying to find accommodation that would actually suit and prevent health clinicians from contracting not only COVID but any disease that might be in the hospital at a particular time. And that's not being listened to. That is but one example that we are actually hearing.

1295 The Hon. N.J. CENTOFANTI: So despite it still being in the planning process, clinicians are being told what they are and aren't going to get?

Ms MULHOLLAND: Correct.

1296 The CHAIRPERSON: Ms Mulholland, we have heard harrowing accounts this morning about what's happening in cardiac. Can we confirm under the current situation that we are facing similar circumstances in chemotherapy and cancer?

Ms MULHOLLAND: I haven't gone into the discussion. Associate Professor Svigos is probably in a better position. Doctors who are in that service are a bit fragile. For two years they tried to get additional staff and they got one additional consultant and one additional fellow. They are very fragile about this whole process. I haven't sought to get any more information from them. I have left that to Professor Svigos.

1297 The CHAIRPERSON: Even if we just limit it to the evidence that you have given today and the account that you have given today, the reality in relation to the register that you alluded to earlier in your evidence is that this is happening in other units that pose a potentially similar risk to children, not just in the cancer unit or the cardiac unit, but units across the Women's and Children's Hospital: neurology being one of them.

Ms MULHOLLAND: Correct.

1298 The CHAIRPERSON: We've got children at risk across the board because of a failure to invest in new equipment or additional resources and funding and clinicians, and nothing has been done to address those.

Ms MULHOLLAND: No.

1299 The CHAIRPERSON: Is it fair to say that there's a risk matrix that goes along with these? Can you explain the risk matrix to members of the committee or where we fall in terms of the risk matrix and the seriousness of it?

Ms MULHOLLAND: I can tell you with regard to the PICU, the intensive care units, they were told that even though they couldn't put it in the SLS they could try to put it on the risk register. They have been trying to do that since February—February or May; one of those two dates—but they confirmed that this morning.

There is incredible difficulty getting this on a risk register. You would think that to put it on the risk register would actually provide some protection not only for the medical workforce but also for the executive, but there's real resistance to do that. I don't know why they won't put it on there. I don't understand it, and I haven't come across that problem in other local health networks or in other hospitals. It's incredibly frustrating, and I'm very uncertain to the point that that's why we've actually sought to FOI the register.

1300 The CHAIRPERSON: In relation to the business cases, and to confirm the evidence that you gave earlier, you have told this committee that there are business cases that were made to the board that the board denied—

Ms MULHOLLAND: To the executive.

1301 The CHAIRPERSON: To the executive, rather.

Ms MULHOLLAND: Yes.

1302 The CHAIRPERSON: They denied those having been made to them, but they were subsequently disclosed under FOI, so we know that—no?

Ms MULHOLLAND: No. We were aware that business cases had been made to the executive. We sought to FOI—we had them; we had them unofficially.

1303 The CHAIRPERSON: You have them unofficially.

Ms MULHOLLAND: We sought to FOI them, and the correspondence from the local health network said they had never had any, but we had them, so we have escalated that to the Ombudsman to investigate.

1304 The CHAIRPERSON: To be clear, we have cases that have ended up in your hands which you have then FOI'd?

Ms MULHOLLAND: Yes.

1305 The CHAIRPERSON: And the response back has been that those cases don't exist?

Ms MULHOLLAND: Correct.

1306 The CHAIRPERSON: Those matters have been referred to the Ombudsman for investigation?

Ms MULHOLLAND: Correct.

1307 The CHAIRPERSON: Thank you. Can we just turn quickly to the issue of funding. I note that you wrote to the minister in relation to the $65 million of funding and what that involves. Can you just elaborate on that a bit further and also confirm: is it your understanding that all these

consulting fees that we keep hearing about are wrapped up in that $65 million of funding or is it separate money? What's your understanding of that?

Ms MULHOLLAND: It's separate money, as far as I'm aware. We have now been advised—and looking through the budget and estimates committee where Dr McGowan gave evidence, he said there were two lots of $65 million. The first lot of $65 million is for sustainment work, $50 million was given for the current round of sustainment work, and I think another $15 million was provided—and I can absolutely clarify this; I have gone through the figures. The other $15 million was under the previous government for some other work. That was spent, I think, back in 2012-13, and the other amount of that $15 million, in 2018. So that's the first $65 million.

We were then told by Dr McGowan, which I have actually asked for clarification—which I think you also have, Ms Bonaros, about the moneys in the transcript that I have read—he mentioned another $65 million. We are uncertain where that money is, we are uncertain whether it's recurrent funding, so we have asked the question: what is this other $65 million? Until a couple of weeks ago, I only thought there was one lot and I was unaware of the extra hundred staff as well, so we have asked about that.

1308 The CHAIRPERSON: I think we have all been a little unaware of these figures that have been quoted, whether it's one sum or two. Given that we may be talking about at a minimum $65 million, and at a maximum $130 million, what do you say to the fact that the government has set aside $600,000 for clinician involvement in the new Women's and Children's Hospital?

Ms MULHOLLAND: The $600,000 isn't for clinician involvement; it's for doctors' involvement. It is insufficient. They know it's insufficient, we know it's insufficient, and we've debated this with the Women's and Children's now for six months. As an aside from that, we are aware that the chief operating officer could not do both jobs—the same jobs that we are asking the doctors to do, both their work and the new Women's and Children's Hospital consultation—but they have just employed, to support that chief operating officer, a director of operations.

So that is worth in our view—looking at the award that applies—$250,000 for one person and $650,000 for about 40 doctors to actually attend. It is just insufficient, it is ridiculous and it just goes to show you how little they respect the consultation and involvement of the medical staff in the development of the new Women's and Children's Hospital.

1309 The CHAIRPERSON: Can I ask a couple more questions before I go to the Hon. Ms Bourke. The SA Health CEO has recently said that the Women's and Children's Hospital, if anything, is overstaffed. What do you have to say to that?

Ms MULHOLLAND: I would say that he is out of touch. He obviously hasn't spoken to the clinicians.

1310 The CHAIRPERSON: Do you think there's any coincidence, given the contributions that you and the alliance have made recently, with SCBU opening today?

Ms MULHOLLAND: Sorry, what was the question?

1311 The CHAIRPERSON: The special care baby unit. We understand that there is an opening today after weeks and weeks of absolutely nothing. Do you think that is in anyway coincidental?

Ms MULHOLLAND: I wouldn't assume anything. I am a bit surprised. I was a bit surprised that it was opened before they had the staffing necessary to run it.

1312 The CHAIRPERSON: What about the pods?

Ms MULHOLLAND: The pods I have been involved in. When the pods came to light, SASMOA wrote to the chief executive stating that you actually need to staff the pods, and that they were going to look at the emergency department clinicians to staff the pods. When we raised that they were actually there to run the emergency department and that we were already running it on a very thin line, they said that because of COVID the emergency department presentations were down by 20 per cent and, therefore, they can use those additional clinicians to staff those pods.

We then became aware that of course everything is back up and running, so we have now written—I think I've sent the email; if not, it is on its way—to find out how they are now

going to staff those pods and will there be additional staffing, because as far as I'm aware they sit vacant without any staffing.

I know from clinicians' point of view, because they have taken the area of outpatients for the COVID testing, that that could be transferred over to those pods and then they could take back the outpatients area, so that's been certainly put. I also know from the clinicians that, even if those pods were operational for COVID needs, there are concerns about the air conditioning. I don't know any more about that and whether that's useful for those pods, indeed, if anyone caught COVID.

1313 The CHAIRPERSON: Do you know whether a budget was set aside to actually staff those pods?

Ms MULHOLLAND: No, I don't. My questions would suggest there wasn't.

1314 The Hon. E.S. BOURKE: I am sure the media has lots of footage from when the minister showed them the new facilities way back in August when they were saying the new specialty facilities were going to open shortly. I want to touch on a report that has been undertaken. Are you aware of any clinicians receiving, in a formal capacity, a copy of the new Women's and Children's task force report and preliminary business case that was completed and handed to the minister 18 months ago?

Ms MULHOLLAND: Am I aware of it?

1315 The Hon. E.S. BOURKE: Yes, or are you aware of any clinicians having been shown that report or provided a copy of that report?

Ms MULHOLLAND: Not that I recall. I know the recent report we have given to clinicians that was received under FOI, if that is the one you are talking about. That raised concerns for our clinicians, particularly around car parking and the size of the Women's and Children's Hospital. For a number of months we had questioned the size of the new hospital and were told that there was no definitive or expected size of the hospital. When we got that report, it was really clear that there had been some thought put into it. But no, I can't say categorically; only what we have shown the clinicians.

1316 The Hon. E.S. BOURKE: Are you concerned that the minister had that report made available to him 18 months ago but, as representatives of medical health specialists, you were not provided a copy of that report?

Ms MULHOLLAND: Indeed, we were very concerned that we weren't provided it. What we were concerned about was a lack of transparency that was in it from the Women's and Children's executive who we work with and have discussions and consultations with about the new hospital. What was clear from those initial discussions was their view that they knew nothing.

Once we had that report, they said to us that they weren't allowed to tell us, so that is concerning and demonstrated to us that there is just not that transparency. This is everyone's hospital. Clinicians should be part of that. If we only have 600 car parks in the new hospital and that's all we can afford, so be it, but we have to start to look at strategies. How are we going to supplement that? Let's not hide it. Let's bring it out into the open and try to work with it.

1317 The CHAIRPERSON: Ms Mulholland, I have two final questions. They are unrelated. The first is in relation to the approach that was made to SASMOA and your involvement in this. Obviously, you have articulated that at the outset saying that the Medical Staff Society were very reluctant. We have basically reached a breaking point before they have reached out for that sort of assistance.

Given that's the case and given the evidence you have given about the fatigue and the pressure that our clinicians and our staff are under, I would like to know from your experience, are there doctors or clinicians or staff who have been spoken to about their involvement in speaking out about some of these issues or had a warning issued to them in any way, shape or form about any repercussions in terms of speaking out on these issues?

Ms MULHOLLAND: We have certainly been involved in one particular matter and had a discussion a few months ago about a doctor speaking out. Since that time, the executive has seemed to step away from doctors speaking out, which is good, but that so far is the only one we are aware of. We have also seen directions where they have said to doctors that they are not using the

appropriate pathways to raise questions, particularly with the Medical Staff Society. But the difficulty is: what is the right pathway in the building of this hospital? For many years they have tried to raise issues through traditional pathways and nothing has happened and now it's impacting on their patients.

1318 The CHAIRPERSON: Finally, in relation to the new Women's and Children's Hospital, there is a lot of discussion taking place about where we are at with that. There have even been suggestions in the past that the footprint has been done, it's done and dusted, and everybody knows that except the clinicians who are being told that they will be engaged in this process, that we are nowhere near the stage that others seem to think we are at. Have you heard those same rumours and suggestions, and are you concerned that this is pretty much done and dusted and that clinicians have been left out of the equation?

Ms MULHOLLAND: Certainly, our clinicians are of the view that the actual shell of the hospital, the outside of the hospital, has been determined. They say that quite frequently. They are still holding out hope that as to where the services are actually placed, if their service is going to the new Women's and Children's Hospital, they would have the ability to inform that direction.

1319 The CHAIRPERSON: Thank you very much for your evidence today, Ms Mulholland. I am sure there may be some questions that come your way on notice as a result of the evidence that was given today, but we are extremely grateful for your frank assessment of where we are at with our Women's and Children's Hospital. Thank you.

THE WITNESS WITHDREW

SA Salaried Medical Officers Association

Serving Salaried Doctors

PO Box 64
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Email: sasmoa@sasmoa.com
Website: www.sasmoa.com
ABN: 60 932 342 397

25 August 2020

Hon Stephen Wade MLC
Minister for Health and Wellbeing
9th Floor, CitiCentre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Dear Minister

Women's and Children's Hospital Funding – Clarification Sought

I refer to the above matter.

Recently you made a statement in the media that:

> ***"To deliver quality services now we have provided $65 million more funding, employed 100 FTE more employees, and are investing $50m of capital works in the current site."***

We assume the "*we*" you refer to is your Government, elected in 2018.

SASMOA sought further information in relation to the above from the Women's and Children's Health Network (WCHN). The advice provided by the WCHN would suggest that the above statement is confusing at best and may be misleading, and so we seek clarification from you.

$65m "more funding" claim

The claim above could be interpreted to suggest you have provided $65 million more funding AND $50 million for capital works. Information provided by WCHN would suggest this would not appear to be the case and the $50 million referred to is part of the claimed $65 million. It would be helpful if you could clarify that, but let's use it as our starting point.

SASMOA accepts that $50 million was set aside for sustainment works for Boylan Inpatient Unit, Neonatal Services, Theatre Compliance Upgrade and Paediatric Emergency Department, however the Association struggled to understand the additional $15 million referred to in your public statement.

Was it for other capital works? Or for the "*100 FTE more employees*"? Or for something else?

Inquiries from SASMOA to the WCHN have led to suggestions that part of the additional $15 million dollar amount may refer to monies for building works for Cassia Ward, which commenced in 2011 and were completed in

2012 at a cost of approximately $10 million dollars, and $4 million dollars for other building works which were completed in 2018.

Can you confirm that these are indeed the amounts which you have used to make your claim that "*we have provided $65 million more funding*". And – if that is the case – then where has the money for the "*100 FTE more employees*" come from?

Additional FTEs

SASMOA sought advice from the WCHN regarding the "*100 FTE more employees*" claimed in your public statement. The WCHN delegates understood those figures were provided by the Department for Health and Wellbeing derived from the CHRIS21 System.

Unfortunately, it would appear that the FTE number claimed is not **additional** but simply the CHRIS21 System reflecting the rotation of existing staff through the WCHN.

So that we can be certain, can you please clarify if and where you believe there has been an "additional" 100 FTE allocated to the WCHN by answering the following four specific questions:

- When was funding for the additional 100 FTE allocated by your Government to the WCHN?
- What specific services were allocated the additional 100 FTE in the WCHN?
- What were the classifications of the employees in the additional 100 FTE, for example medical officers, nursing, medical allied health, administration, executive etc?
- How was the recruitment process and due diligence undertaken for the additional100 FTE?

Is it your view, on reflection, that your comment that "*we have … employed 100 FTE more employees*" at the WCHN is factually correct?

Definition of "World Class, State of the Art" New Hospital

Finally, SASMOA recently emailed your office seeking the Government's exact definition of what would constitute "a World Class, State of the Art" new Women's and Children's Hospital. We are awaiting your reply with interest.

We look forward to all your responses as a matter of urgency.

Yours sincerely

Bernadette Mulholland
SASMOA, Chief Industrial Officer

C.C. Dr Chris McGowan
SA Health, Chief Executive

South Australian Salaried Medical Officers Association

New Women's and Children's Hospital

South Australian
Salaried Medical
Officers Association

SASMOA
The SA Doctors' Union
sasmoa4doctors.com.au

Car Parking

ILF Minutes 20 February 2020

- The WCH delegate advised "the nWCH will have 11 floors above the ground with a yet to be determined amount of car-park spaces...The whole precinct has been reviewed, areas where car parks could be built in close proximity of the WCH precinct will be identified and other options are being considered..."
- Advised that the location and spaces within car park will not be determined until next year.

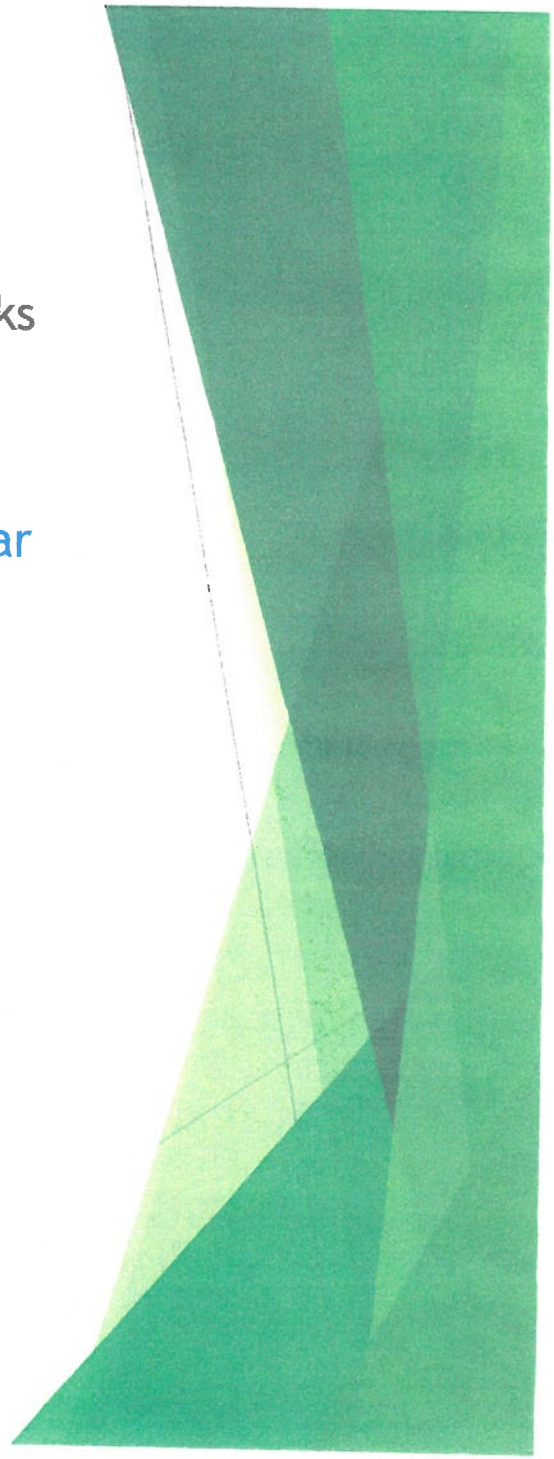
nWCH Capital Costs Memo (8 April 2019)

- "Early discussions with developers have identified a number of functions currently in scope in nWCH site, which from a formal capital perspective, could be more efficiently accommodated in a redevelopment of North Terrace and West Terrace site in particular there is a significant opportunity to address a majority of car parking requirements for nWCH more cost effectively

Car Parking

- $195 million for site preparation and car parking works
- In addition four levels of underground car parking for 600 spaces is included in the area and cost model
- Loss of 172 car parking spaces and approx. and 150 car parks on the surrounding roads
- Disabled car parking

"Why has the WCHN said they do not know the actual spaces of the car parking facility attached to the new Women's and Children's Hospital when the documents identify that the employer knows?"



Size of the new hospital?

21 November 2019 - Minutes

- BM asked "What is the size of the new hospital, the size of the existing hospital and the actual size of the nRAH"
- WCH response, "the nWCH has the capacity to be 11 floors, however we are unable to predict the size of the building as yet as we do not know the extent of services required.

nWCH Capital Costs Memo (8 April 2019)

- A facility compromising 100,000 m2 for the hospital plus unenclosed area and car parking for a total of 174, 150 m2

"Why did the employer state it did not know the size of the hospital when the document clearly indicates the employer did know?"

$65 million dollars, $115 million dollars and 100 extra staff

- $10 million Cassia Ward in 2012
- $4 million Medical Day Unit in 2018
- $50 million current sustainment works
- $1 million for internal team of project managers
- Para 12165 of the Budget and Finance Papers (Mr Don Frater) – *Highlights (if I am reading this correctly) that "WCHN has been provided $50 million for sustainment works and an additional $65 million for operating expenditure."*
- *SASMOA is seeking to determine whether this operating expenditure was recurrent funding and when it was provided to WCHN and for what purpose?*

$65 million dollars, $115 million dollars and 100 extra staff

- Para 12174 – A question is asked of Dr McGowan in the Budget and Finance Committee regarding 100 FTE. The question appears to suggest an additional 100 FTE medical consultants at WCHN. I would be surprised if this is correct. However, there has been several recent media comments regarding 100 additional FTE at WCHN by the Government (Media Release attached). Is the Department able to clarify the breakdown what the breakdown of these staff are, for example, are they additional doctors, nurses and allied health and if so how many.
- *SASMOA is seeking to determine whether these 100 positions are additional clinical positions or are non-clinical positions and what is the breakdown?*

PUGS AND SUGS

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Quorum

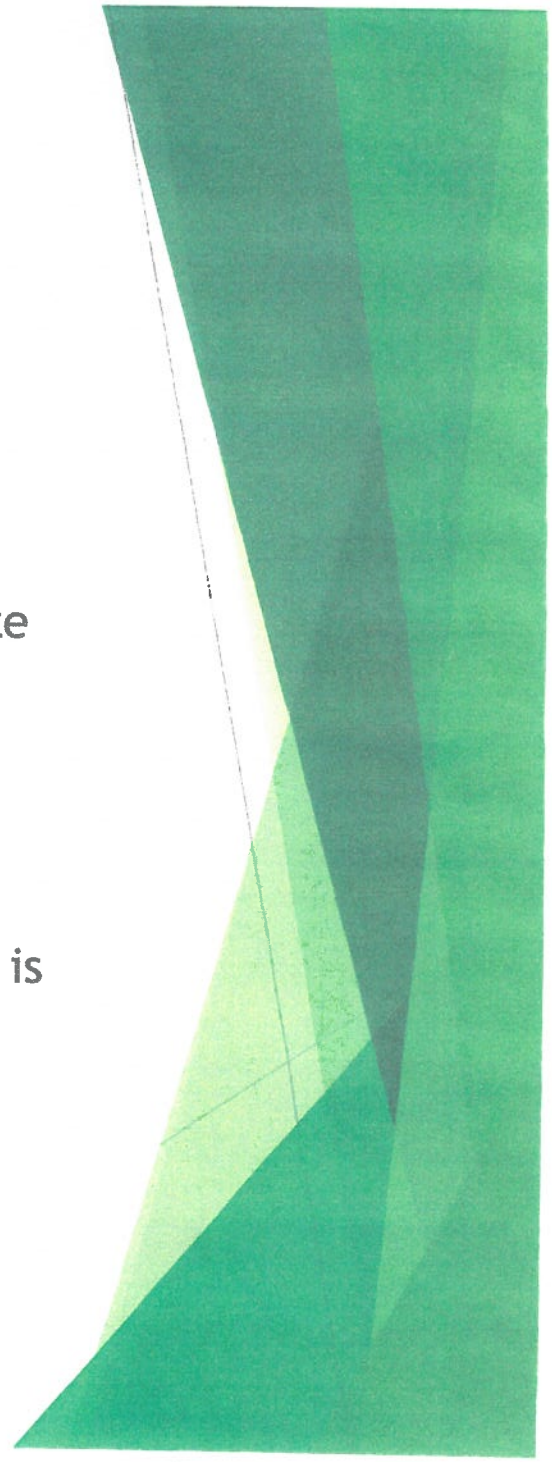
Chair and 50 %members

WCHN Major Capital Works Team will Record and circulate minutes for PUGs that support WCHN Work Groups

Clinical Service Planner (Consultant) will record and circulate minutes (Functional Design Brief). Architect secretariat will record and circulate minutes (design)

The role for each group with respect to each deliverable is set out in the terms of reference for each group

Meant to have a dispute resolution process



PUGS AND SUGS

20 August ILF

- 350 EOIs for 93 PUGs
- WCHN advised that the PUGS will need to provide agreement on functional design brief
- A PUGS sign off process can be included. WCH will provide process for sign off

When will Union Consultation commence in relation to the information that comes from the PUGS?

What are the processes for sign off and noting acceptance or disagreement with final PUG document?

When will Unions commence consultation on SUGS documents?

What is the dispute resolution process?

Feedback from Members

- Pretense of consultation
- "Dismayed, Disillusioned and Disappointed"
- The Clinical Service Plan is inadequate and there are significant failures within the documentation
- No authors on the document. No one is accountable or responsible.
- Service Design Brief is inadequate
- The data relied upon is wrong, this is being fed through the PUGS and SUGS but not recorded.
- There are no meeting minutes from PUGS, no ToRs, no dispute resolution process or escalation.
- No backfill for nursing and allied health to attend the PUGS
- The hospital planners have learnt nothing from COVID 19

Bed Numbers at nWCH

Attachment 1 - Bed and Treatment Space Summary for nWCH

Treatment Space/ Type	Current WCH	New WCH
Beds		
Paediatric and Adolescent Overnight Beds	183	180
Women's Overnight Beds	70	60
Neonatal Costs	56	65
Perinatal and Infant Mental Health Treatment Spaces	6	12
Total Beds	315	317
Paediatric Same Day Spaces / Bed Alternatives	27	36
Emergency and Assessment Treatment Spaces		
Paediatric Emergency Spaces	20	37[a]
Women's Assessment Spaces	10	10
Total Emergency and Assessment Treatment Spaces	30	47
Operating Theatres	8[b]	12[c]
Birthing Suites	18	20
Total Beds and Treatment Spaces	398	432

Notes: a) Includes 4 mental health spaces; b) 8 plus 1 procedure room; and c) 12 plus 2 cold shell.

RAH integration

- ILF 21 May 2020 Minutes - RAH integration work has been a desktop exercise to date e.g. WCH vs RAH loading doc volume and capacity and we will be consulting with back of house areas.
- ILF Minutes 16 July 2020 - Some of the current nWCH/RAH Interface work is focusing on the RAH ICU. Other areas under consideration is Back of House, Food Services, CSSD & ICU. This will form part of the PUG work.
- RAH interface group will inform co-located services, when will this information be available? (August ILF)

nWCH Capital Costs Memo (8 April 2019)

- *"High level analysis has identified the potential to utilize facilities and services with the RAH... Pathology, Pharmacy and back of house services. The opportunities have the potential to reduce the facilities constructed in the nWCH, with associated capital cost savings, and to capitilise on investment in the RAH."*
- Are there any other services being considered?

Quarantined backfill

- Para 12178 – Dr McGowan advised the Budget and Finance Committee that the Department has allocated $8 million dollars to fund cover and roster relief to allow front-line staff clinicians to attend planner user groups can the Department how long this allocation is for and for whom.
- How has the $8 million dollars been allocated for backfill and over what period of time?

Accommodation

- Frontline doctors have requested individual offices to conduct their duties and responsibilities.
- Doctors are being advised at PUGS and SUGS that there will no individual office accommodation.

Is it true that there will be no individual office accommodation for doctors?

What is the advice of ID?

When will SASMOA receive a response to correspondence on this matter?

Can SASMOA have all feedback submitted on this issue?

Work Health and Safety

- ILF 21 May 2020 - Minutes
- SASMOA requested updates on work, health and safety including ongoing participation of the work health and safety representatives.

What has been the involvement of WHSR at PUGS - Patrick Smith to chase up - 16 July 2020 ILF?

Who is the Work Health and Safety Committee communicating with? - 16 July 2020 ILF?

What has been the advice given by ID?

Matters remaining outstanding

- Deloittes presentation - 21 May 2020 ILF
- WCH agreed to take on notice and determine the best way to feed in WCYH Plan to update the committee- 16 July 2020
- Consumer Group Advisory Committee minutes were agreed at the August ILF to be distributed at this ILF once endorsed. When will the Unions receive a copy?
- Professional Services Contractors - Unions requested a presentation - Wendy Rowell to chase up.

Questions on notice

- Presentation from the architects - 16 July 2020
- Service Delivery Models information video - 16 July 2020
- Research committee additional FTE - 16 July 2020

Matters to be included on issues log

- PUG documentation and consultation with Unions
- Service Delivery Models to be provided to Unions for consultation.
- nWCH/RAH Interface Work
- Outpatients
- SA Pathology
- Storage and Medical Records

Ms Lindsey Gough
Chief Executive Officer
Women's and Children's Hospital
72 King William Road
North Adelaide SA 5006

21st October 2019

Dear Lindsey,

In my position of recently elected Chair of the Women's and Children's Health Network (WCHN) Medical Staff Society (MSS) and working with the Deputy Chair, I am writing to you at the request of the membership.

The MSS is open to all members of the WCHN medical staff and recent attendance at meetings demonstrates a high level of engagement from all divisions of the Women's and Children's Hospital as well as community-based practitioners. The MSS has a long history of advocacy and can be a powerful ally in planning and prioritising service provision for the patients and the community served by WCHN. It is our preference that we do so together with our Executive team.

The universal concern, expressed by all medical staff, is that many services that our community (a catchment population of ~2 million, in a developed country) should expect to receive from a specialist Women's and Children's Hospital, seem unachievable in South Australia. The resulting adverse effect on the safety and quality of the care that we can provide has become increasingly hard to justify to our patients and the community.

The MSS wishes to ensure that decision-makers are fully aware of unintended consequences of making cost savings our ongoing primary focus. The most recent meeting of the MSS included a period of open discussion where individual members shared their concerns regarding the safety and quality of patient care currently being delivered. From this, common and unifying issues have been identified which we are sharing with you in the hopes of us all acting collaboratively with a common purpose.

The themes are:

Current medical influence on decision making

- There is concern that medical advice relating to the provision of appropriate contemporary care is being consistently ignored without explanation or justification. This relates to the resourcing of both hospital and community departments. The medical interventions and equipment provided at the Women's and Children's Hospital are falling behind those available in peer hospitals in Australia.

- A diversity of medical staff should have more leadership and decision-making roles in the clinical development and direction of this hospital at the highest levels. Wider and more direct consultation with medical staff with improved communication processes is required.
- The MSS questions the value of certain activities that medical staff are required to undertake. It is not clear how these are contributing to improved patient care.
- The "Your Voice" survey indicated that medical staff have concerns that hospital technology is not being kept up to date. The introduction of an EMR in the future promises greater patient safety and financial accountability but at the same time is likely to significantly increase medical workload and "burnout". This must be considered when planning medical staff numbers.
- The existing risk register does not allow clinician access to lodge, review or audit patient safety risks. This is hampering effective medical contribution to WCH safety culture.
- The current high levels of workload related stress in both junior and senior medical staff should be acknowledged and effectively addressed by the leadership team.

Future direction of the WCH

- There is a strong view that a building does not equal a service. The design of the new Women's and Children's Hospital is seen as an opportunity to improve and develop the existing and future services delivered. Gaps in current care have already been identified and documented by medical staff to our Executive. The experience of services transitioning to the nRAH has demonstrated that failure to secure necessary clinical resources prior to moving to a new site is likely to further compromise patient care. The WCHN medical staff will continue to take an active and lead role in planning clinical service delivery, but feel their decisions and recommendations remain marginalised or ignored in this process.
- Medical succession planning is a significant and ongoing concern. The lack of advanced training positions (both senior registrars and fellows) at the Women's and Children's Hospital compared with other local and interstate hospitals is compromising our ability to achieve consistently high standards of service delivery, blocking career development, sending high quality trainees interstate and jeopardising the future medical consultant workforce for South Australia.
- The clinician/researcher model drives many of the improvements that result in safer, more efficient care. Medical clinician-led research at the Women's and Children's Hospital is hampered by lack of leadership, resources and dedicated clinician time for research and audit activities.

Medical engagement with WCHN Executive

- Responses from junior and senior medical staff in the recent WCHN "Your Voice" survey consistently demonstrated dissatisfaction with Executive leadership, vision, behaviour and communication despite being highly satisfied with relations between and within clinical teams. Worryingly, medical staff did not feel confident that safety concerns that they raised with management would be acted upon. Similar concerns with medical engagement by Executive and Executive performance, action and transparency have been repeatedly raised at MSS meetings.

Constraints to the provision of multi-disciplinary care

- The move from provision of care by an individual medical practitioner to a multi-disciplinary team approach should be recognised as one which, while improving care, uses significant resources. These are not captured by current healthcare indicators and thus this contemporary approach is not adequately resourced.
- The reductions across nursing and allied health services such as social work and psychological services, in particular, are negatively impacting on the overall quality of patient care. Medical staff are having to independently seek supports from other LHNs due to lack of our own care resources. This is not in the best interests of either patients and/or their families.
- Pathology services are being progressively moved off site. This has a negative impact on the efficiency and quality of patient care at Women's and Children's Hospital. The capacity of the Clinical Reference Group to deliver any measurable improvements in service remains to be demonstrated.

Measurement of workforce activities

- Current data collection pays insufficient attention to the complexity of multi-disciplinary team care.
- The input of individual teams to patient care is not being adequately measured.
- Inadequate allowances are being made for teaching, research and clinical trial involvement by medical staff.

The recent evolution of medical care and change into the future

- Clinical medicine is evolving rapidly. Diseases of the past are becoming less frequent. Children with congenital diseases, malignancies and extreme prematurity have become long-term survivors but demand intensive and expert medical care.

- Similarly, a successful pregnancy is now achievable for women with complex medical conditions. This places a higher demand on our maternal-foetal medicine and obstetric departments.
- New treatments and technologies that are life-saving but extremely expensive have already arrived. Medical staff can explain the benefits of these treatments to the Executive as well as to the community. It will benefit the Women's and Children's Hospital to have an informed opinion on the role, significance and implementation of these new medical developments.

Medical staff understand and appreciate that efficiencies in care must be managed. There are excellent contemporary examples of clinical teams at the Women's and Children's Hospital delivering these efficiencies. However, medical staff would like a commitment from Executive that, when cost savings are demonstrated, these savings will be invested back into clinical services. This is not a transparent process currently.

The medical knowledge base is in a phase of exponential development. New resources must be found to ensure that our patients and families will benefit from new life-saving and life-extending treatments for babies, children and women.

As we all prepare for a new Women's and Children's Hospital, there is a unique opportunity for the Executive, the Board, SA Health and the community to understand the opportunities and needs for health care improvements for our patients and the way in which the current budgetary constraints will impact upon these. The MSS can take a lead role in this.

The MSS cordially invites you to attend an upcoming meeting, on Tuesday 22nd October 2019 at 17.30 – 18.30, to address the concerns raised in this letter and explain how they will be addressed.

This letter has been shared with the Medical Staff Society for comment, their comments incorporated and this final version has been endorsed by 190 members at the time of sending. Their email addresses are attached (see attachment 1).

Yours sincerely,

Dr Brett Ritchie
Chair, MSS

Dr Steve Keeley
Deputy Chair, MSS

To the Executive Director, SafeWork SA

We provide the following report in accordance with the provisions of section 117 (6) of the Work Health and Safety Act 2012 (SA) and regulation 28(2) of the Work Health and Safety Regulations 2012 (SA).

We are aware that this report, either in part or in full, may be published on the SafeWork SA website.

ENTRY PERMIT HOLDER (EPH) DETAILS

Name:	**Bernadette Mulholland and Tea Boromisa**
Contact number:	**08 8267 5151**
Permit No:	**ET-19-00307 and ET – 19-01624**
Name of union represented:	**South Australian Salaried Medical Officers Association (SASMOA)**

WORKPLACE ENTERED

Workplace Name:	**The Women's and Children's Hospital Paediatric Intensive Care Unit**
Street Address:	**72 King William Street North Adelaide**
Date:	**Thursday, 15 October 2020**

DETAILS OF ALLEGED CONTRAVENTION

The Women's and Children's Hospital ("WCH") forms part of the Women's and Children's Health Network (PCBU).

The Women's and Children's Hospital provides health care for women and children in Adelaide and South Australia. It is the state's largest maternity and obstetric service. Each year, about 5000 babies are born at the hospital.

The WCH includes a Paediatric Intensive Care Unit (PICU) which is specially staffed and equipped, separate and self-contained section of a hospital for the management of children

with life-threatening (or potentially life-threatening), reversible (or potentially reversible) organ failure.

The EPHs were told by doctors during the inspection that the PICU does not have access to a paediatric cardiac surgeon or ECMO, which is lifesaving treatment for babies who suffer from life threatening cardiac condition when born, in South Australia. The PCBU have outsourced the provision of this service to the Royal Children's Hospital in Melbourne. The PCBU has a formal financial arrangement with the Royal Children's Hospital to provide life-saving clinical care to the babies of South Australia in the event of immediate, life-threatening cardiac conditions for babies. The EPHs were advised by doctors that in Australia and New Zealand ECMO services occur under the supervision and immediate availability of Paediatric Cardiac Surgeons. When a baby is retrieved from WCH for ECMO, the team is always accompanied by an experienced Paediatric Cardiac Surgeon.

The EPHs were advised by doctors that Victoria has been hit hard by COVID requiring significant COVID restrictions to be implemented in this State. One of the restrictions is the prohibition of babies being transferred from WCH to the Royal Children's Hospital in Melbourne for lifesaving cardiac treatment which is usual practice. The alternative for WCH is to transfer babies to Sydney, to Westmead Children's Hospital however, there is no formal arrangements between WCH and Westmead thus life and death situations for babies is reliant on the goodwill and availability of the service and paediatric cardiac surgeons in Sydney. This transfer also requires babies in life-threatening situations to travel further.

The WCH Administration is aware of three recent deaths of babies, within nearly three weeks, due to WCH's inability to transfer babies to either Melbourne or Sydney for reasons stated above. The EPHs have since been advised by the doctors interviewed a further death occurred on Friday following the inspection. The EPHs were told by the doctors during the inspection that although this situation was and is known to the PCBU, nothing has been done to address the process meaning more babies will die and the anxiety, frustration, mental stress and wellbeing of frontline clinicians attempting to address the gap has and will escalate. The EPHs were told that although this advice has been provided to the PCBU and reported through the Safety Learning System there has been no action by the PCBU indeed the EPHs were told by the doctors the PCBU has rejected SLS reports submitted by the doctors because the safety issue relates to ECMO. This has left frontline clinicians distressed.

PCBU Safety Learning System

The EPHs were advised during the inspection by doctors, that the PCBU Safety Learning System (or SLS) is the only system available to report patient incidences and health and safety incidences. If the SLS is unable to be accessed by workers, then there is no formal reporting system to log when a significant safety incident occurs this includes delays in lifesaving care and provision in South Australia of a paediatric cardiac surgeon and ECMO services. If the SLS report is rejected then in effect there is no SLS report. In the absence of an SLS report the PCBU has advised clinicians that "open disclosure" with the family, including the mother and father of the deceased baby is not required, nor is the matter recorded as a SAC 1 or SAC 2 which, if it were, would be drawn to the attention of the Minister for Health and Wellbeing.

A SAC 1, the EPHs understand, is a clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

A SAC 2, is a clinical incident that has or could have (near miss), caused moderate harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The SA Health website states:

> *"The Safety Learning System is an application that enables all SA Health services to record, manage, investigate and analyse patient and worker incidents as well as consumer feedback. It is also used for capturing information about security services and to record formal notifications such as those for coronial matters or medical malpractice."*

The SA Health website further state:

> ***"Patient incidents in SLS***
>
> *Everyone providing services on behalf of SA Health must record all patient related incidents, including near misses, into SLS. All incidents reported into SLS are reviewed and serious incidents undergo more detailed investigation.*
>
> *Incident management and review is a requirement under SA Health policy (PDF 1.9MB) and the National Safety and Quality Heath Service Standards.*

Answers to frequently asked questions (FAQs) about reporting patient incidents (PDF 103KB) are available.

Further information is available on the Patient incidents in Safety Learning System page."

"Work Health Safety incidents in SLS
Work Health and Safety (WHS) reporting into SLS ensures a standardised process to comply with legal requirements and to provide data to support future hazard control and WHS prevention programs.

Information in WHS incident reports on SLS is governed by the Work Health and Safety Act 2012 (SA).

All workers are encouraged to report Work Health and Safety incidents including:

- *hazards, such as equipment faults, environmental factors*
- *Incidents with no harm*
- *Incidents with injury or harm, including bodily injury or mental stress*

Further information is available on the Work Health and Safety incidents in Safety Learning System page."

The EPHs understand there are no exemptions to the systems above, that is, there is no ability for the PCBU to reject an SLS either for a patient incident or harm to workers, including incidences or harm relating to mental stress of workers.

Safety Learning System - Hibbert Review – Coroner Findings Chemotherapy Treatment – Oakden Report

The EPHs are aware and were told by the doctors they have participated in a review of the Safety Learning System. The EPHs believe this to be the Hibbert Review commenced in February 2020, commissioned by the Department for Health and Wellbeing.

The reviewers stated, "the objectives of the review are to:

- *Consider recommendations made by the Deputy State Coroner and independent reviews conducted in response to chemotherapy underdosing that relate to incident reporting and management;*
- *Determine and describe how the SLS is used across SA Health for patient incident reporting and management; and*
- *Identify factors that are impeding or may impede the use of SLS.*

The Review is being undertaken by independent consultants, Associate Professor Peter Hibbert and Dr Tim Schultz. Responses to the review were to be submitted by the end of February 2020. To date no report or review outcome has been viewed regarding the Safety Learning System by either the doctors or the EPHs conducting the inspection.

- **Chemotherapy underdosing that relate to incident reporting and management**

The Coroner found in 2019, *into the deaths of Joanna Pinxteren, Christopher McRae, Bronte Ormond Higham and Carol Anne Bairnsfather the following;*

> *"In my view the Safety Learning System method of reporting adverse incidents does not work. Not only that, it does not work across the entire SA Health system. It has not been necessary to go into minute detail about the operation of the Safety Learning System as it functioned, or rather failed to function, here. "*

The Coroner's recommendations proposed the following.

> *"That the current Safety Learning System (SLS) be abandoned and be replaced by an adverse event reporting system that includes the following elements:*
>
> *An adverse event such as the detection of a protocol error or the treatment of a patient in accordance with an erroneous protocol should immediately be reported to the head of the relevant department and immediately be reported to the chief administrative officer of the hospital in question. It should also be immediately reported to the Chief Executive of the Department of Health and Wellbeing. The fact of the adverse event, a detailed description of the event and of measures taken to rectify any underlying error should immediately be communicated to the chief administrative officers of each tertiary public hospital in South Australia and also be reported to the heads of the relevant departments within those hospitals."*

The above needs to be considered by SafeWork SA in the advice received from doctors during the inspection conducted by the EPHs on Thursday, 15 October 2020 at the Women's and Children's Hospital.

Inspection of Site

On Thursday, 15 October 2020, at approximately 02.00 PM, the named permit holders entered the Women's and Children's Hospital as per the Notice of Entry to discuss with doctors, concerns regarding the submission of health and safety reports regarding patients and workers utilising the PCBU's Safety Learning System. This inspection arose following reports of the concerns of medical staff with the dismissal of SLS notifications by the PCBU, of the deaths of three babies in quick succession linked to cardiac surgical support and the provision of ECMO.

Safety Learning System Reporting

The EPHs interviewed several senior doctors in the Unit regarding their concerns. The doctors state they were unaware that a Safety Learning System ("SLS") report could be rejected by the PCBU until the recent rejections occurred. One had doctor become aware in July 2020, when their report submitted on 6 July 2020 following the death of a baby in December 2017, classified as a SAC 1 which was rejected on 9 July 2020 by the PCBU on the basis the PCBU determined the incident was not an incident allowable to be reported on the Safety Learning System. This was the first time doctors became aware in the Unit that SLSs could be outrightly rejected.

The EPHs were told at the inspection, the doctor advised the PCBU in the SLS report the incident was rated a SAC 1. The doctor indicated in the SLS report that if the baby had been transferred to the Royal Children's Hospital in Melbourne, who is funded by the PCBU to provide this paediatric cardiac surgery and extracorporeal membrane oxygenation service (ECMO) the baby had a significant chance of survival. Retrieval by airplane with a paediatric cardiac surgeon is the only option for the provision of care to South Australian babies who

require these lifesaving services. Failure by the doctors at WCH to secure the services will result in a baby's death.

The doctor states there is a small window of opportunity for babies suffering the condition and sought immediate transfer to Royal Children's Hospital. The Royal Children's Hospital declined the transfer due to logistical reasons. The doctor stated to the EPHs that all treatment available at WCH had been exhausted and the baby died shortly thereafter. The doctor indicated in the SLS report to the PCBU that the incident was preventable.

The EPHs were told by the doctor that the SLS report was reviewed by the Executive Director Medical Services and the Divisional Director Paediatric Medicine who advised the doctor after asking the Director of the Royal Children's Hospital PICU that an SLS report could not be submitted by the doctor as *"there was no evidence of an incident"* and the PCBU determined the *"incident rejected"*.

The doctor *"felt terrible"* and stated that the PCBU decision makers who rejected the SLS report, was flawed. The doctor stated that the PCBU relied on the advice of the Royal Children's Hospital Intensive Care Unit who concluded there was no incident for reporting as the WCH does not have a paediatric cardiac surgeon and ECMO and therefore could not call the matter an *"incident"* for the purposes of a SLS report. The doctor stated, *"this was a conflict of interest and the advice sought from the individual was not independent."* One Doctor says he stated in the SLS, *"That some of the children who died in South Australia would have been put on ECMO had they been in Melbourne and some of them would have survived"*.

The doctor stated to the EPHs that the PCBU delegates advised the doctor that because the services were not available at the WCH the SLS report would be rejected as the system would not record such a safety incident. The doctor stated that the PCBU delegates claimed there could be no safety issue if there is no service. The doctor stated to the EPHs, *"to state that this was not a safety incident is bizarre". The PCBU delegates stated that it was not an incident as the baby had no chance of survival because the service that would have assisted*

was not available at WCH. There was no review of the system that lead to the baby's death or flaws in the transfer process."

The doctor stated, "I felt powerless and helpless, I could not change the system and the situation using the only system available that records these incidences, I was prohibited from using to record the incident."

The doctors told the EPHs that the PCBU delegates, "*are two-faced, they state to the public and to us that they want us to speak up on health and safety issues for patients and staff, and when we do they either do nothing or bully us to withdraw the concerns."*

One doctor stated, "*I felt bullied by the WCH representative when I recently raised health and safety issues when a baby died, they were more interested that the matter was not referred to the Coroner. All he was interested in when he made contact was that the death was reviewed as a "routine matter".*

SLS Report - 16 September 2020 – Rejected by PCBU on 17 September 2020

The EPHs were advised the baby was 9 days old and diagnosed with congenital cardiac disease and was waiting to be transferred to the Westmead Children's Hospital. The EPHs were advised the WCH has a formal agreement to transfer babies with cardiac surgical needs to the Royal Children's Hospital in Melbourne for life saving surgery but, due to COVID restrictions in Victoria this avenue, was prohibited for the last few months. The EPHs were told the doctors were therefore reliant on Westmead Children's Hospital. The arrangement was and still is an adhoc informal process, for babies when in distress. The EPHs were told by the doctors, "*the baby died on this occasion due to our inability to access a paediatric cardiac surgeon and ECMO facilities."*

The EPHs were told by the doctors the PCBU has no official agreement (with the loss of the Royal Children's Hospital, Melbourne) to access the lifesaving services at Westmead and "*we are very much reliant on the goodwill and how busy the service in Sydney is to determine the*

ability to accommodate our request for immediate transfer for babies needing the lifesaving services."

The EPHs were told one of the doctors submitted an SLS report stating that due to the lack of an ECMO service and paediatric cardiac surgery and inability to transfer the baby, the baby died. The doctor also recorded in the SLS report the negative impact the situation had on the clinical staff in the service. It was the strong view of the doctor and service, *"if the paediatric cardiac surgeon and ECMO service had been available the baby would have survived."* The doctor submitted the SLS report as a SAC 1.

The incident was reviewed by the PCBU delegate and a determination was made to reject the SLS report submitted by the doctor as the incident did not meet the definition of a patient incident. The reviewer stated to the doctor, *"a recent external review of comparable clinical cases conducted by an interstate PICU medical expert from the Royal Children's Hospital, Melbourne did not support notification of an incident on the basis of the lack of a paediatric ECMO service. This has confirmed the rationale to reject the incident."*

The EPHs and doctors felt there were several concerns with the PCBU's reliance on this review (see attached), and *"significantly concerned by this reliance"*. The reviewer, the doctors submit, amongst other concerns had, *"a clear conflict of interest"*, and only reviewed the issue of *"not having an ECMO program"*. The PCBU failed to consider other parts of the incident reported including the delays in transfer, the ad hoc relationship of Westmead with the WCH, COVID restrictions with Royal Children's Hospital, Melbourne, the impact the lack of these services had on the baby's death and the mental stress of staff as a result of the incident.

SLS Report - 28 September 2020 – Status unknown

The EPHs were told by the doctors during the inspection that it had been already clinically determined that there was a serious health risk for both mother and unborn baby and there needed to be transfer of both mother and baby within the week to Westmead to protect

both patients. The EPHs were told given there was no ability to transfer the patients to Melbourne due to COVID restrictions, attempts were made to transfer the mother and baby to Westmead, Sydney. The EPHs were told by the doctors there were extensive requests to transfer the mother to Sydney to get the necessary expertise.. There has high anxiety amongst clinical staff in the Unit that if the baby were born in WCH the baby would die and there would be serious health risks for the mother. It was known that the baby needed immediate lifesaving assistance on delivery which could only be provided at Westmead, *"We did not have the tools, and this was known to the hospital administration."* The doctors stated to the EPHs, *"The baby arrested, we did not have the clinical tools to save the baby. We should have sent Mum and baby to Sydney we kept saying this to executive. We tried for two weeks, high anxiety, everyone was asking why we cannot get the mother to Sydney, it was time critical".*

The doctors stated that the PCBU delegates kept saying, *"you did everything you could. This is a lie not only to us but to the families, I did not do everything I could, if we had the services here or we got the mother before the child birth to Westmead the baby would have survived."*

The EPHs were told again the doctors submitted an SLS report as a SAC 1 and again the report was rejected by the PCBU on the basis that the services were not available in South Australia.

The Doctors told the EPHs that again the PCBU did not inquire into the mental distress of the staff which was significant given the recent distress of the previous incident detailed above.

The doctors told the EPHs, *"There was no follow-up with staff, the whole unit was demoralized, executive and senior clinical management were aware of situation did nothing to help or ask how staff were going."*

SLS Report submitted 13 October 2020 – not yet determined re rejection

The EPHs were told by doctors that a 4-day old baby had been transferred from another hospital with pneumonia and septic shock. There were many discussions with the PICU at the Royal Children's Hospital Melbourne and Westmead Children's Hospital. The EPHs were told the baby was a candidate for ECMO which was not practicably possible at the Royal Children's Hospital, Melbourne due to COVID restrictions and Westmead was exploring options to get a team to the baby. The baby continued to deteriorate whilst discussions occurred.

Westmead finally were able to agree to send a retrieval on Saturday morning, the baby died on Friday night. The EPHs were told one of the doctors at Royal's Children's Hospital Melbourne contacted one of the doctors at WCH to find out how the transfer went and was advised of the baby's death. The EPHs were then advised by the doctor in a text that *"for the next 6 months that Royal Children's Hospital, Melbourne won't be able to rush over until the borders open and would send an email confirming the advice."*

The EPHs spoke to another doctor not in the PICU but had also care of the baby. The doctor said they had been told not to put in a SLS report. The doctor said, *"This is distressing for the doctors, they were upset"*. The doctor stated, *"This was a tiny little baby, it was distressing, it's awful this care should be accessible, this is completely avoidable, people are blocking and are lying"*.

The EPHs were advised by the doctors that the PCBU delegate sought to have the matter *"reviewed as a routine death"*, by which he meant reviewed only within the intensive care unit and by the hospital mortality committee. The doctors lodged the SLS report recording the matter as a SAC 1.

The doctor advised the EPHs that the incident was again rejected by the PCBU. The PICU doctor also informed other stakeholders via email of the death of the baby confirming that there was *"no access to ECMO even from interstate"*. One of the doctor's stated, *"This was an otherwise healthy child who died of infection. Any other paediatric hospital in the country*

would have offered ECMO to this baby and hence given the baby a chance of survival... Avoidable deaths will continue. "

The doctors stated to the EPHs there were now three babies that had died within nearly three weeks due to the lack of services at the WCH but also an inability to transfer these babies to either Royal Children's Hospital or Westmead in Victoria and NSW. The doctors stated to the EPHs', *"this is too much, when you have been unable to give these babies all the opportunities any other baby would have in any mainland state of Australia."*

The doctors stated to the EPHs that the PCBU delegate had stated after this last incident that, *"we encourage SLS reports but not SLS reports connected to ECMO or paediatric cardiac surgery"*

"This is unacceptable. The risk of doing nothing is real." Amongst other matters, in a return email from a PCBU delegate, the PCBU delegates told the doctor that he was not to escalate *" directly to the Minister."*

The doctors stated to the EPHs, *"It is evident, depending on the State the baby is born in Australia, there will be different outcomes. If you are a baby anywhere in NSW you will be transferred to Westmead in any of the three situations, this is how it should be. In Adelaide it is hit and miss, and some babies have survived just through "dumb luck" and the determination of clinicians to try and save the baby."*

The doctors state that the PCBU, *"continue to reject and provide barriers to access the Safety Learning System when babies die or there is an adverse outcome due to a lack of cardiac surgery and an ECMO service"*. The doctors also stated to the EPHs that the PCBU *"reject SAC 1 and SAC 2 reports because these are required to be referred to the Minister."* The doctors also stated that, *"the WCH will not allow these incidences to be recorded as a SAC 1 or SAC 2 as we are then required to undertake open disclosure with the families and the WCH representatives are rejecting the SLS reports on this basis of this as well as they do not wish*

families to know that a death may have been prevented if the services were provided in South Australia or at the very least timely and equitable access to the services in another State".

One doctor interviewed stated, *"I did not know an SLS report could be downgraded without my knowledge, never mind rejected. I have been putting in SLS reports for years regarding adverse events for babies, I did not know what happened to the reports once submitted but assumed the employer did something. No one ever contacted me to tell me what had happened with the SLS or whether amended, the administration is deceitful and liars if they are changing the SLS reports submitted without telling us".*

The doctors reiterated that, *"No one from Executive or senior management have asked any staff within the service, in all three deaths, are we okay or asked after the staff's welfare, they only care about minimising the information."*

The doctors stated they were *"angry and frustrated"* with the SLS reporting, *"It is a joke and a tool for management to hide poor patient care and the distress of staff."*

The doctors stated that the Royal Children's Hospital is now down two paediatric cardiac surgeons. *"To air lift a baby from WCH, with life threatening cardiac needs, requires the paediatric cardiac surgeon to be on the plane thus the minimal medical staffing of the Melbourne service threatens the provision of service to South Australia."* The doctors stated to the EPH, *"South Australian babies are not Melbourne babies, given the demands on the service, South Australian babies are not the priority, it is not equitable and it is not equitable access for these lifesaving services."*

The EPHs were told by the doctors interviewed, that clinicians on the ward were demoralized and disappointed and morale was low following the recent baby deaths.

One doctor advised that he had attended a presentation on safety and quality and sought to present on the lack of paediatric cardiac surgery and ECMO services and the impacts this is having on babies. The EPHs were advised that the PCBU delegates blocked the

presentation and did not want the presentation to proceed. The doctor told the EPHs that he sent the delegates his presentation via email.

The doctors also advised the EPHs that when they questioned the PCBU delegates regarding the notifiable risk to patients in the absence of a paediatric cardiac surgeon, ECMO at the WCH and delay in retrieval of babies and lifesaving care interstate the doctors were advised to place the risk on the risk register. The doctors advised the EPHs that they commenced attempting to place the risk on the risk register in May of this year and the PCBU, "has provided significant barriers to allow the recording of the risk on the register".

Work Health and Safety Act, 2012

The EPHs will be seeking all documents relevant to the above including the SLS reports submitted for each incident and will submit a further report if required once the documents have been received.

On conducting this inspection, the following contraventions have occurred and continue to occur by the PCBU and its Officers, in relation to the *Work Health and Safety Act, 2012*. The PCBU have failed to provide a safe system of recording health and safety incidences.

The EPH is of the view that the PCBU, responsible for the WCH PICU, has contravened the following sections of the *Work Health and Safety Act 2012 (SA)* 2012, Section 17, 19, 20 and its officers, have failed to implement any appropriate or reasonable response to eliminate or remove the risk to health, safety and welfare of workers at the site and patients who are seeking health care from the site.

The EPH submits the PCBU failed to consult with workers at the site on matters pertaining to health and safety and who are directly impacted by the PCBU's omission.

The PCBU has failed to escalate a notifiable incident and to address the notifiable incident.

The PCBU has failed to implement a reasonable reporting health and safety system for workers. Noting the Coroner's comments regarding the current Safety Learning System;

> *That the current Safety Learning System (SLS) be abandoned and be replaced by an adverse event reporting system that includes the following elements:*
>
> *An adverse event such as the detection of a protocol error or the treatment of a patient in accordance with an erroneous protocol should immediately be reported to the head of the relevant department and immediately be reported to the chief administrative officer of the hospital in question. It should also be immediately reported to the Chief Executive of the Department of Health and Wellbeing. The fact of the adverse event, a detailed description of the event and of measures taken to rectify any underlying error should immediately be communicated to the chief administrative officers of each tertiary public hospital in South Australia and also be reported to the heads of the relevant departments within those hospitals."*

The EPHs request a complete and independent review by SafeWork SA into the matters articulated above before further adverse outcomes result.

4	Signature of EPHs:	*Date: 19 October 2020*

5	**SAFEWORK SA USE ONLY:**	**InfoNET File No.:**	**Report triaged by:**	**Names redacted:** ☐
				Report saved on Q:/: ☐
		Report saved on InfoNET: ☐	*Further action required Yes / No*	**Report sent to Comms Unit:** ☐
			Date **/ /20**	**EPH s/sheet updated:** ☐

Att. 1

I have been asked by the CEO of Women's and Childrens Health Network to do a Clinical Review of the care of a number of patients at WCH and whether there were any deficiencies in care that constituted an incident, that should have been notified on the Safety Learning System.

I have been provided:

A list of the 29 cases collated by the Paediatric Intensive Care team.
Terms of Reference.
Women's and Children's Health Network Patient Incident Management and Open Disclosure Procedure.
Case notes for each of the 29 patients.

I have known and worked collaboratively with the intensive care consultants at WCH for many years. They are excellent clinicians. I also am aware that WCH does not offer Extracorporeal life support to patients but discusses these cases with RCH, Melbourne. I do not believe I have any conflict of interest.

The care received by all of these patients was to the standard expected of a major tertiary PICU. There were no breaches of practice or adverse events that would warrant notification, pursuant to the Safety Learning System guidelines. I do believe that, if an ECMO program existed, then many of these patients may have received ECMO and some may have had their outcome altered.

However, ECMO is a complicated therapy with substantial risks and, in order to be done safely, an organised neonatal and paediatric program needs to be developed. Modern day, small volume centres have excellent results.

Yours Sincerely

Definition of "World Class, State of the Art Hospital

The nWCH will provide a modern, safe, high quality, cost effective service that encompasses best practice and innovation . The new hospital build will be flexible to accommodate improvements and advancements in technology and health care delivery. Our clinicians, through their clinical relationsh ips with their peers interstate and overseas combined with medical research will play an important role in informing continuous improvement and best practice in the delivery of health care at the nWCH.

The A+ Team comprising Woods Bagot, BOP, Bates, Jacobs and ERA-co bring a wealth of expertise with local, interstate and overseas hospital builds, and will work in collaboration with the WCHN management, staff, consumers and stakeholders across all levels of planning, design and delivery phases of the nWCH.

In Australia, the hospitals that have been considered include the Royal Children's Hospital, Melbourne; Sydney Children's Hospital - Randwick and Westmead, Queensland Children's, the Royal Perth Hospital, and for women we have considered the Royal Women's Hospital, Melbourne; King Edward Memorial in Perth and the Royal Brisbane and Women's Hospital.

Hospitals overseas including the Alder Hey Children's Hospital, England; Dunedin Hospital, New Zealand; the Children's Hospital, Dublin, Ireland and the Copenhagen Children's Hospital.

MINUTE

Government of South Australia
SA Health

MINUTES forming ENCLOSURE to

File no: 2018-04141
Doc no: A1391141

To: **THE OFFICE OF THE MINISTER FOR HEALTH AND WELLBEING**

Submitted by **Brendan Hewitt, Executive Director Infrastructure**

☐ Authorised by **Dr Christopher McGowan, Chief Executive, SA Health** 10/4/19

Endorsed by **Don Frater, Deputy Chief Executive** 9/4/19

NEW WOMEN'S AND CHILDREN'S HOSPITAL CAPITAL COSTS

Timing: REQUIRED DATE: 08/04/2019
Reason: Meeting scheduled with the Minister and Chief Executive on Monday 8 April 2019

Recommendations: It is recommended that you:

1. Note that Outline Business Case, as approved by the nWCH Taskforce, will be submitted for Government consideration in May 2019.
2. The preliminary cost estimate for the nWCH is $1.895 billion. This is comprised of:
   a. $195 million for site preparation and car parking works;
   b. $1.143 billion for construction and equipping of the nWCH, in 2019-20 costs;
   c. $241 million for cost escalation to project completion in 2025-26;and
   d. $316 million in project contingency, representing 20% of total project costs.
3. Note the preliminary cost estimate is based on an initial building concept developed for the purpose of testing that it will fit on the expansion site to the west of the Royal Adelaide Hospital. This concept needs substantial further development.
4. Note the potential to explore precinct wide opportunities that could improve the nWCH solution and reduce cost. This work will focus on three areas:
   a. optimising service linkages with the Royal Adelaide Hospital;
   b. exploring facility and service opportunities across health precinct; and
   c. reduce the size of the nWCH on the basis of a) and b) along with efficiencies identified through the development of models of care and the development of the functional brief.
5. Significant clinical and consumer engagement was undertaken by the nWCH Taskforce in the development of the nWCH Service Statement, leading to the identified treatment spaces and Schedule of Accommodation (SOA) as reflected in the nWCH Outline Business Case. While there may be opportunities to reduce the number of treatment spaces and area provided there are risks associated with such reductions
6. Note that there has been an independent review of the SoA and cost estimates. These have been considered appropriate for this phase of the project. There are opportunities to improve efficiencies through more detailed service planning and refinement of project planning.
7. The nWCH is expected to be completed in 2025-26, assuming an adequately resourced project that commences from mid-2019 and is uninterrupted.
8. Benchmarking the nWCH with other recently completed major children hospitals around Australia indicate the size and indicative cost estimates developed to be appropriate based on a completion in 2025-26.
9. Note that the next phase of work 2019-20 comprises of the development of clinical

service plans and new models of care and the development of the functional design brief. This will enable a Full Business Case to be completed in the first half of 2020. The Full Business Case will include a revised capital cost based on the exploration of a range of site and service opportunities, as well as an understanding on operating costs of the nWCH.

Noted

Stephen Wade

Minister for Health and Wellbeing

25/4/19

PURPOSE

- To provide the Minister a brief status of the nWCH project, in particular the completion of the Outline Business Case as undertaken by the nWCH Taskforce and the next steps in the nWCH project.

SUMMARY

- The nWCH Taskforce selected the site immediately to the west of the Royal Adelaide Hospital (RAH) largely due to its ability to provide the shortest direct clinical link between the nWCH and the RAH. Cost modelling has been undertaken for the nWCH based on the site selected by the nWCH Taskforce.
- The Cost Model has been prepared as part of the Outline Business Case for the nWCH which will be submitted in support of a Cabinet Submission scheduled into Cabinet on 6 May 2019.
- This Cabinet Submission will ask Cabinet to note the current cost estimate for the nWCH and that further work will be undertaken over the next 12 months with a view to reducing cost. This needs to be done with the WCH clinicians in progressing clinical service planning and development of the functional brief for the nWCH. This will provide the opportunity to refine and optimise the cost for the new hospital and site planning for the relocation of existing services. This will be developed through the Full Business Case, anticipated to be provided to Government in the first quarter of 2020.
- The Taskforce has approved an Outline Business Case that details the requirement of a new WCH in context of state-wide service provision, required treatment spaces, the preferred site location, capital cost and indicative program.
- Overall overnight beds are broadly consistent with the WCH current capacity. Growth is provided in ambulatory spaces, increased Paediatric Emergency Department capacity and as well as Operating Theatres, and a small increase in birth suites. Attachment 1 provides a summary of treatment spaces for the current WCH as well as the nWCH.
- The new WCH test concept identifies a facility comprising 100,000m2 for the hospital plus unenclosed areas and car parking for a total of 174,150m2.
- Progression of new WCH planning would include detailed clinical service planning, functional brief development, traffic planning, planning/designing for existing service relocations and progression of the building concept. These works will enable development of a robust schedule of accommodation, assessment of future operating costs and refinement of the cost estimate and project program. Procurement options and risk assessments will also be completed leading to the completion of the Full Business Case at which point Government can fully consider the project.

- The cost estimate for the nWCH is $1.895 billion based on completion in 2025-26. This is comprised of:
    - $195 million for site preparation and car parking works;
    - $1.143 billion for construction and equipping of the nWCH, in 2019-20 costs;
    - $241 million for cost escalation to project completion in 2025-26;and
    - $316 million in project contingency, representing 20% of total project costs.
- Clinical services planning and the development of a functional design brief are expected to commence in 2019, with construction due to commence in the first quarter of 2021, subject to the procurement options. At this stage completion is forecast for 2025-26.
- The cost model for the nWCH includes $100 million for ICT infrastructure to be delivered as part of the overall construction cost by the building contractor to enable the hospital building to function. The cost model currently excludes active clinical ICT equipment, which is based on further development based on clinical requirements and is yet to be determined.
- The key factors that impact on the cost of the nWCH areas modelled in the Outline Business Case are:
    - Construction works for the nWCH on RAH West will require the relocation of existing services, such as the storm water retention basin, the RAH fire water tanks and in-ground high voltage cables. Works are also likely to require temporary truck access to the site.
    - The SoA for the nWCH has been based on the scope of services to be provided at the new hospital and the number of treatment spaces required to enable these services to be delivered. Based on the Australian Health Facility Guidelines and consultation with WCH clinicians the SoA is in the order of 100,000 square metres. In addition unenclosed areas are required for outdoor areas, under croft walkways, suspended balconies and terraces. In addition, four levels of underground car parking for 600 spaces is included in the area and cost model.
    - It is important to note that while opportunities have been considered for efficiencies arising from the colocation with the RAH, that the outline Business Case provides for a standalone nWCH, with access to the RAH helipad being the primary facility integration. There remain opportunities to be further investigated, however some of these are subject to negotiations with Celsus.
- Significant engagement was undertaken with clinicians and consumers on the development of the SOA to determine the number of treatment spaces necessary to deliver patient care, as described in the Service Statement, in the nWCH. Consumer engagement highlighted the importance of the nWCH facility being designed to be patient and family centred, which is of greater importance to a women's and children's hospital when compared to an adult acute hospital. For instance, when a child is admitted to the WCH it is common that one or both parents will spend significant time with their child to minimise any distress that can arise from hospitalisation and separation from family and loved ones. This may involve siblings visiting as well. Likewise, pregnant women are likely to be accompanied by their partner when presenting in labour, and to be visited by significant numbers of family and friends on the arrival of their new born child.
- Significant work has been undertaken to develop sufficient detail to enable the nWCH cost model to be developed, however further work is required to fully explore cost saving opportunities and to provide the required certainty on the most efficient cost option of the nWCH.
- The opportunities that have been identified for assessment include:

- Optimising the service interfaces between the nWCH and the Royal Adelaide Hospital (RAH). High level analysis has identified the potential to utilise facilities and services within the RAH in areas such as Pathology, Pharmacy and back of house services. These opportunities have the potential to reduce the facilities constructed in the nWCH, with associated capital cost savings, and to capitalise on the investment in the RAH.
- Exploring the service and facility opportunities with the health precinct, including Biomed City and the adjacent area in the north west corner of the CBD through the redevelopment of the North Terrace and West Terrace site. Early discussions with a developer have identified a number of functions currently in scope in nWCH site, which from a capital perspective, could be more cost efficiently accommodated in a redevelopment of the North Terrace and West Terrace site, in particular there is a significant opportunity to address a majority of car parking requirements for nWCH more cost effectively.
- Reducing scope through the strategies described above. In addition the work undertaken in the next phase of the project, specifically clinical service planning and the development of the functional design brief, and will focus on identifying area efficiencies.

- In parallel with the exploration of opportunities, the nWCH project will further identify and evaluate potential risks to the project cost and project delivery. Some risks will have a direct cost, while other will have program and cost impacts.
- Some identified risks include:
  - Relocating RAH infrastructure on the RAH West site requires positive engagement with, and cooperation by, the RAH operator Celsus.
  - Protracted planning will have a time and cost impact on the project.
  - With a commencement in 2019 and completion in 2025-26, changes in technology, equipment and or clinical practice may require in a change in project scope. These areas will require clear management.
  - Increased facility cost arising from any increased floor area and treatment spaces.
  - Operating costs have yet to be fully determined.

- A comparative analysis of the cost model and scale of the nWCH with other like hospitals presents a number of challenges, in particular due to the nWCH being unique in Australia as a combined women's and children's hospital providing: neonatal; paediatric, adolescent; obstetric and gynaecology services. Other jurisdictions have dedicated women's hospitals, or women's services integrated with adult hospitals, which are separate from dedicated children's hospitals. Some of these may be collocated, but they are structurally and functionally separate hospitals.
- Over the past decade three quaternary children's hospitals have been built in Australia. These can be considered peer hospitals to the nWCH in terms of the scope of specialist and complex clinical services provided. In order to undertake a comparative analysis with the nWCH, the costs at completion of these three hospitals escalated to assume a commencement in 2019 and a completion in 2025-26.
- Comparing the three interstate children's hospitals with the nWCH requires caution, in particular when assessing the inclusion or exclusion of car parking. The Royal Children's Hospital is located on Flemington Road, Melbourne, is well served by public transport 24/7. It does include some car parking spaces below the hospital. The Perth Children's Hospital does not have its own car park, instead sharing an above ground multi-deck carpark with the Sir Charles Gardiner Hospital. The Queensland Children's Hospital has some 670 car parking spaces below the hospital, as well as sharing an above ground multi-deck carpark with the adjacent Mater Hospital.

- In addition to comparison with these peer hospitals comparison is also made with the new RAH which comprises 182,990m2, plus a further 64,010 m2 for 2,300 car parking spaces below the facility.
- Costs have also been adjusted to the Adelaide market regarding escalation rates. This then indicated what the cost of these three hospitals would be if they were built in Adelaide to the nWCH program, commencing in 2019 and completed in 2025-26. The costs are summarised in the table below.

Hospital	Beds	Gross Area (m2)	Actual Completion	Built Cost	Adjusted Completion 2026
Royal Children's Hospital - Melbourne	353	154,000	2011	$946,000,000	$1,505,964,000
Perth Children's Hospital	298	125,000	2017	$1,168,700,000	$1,714,052,000
Queensland Children's Hospital	407	145,000	2014	$1,165,901,000	$2,184,244,000
New Women's and Children's Hospital South Australia	337	174,150	2026		$1,895,000,000
Royal Adelaide Hospital	700	247,000	2017	$2,400,000,000	$3,520,000,000

- The new RAH was completed in 2016, and clinically occupied in 2017. The total cost for this hospital in 2017 includes the construction cost included by Project Co, as well as State-side costs of almost $600 million for a total cost of $2.4 billion. State-side cost included specialist medical equipment, ICT, project office, contract administration, and commissioning. If the new RAH project were to commence in 2019 and be completed in 2025-26, the escalated cost at 5% per annum (p.a.) would be in the order of $3.3 to $3.6 billion.
- Further to these comparisons analysis has been undertaken of costs for construction of private/public hospitals and specifically for the nWCH and the under construction private Calvary Hospital. Attachment 2 provides a waterfall diagram depicting the cost difference of these hospitals.
- It is important to note that the operational cost efficiencies that can be achieved from a new purpose built WCH, over the current WCH, have not been explored in the Outline Business Case as the design phase for the nWCH is yet to commence. A nWCH will be designed to optimise operational efficiencies, both clinically and clinical support services. The results of this work will be included in the Full Business Case.
- It is expected that as the project moves into the next phase of clinical service planning and the development of the functional brief that detailed modelling will be undertaken on achieving a more efficient operating cost. For instance, larger ward sizes than those currently in place may enable more efficient staffing models. The next phase of planning will also incorporate simulation analytics, in outpatients, operating theatres and the paediatric emergency department to optimise area treatment space requirements and area efficiency, enhancing patient flow and the flexible use of space. It is expected that this analysis will also have a positive effect on the total floor area, and in turn costs.
- The Women's and Children's Health Network (WCHN) will need to undertake further extensive and detailed consultation with clinicians, consumers and stakeholders to undertake the clinical service planning and the development of models of care for the nWCH.

- SA Health Infrastructure will lead the project management activities for the nWCH. This will include: health facility planning; clinical support planning; program management and planning of specialist biomedical equipment.

- The Department of Planning, Transport and Infrastructure (DPTI) will engage, on behalf SA Health, a range of professional service contractors (PSC). These will include:
  - a clinical service planner, who will also develop the functional design brief;
  - a lead PSC comprising of health architect with engineering support;
  - a cost consultant;
  - a simulation analyst to optimise functionality and area efficiencies in the Outpatient, Operating Theatres and Paediatric Emergency Department;
  - a traffic engineer; and
  - a PSC to develop the Full Business Case.

- The Cabinet Submission will seek approval for expenditure to support the above works in order for Government to consider the Final Business Case including the design solution and capital cost in early 2020.

SA HEALTH REPRESENTATIVE

- Dr Christopher McGowan, Chief Executive, SA Health
- Mr Jim Birch, AM, Chair, nWCH Taskforce
- Mr Brendan Hewitt, Executive Director Infrastructure

Attachment 1 - Bed and Treatment Space Summary for nWCH

Treatment Space/ Type	Current WCH	New WCH
Beds		
Paediatric and Adolescent Overnight Beds	183	180
Women's Overnight Beds	70	60
Neonatal Costs	56	65
Perinatal and Infant Mental Health Treatment Spaces	6	12
Total Beds	315	317
Paediatric Same Day Spaces / Bed Alternatives	27	36
Emergency and Assessment Treatment Spaces		
Paediatric Emergency Spaces	20	37[a]
Women's Assessment Spaces	10	10
Total Emergency and Assessment Treatment Spaces	30	47
Operating Theatres	8[b]	12[c]
Birthing Suites	18	20
Total Beds and Treatment Spaces	398	432

Notes: a) includes 4 mental health spaces; b) 8 plus 1 procedure room; and c) 12 plus 2 cold shell.

BACKGROUND

- The Minister's office requested a briefing in preparation for a meeting with the Minister scheduled for 4pm on Monday 8 April 2019.

COSTING COMMENT

- N/A

IMPACTS ON ANOTHER CEO OR DCE OR EXECUTIVE DIRECTOR

- Chief Executive Officer, WCHN

ADVICE FROM OTHERS

- N/A

ATTACHMENT(S)

- Attachment 1 – Bed and Treatment Space Summary for nWCH
- Attachment 2 – Waterfall Cost Diagram

(via Objective workflow)

BRENDAN HEWITT
EXECUTIVE DIRECTOR INFRASTRUCTURE
FINANCE AND CORPORATE SERVICES

Contact Officer: Brendan Hewitt	Telephone: 8463 6084
Preferred direct/generic email: Brendan.Hewitt@sa.gov.au	

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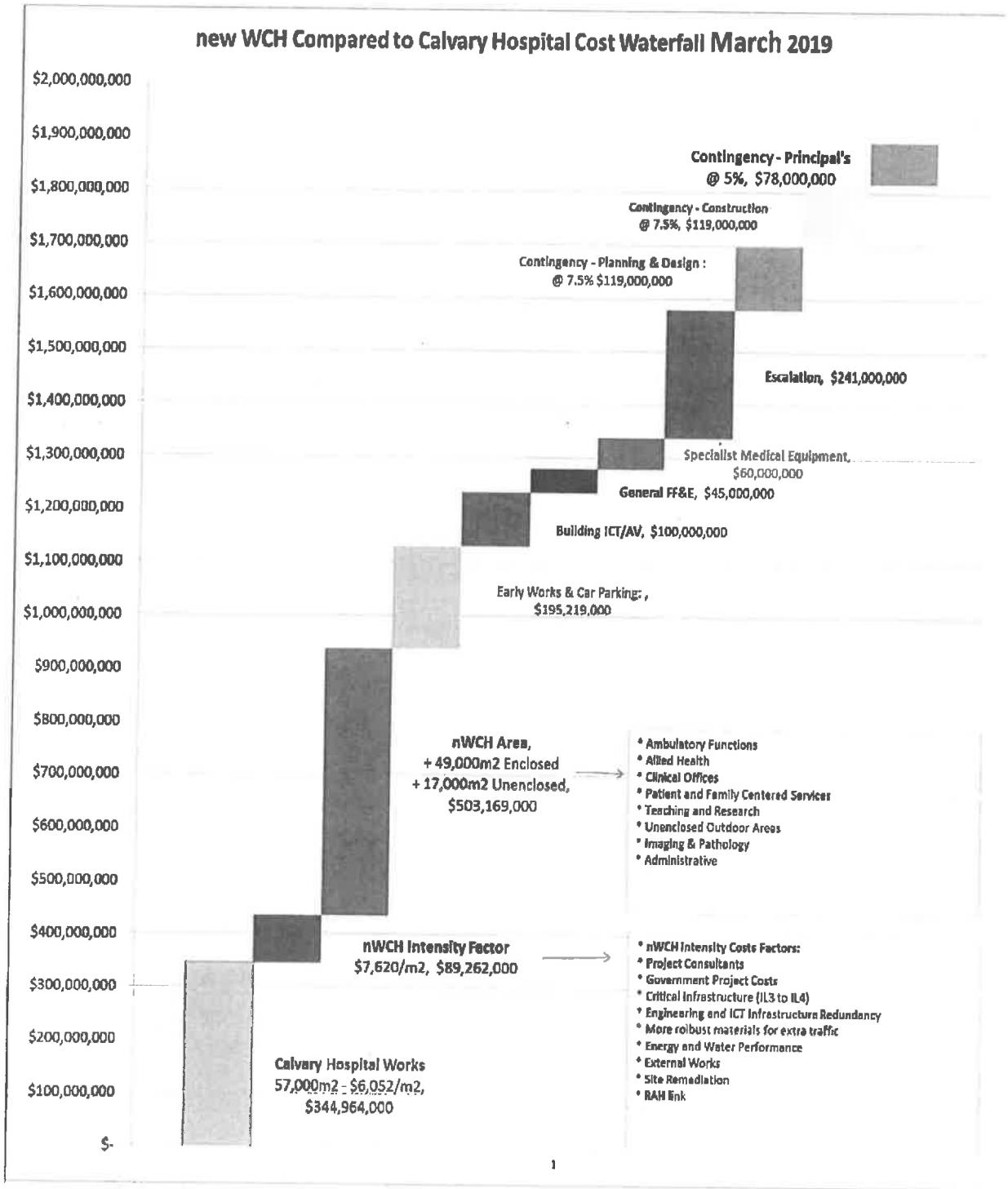
OCE will determine if briefings require the Chief Executive, SA Health to authorise (if front page not ticked) or as below

☐ Copy to be provided to the Chief Executive, SA Health (Office of the Chief Executive to provide)

☐ Departmental record only (Office of the Chief Executive to retain)

Attachment 2 – Waterfall Cost Diagram



Meneaud, Georgia (Health)

From: Hewitt, Brendan (Health)
Sent: Monday, 6 May 2019 09:31
To: Nicholls, Jonathan (Health)
Subject: RE: Information request: MHW-H19-2059

Morning Jonathan
Apologies for not getting back to you sooner on this one. Active clinical ICT is a difficult one to forecast this far out from opening a major new hospital and accordingly is often excluded. The extent of costs would be very much determined by whether the new WCH is utilising existing systems or installing new systems. Industry experience is that it is best to undertake major ICT change at the existing site well before transferring to a new hospital. Attempting to do a new hospital and new ICT system is combining too much change and adds significant risk. The current expectation is that the existing WCH will have installation of a new electronic medical record system well before any move and accordingly that for a new WCH then the costs would largely be attributable to configuring the systems to the new hospital. We would look at getting clarity on direction over this next 12 months. As a point of reference the new RAH ICT costs totalled some $120 million for a complex installation of new systems and interface with the PPP operator.

Regards
Brendan

From: Nicholls, Jonathan (Health) <Jonathan.Nicholls@sa.gov.au>
Sent: Monday, 29 April 2019 12:43 PM
To: Hewitt, Brendan (Health) <Brendan.Hewitt@sa.gov.au>
Cc: Shaw, Scott (Health) <Scott.Shaw5@sa.gov.au>
Subject: Information request: MHW-H19-2059

Hi Brendan

Stephen has asked for some additional information in relation to the New Women's and Children's Hospital Capital Costs briefing. His request relates the following statement (which appears on pg3 of the brief):

- **The cost model for the nWCH includes $100 million for ICT infrastructure to be delivered as part of the overall construction cost by the building contractor to enable the hospital building to function. The cost model currently excludes active clinical ICT equipment, which is based on further development based on clinical requirements an is yet to be determined.**

His questions are:

- Would "active clinical ICT" normally be included in a cost model? If so, what is the likely cost?

If you could get back to me in the next day or two that would be helpful.

Kind regards

Jonathan Nicholls
Senior Ministerial Adviser
Office of the Hon Stephen Wade MLC
Minister for Health and Wellbeing

Level 9, Citi Centre Building, 11 Hindmarsh Square | GPO Box 2555 Adelaide SA 5001
T: (08) 8463 6270| F: (08) 8463 6277 | E: jonathan.nicholls@sa.gov.au | W: www.sahealth.sa.gov.au

Government of South Australia SOUTH

MINUTE

Government of South Australia
SA Health

MINUTES forming ENCLOSURE to

File no: A1532781
Ref no: 2018-04141

To: **THE OFFICE OF THE MINISTER FOR HEALTH AND WELLBEING**

Submitted by **Brendan Hewitt, Executive Director, Infrastructure** / /

☐ Authorised by **Dr Christopher McGowan, Chief Executive, SA Health** 23/7/19

Endorsed by **Julienne TePohe, Deputy Chief Executive** / /

NEW WOMEN'S AND CHILDREN'S HOSPITAL PROJECT GOVERNANCE MANUAL

Timing: REQUIRED DATE: 08/08/2019
Reason: To enable the activation of the new Women's and Children's Hospital Project.

Recommendations: It is recommended that you:

1. Note the contents of this Brief and the attached new Women's and Children's Hospital (WCH) Project Governance Manual.

   Noted

2. Approve the new WCH Project Governance Manual.

   Approved / Not Approved / Noted

3. Approve the Terms of Reference for the new WCH Executive Steering Committee

   Approved / Not Approved / Noted

Minister for Health and Wellbeing
/ /

PURPOSE

1. To provide the Minister for Health and Wellbeing with the attached new WCH Project Governance Manual (May 2019) for approval.
2. To provide the Minister for Health and Wellbeing with the attached new WCH Project Executive Steering Committee Terms of Reference for approval.

SUMMARY

3. The new WCH Taskforce completed its role in February 2019 with the completion of the Outline Business Case for the new WCH.
4. The 2019 State Budget announced in June 2019 committed $550 million towards the development of the new WCH.
5. In mid-2019, the new WCH Project will commence the Planning and Design phase of the Project. This phase will comprise the development of Clinical Service Plans, Models of Care and the Functional Design Brief. Work will also be undertaken on site master planning and early concept development. Site planning works will also be undertaken. This work will take approximately 18 months, and will be completed in late 2020.
6. Work will be undertaken in parallel with the above activities on the development of a Final Business Case for the new WCH, which is also expected to be completed in late 2020.
7. The new WCH Project has developed the new WCH Project Governance Manual (May 2019) to provide the governance structure for the new WCH Project moving forward with clearly articulated responsibilities, reporting lines and appropriate delegations for the development of the Final Business Case and project development.
8. The draft new WCH Project Governance Manual was reviewed as part of the Infrastructure SA Gateway 1 Review, with recommendations from this review included in the updated and attached Governance Manual.
9. The Governance Manual identifies Cabinet as the ultimate decision making authority within the new WCH Project structure, with the Executive Steering Committee being the primary decision making authority within the Cabinet approval set. The Executive Steering Committee reports to the Minister for Health and Wellbeing, who in turn reports through to Cabinet.
10. The Executive Steering Committee will be chaired by the Chief Executive of the Department for Health and Wellbeing with senior executive representatives including:
    - Deputy Chief Executive, Department for Health and Wellbeing;
    - Chief Executive Officer, Women's and Children's Health Network;
    - Board Chair, Women's and Children's Health Network;
    - Executive Director, Infrastructure, Department for Health and Wellbeing;
    - Department of Treasury and Finance; and
    - Department of Planning, Transport and Infrastructure.
11. A number of other senior staff will be invited to attend Executive Steering Committee meetings as required. A Consumer Representative will also be invited to these meetings.

12. Approval of the new WCH Project Governance Manual is required to enable the new WCH Project to move into the next phase of the project (Planning and Design).

ADVICE FROM OTHERS

13. Infrastructure SA on the new WCH Governance Manual
14. Ms Lindsey Gough, CEO, WCHN

COSTING COMMENT

N/A

CONSUMER, COMMUNITY CONSULTATION

N/A

CLINICIAN CONSULTATION

N/A

IMPACTS ON ANOTHER CEO OR DCE OR EXECUTIVE DIRECTOR

15. Ms Lindsey Gough, CEO, WCHN

SA HEALTH REPRESENTATIVE (for meetings only)

N/A

ATTACHMENT(S)

Attachment 1. New Women's and Children's Hospital Project - Governance Manual.

Attachment 2. New Women's and Children's Hospital Project - Executive Steering Committee Terms of Reference.

Director / Manager – Name: Brendan Hewitt
Title, division or LHN/SAAS: Executive Director Infrastructure, C&SSS
Contact Officer: Peter Fitzsimmons Telephone: 0432 002 205
Preferred direct/generic email: peter.fitzsimmons@health.sa.gov.au

Governance Manual

Women's and Children's Hospital Project

June 2019

pwc

File Number: 10201505 **Version:** FINAL

File Name: Women's and Children's Hospital Project **Revision:** H

Version control

Version	Revision	Date	Author	Distribution	Amendments	Reference
DRAFT	A	09/05/19	JS			
DRAFT	B	14/05/19	HH			
DRAFT	C	15/05/19	CG			
DRAFT	D	16/05/19	DK			
RESPONSE	E	23/05/19	DHW			
DRAFT	F	24/05/19	DK			
DRAFT	G	26/06/19	PF			
FINAL	H	03/07/19	AS			

Glossary

The below glossary has been included to assist users in understanding some of the common terminology and acronyms used on this Project.

Item	Description
WCH	Women's and Children's Hospital
ESC	Executive Steering Committee
IMT	Integrated Management Team
PS	Project Sponsor
PO	Project Owner
DOC	Department and Operational Committee
CRF	Change Request Form
PDP	Project Delivery Plan
PD	Project Director
CMS	Cost Management System
CMP	Cost Management Process
IT	Infrastructure Technology
CBS	Cost Breakdown structure
CCM	Change Control Management
RMM	Risk Management Methodology
PMB	Performance Measurement Baseline
MEPF	Mechanical, Electrical, Plumbing (Hydraulics) and Fire services

Contents

A

Overview

1. Introduction

1.1. Purpose of this Governance Manual

This Governance Manual describes processes and systems that have been adopted on the new Women's and Children's Hospital ('new WCH') Project ('project') in order to ensure good governance. It is a bespoke document for the project and provides the blueprint to achieve best practice for management of the project in order to provide good governance.

Post operational commencement all departments will generate their own operating procedures and governance requirements.

Compliance to this manual by relevant parties shall be monitored, and is subject to annual review by the Executive Steering Committee ('ESC').

This governance manual is a live document. It is intended that it is developed and refined as the project develops to reflect the changing environment that the project is being delivered in and the particular risks or issues encountered.

This manual is distributed subject to the condition that it is not to be traded, sold or used for distribution on a commercial basis.

1.2. Structure of the Governance Manual

This governance manual is arranged in three parts as follows:

- Part A (Overview) sets out the background on the project, the broad scope to be delivered, the key stakeholders and some of the parameters and constraints that it will be delivered in
- Part B (Terms of Reference) provides the organisational structure of the project and the key roles, responsibilities and delegations of the major groups within the structure
- Part C (Project Controls) details the key requirements for the management of the project to ensure effective governance

2. Project summary

2.1. Overview

The Women's and Children's Hospital (WCH) is the tertiary and quaternary hospital for women's, paediatric and neonatal services in South Australia (SA). It is the leading provider of specialist care for children and adolescents, providing the highest complexity services for paediatrics, and provides the State's largest maternity and obstetrics service. WCH is also a tertiary mental health facility for children and adolescents, a provider of important community-based services, and a highly regarded facility for research and teaching.

The WCH plays a critical role in women's and children's health services in the State. Each year, around 5,000 babies are born at the hospital, 46,000 children present to the emergency department, 8,000 women and 22,000 children are admitted as inpatients, care is provided to around 2,000 neonates, and over 240,000 outpatient services are provided to women and children. The inpatient services alone account for approximately 40 per cent of paediatric, neonatal and women's services across the State, and health services are provided to residents across SA, the Northern Territory, Far West New South Wales and Western Victoria.

2.2. Context

The South Australian Government (the government) has committed to a range of initiatives to improve how health is delivered in SA. *A Strong Plan for Real Change* (2018) includes a commitment to deliver best practice health services for women and children by building a new WCH (new WCH) co-located with the Royal Adelaide Hospital (RAH). As part of the Government's commitment, a high-level Taskforce (the new WCH Taskforce) was established to oversee the initiation and planning of the new WCH and provide recommendations to the Minister for Health and Wellbeing. The new WCH Taskforce has overseen the identification of state-wide models of care, service specifications and overall size of a new facility, and has also been involved in the development of capital and operating costs.

2.3. Service and clinical requirement for the new WCH

Prior to considering potential site options for the new WCH co-located with the RAH, an estimate of future service and facility requirements has been developed to identify spatial requirements for the new site. The total overnight and same-day beds estimated for the new WCH is 353 (including 12 Perinatal and Infant Mental Health Service treatment spaces), together with 47 emergency and assessment treatment spaces (including 4 mental health treatment spaces), 14 operating theatres (12 operating theatres plus 2 shell spaces), and 20 birthing suites.

These have been developed based on 2031-32 activity projections with input from multiple clinical groups. The approach applied assumes continuation of trends in activity suggesting a reduction in overnight stays and increased ambulatory and same-day services, which result in overall growth as well as some redistribution of spaces.

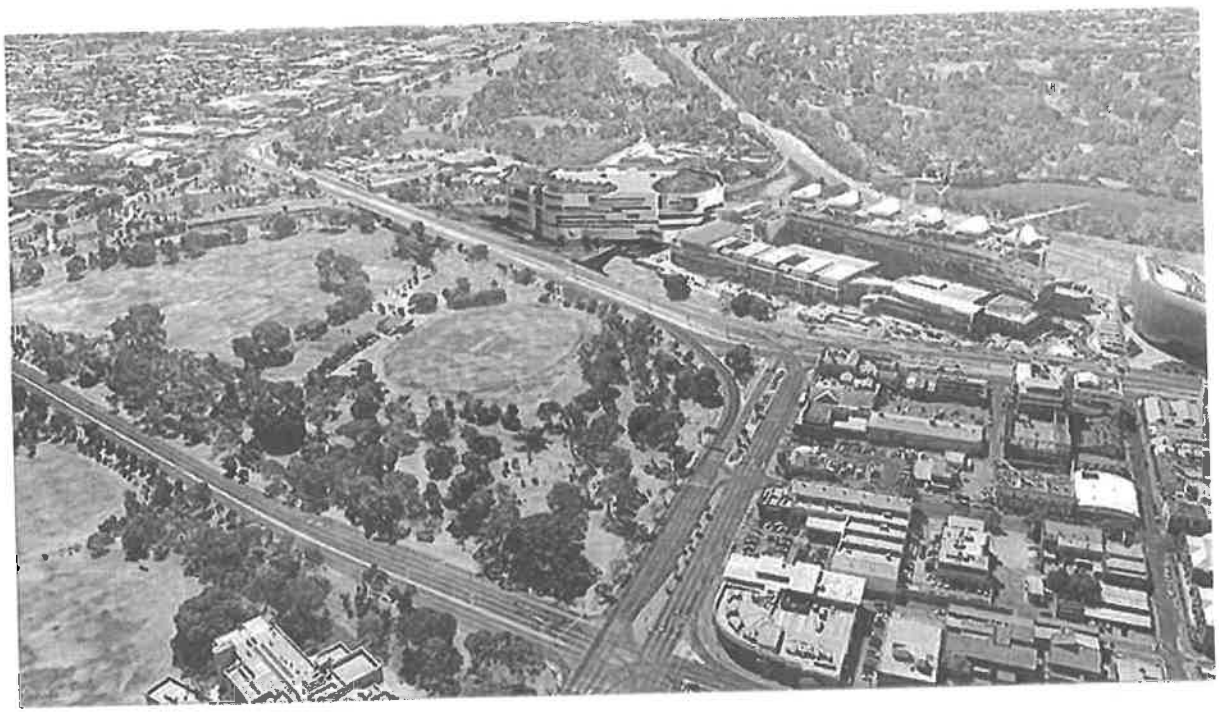
Considering the above clinical requirements, as well as person and family centred care, education, research and clinical trial spatial needs, the estimated facility space required for the new WCH, including travel and engineering space, is approximately 100,000 sqm. As this represents the enclosed facility requirements, it excludes car parking and outdoor space.

2.4. Site

A number of potential site options have been considered to accommodate the new WCH. During initial site identification, five site options were selected that each meet the government's commitment to build the new WCH co-located with the RAH.

Each of the five sites was assessed for key risks against six overarching criteria: clinical, clinical support, site and building infrastructure, transport, planning and approvals, and corporate. Three sites were short-listed for further consideration and development. The three short-listed sites were further evaluated by

applying quantitative measures against five of the six overarching criteria (corporate criteria, including operating and capital costs were not considered as part of this process) and scoring the short-listed sites to identify the preferred site based on the highest scores. The preferred site selected for the new WCH is the vacant land immediately to the west of the Royal Adelaide Hospital site, adjacent to Port Road, as shown in the artist impressions below. This site performs significantly better than the other site options with respect to the clinical outcomes, particularly through the direct link to the RAH, and access to the RAH helipad and associated heliport infrastructure.



2.5. Key stakeholders

Project stakeholders are individuals and organisations that are actively involved and/or exert influence over the project or whose interests may be positively or negatively affected as a result of the project. The key project stakeholders will be detailed in the Project Implementation Plan and are summarised below:

- SA Government
- Department of Premier and Cabinet
- Department of Treasury and Finance
- Department of Planning, Transport and Infrastructure
- Women and Children's Hospital Network
- Partners and suppliers to the Women and Children's hospital
- Royal Adelaide Hospital PPP Operator
- Other Local Health Networks
- Primary Health Network
- City of Adelaide
- University of Adelaide
- University of South Australia
- Flinders University
- Anangu Pitjantjatjara Land Council
- Kuarna Nation Cultural Heritage Association
- SA Power Networks
- SA Water
- Australian Gas Networks
- Women and children of South Australia
- The wider community of South Australia

2.6. Key objectives

The key project objectives are to:

- provide the Women and Children of South Australia with the highest standard of clinical care
- deliver the project within the approved budget
- deliver the project in accordance with the approved master program and milestone dates
- deliver faciltity and infrastructure of the required quality as outlined in the business case
- effectively manage risks through the design, construction and operation of the hospital

Effective governance will be fundamental to achieving the above objectives and delivering to the expectations of the SA Government and the South Australian community.

2.7. Project Phases

The project will be delivered in accordance with SA Government guidelines for the development and delivery of capital projects. For the purposes of this governance manual, governance, including responsibilities, delegations, and terms of reference, has been designed around two key phases:

- Planning and design phase
- Implementation phase

There will be some overlap between these phases after enabling works commence on site and before detailed design is complete. During this period, the terms of this governance plan will apply to activities which belong to each phase.

B

Terms of reference

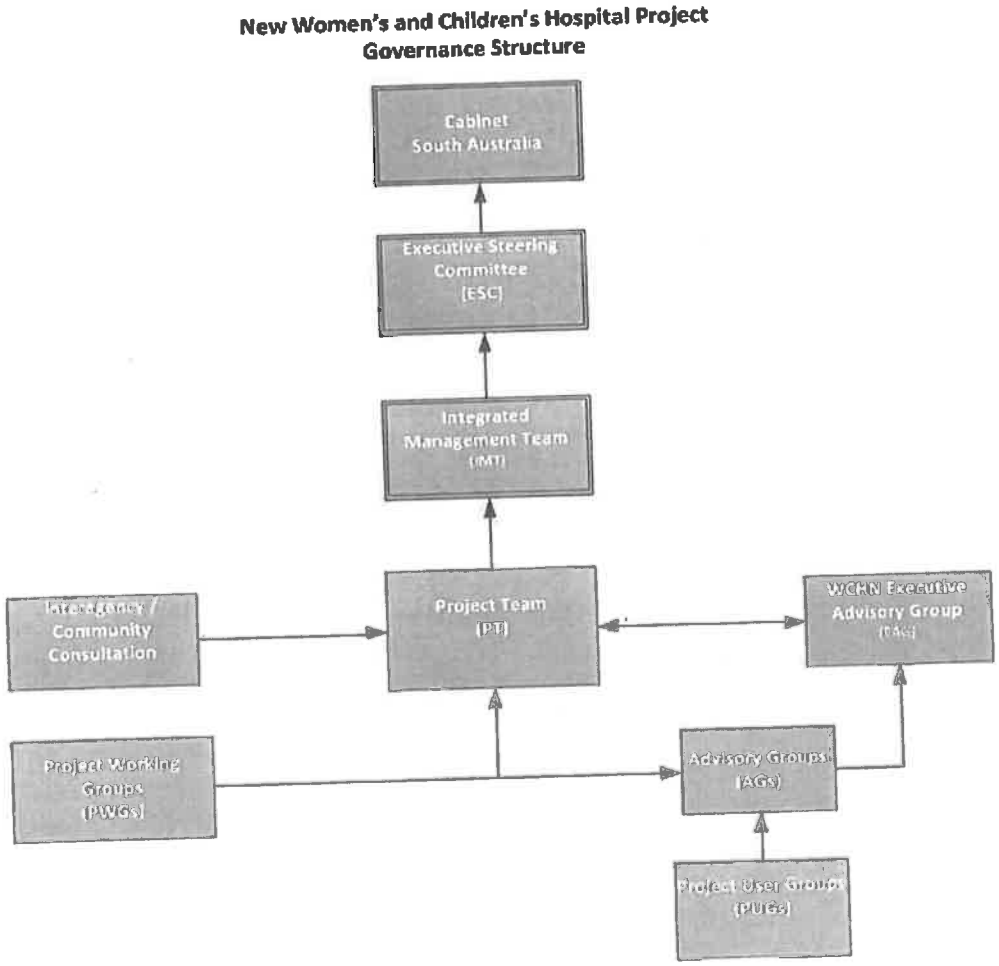
3. Project organisation structure

3.1. Introduction

A clear decision making process is critical for the good governance of the Project. The governance structure is arranged around three levels of responsibilty – project direction, project management and stakeholder input, with further sub-groups in each level.

3.2. Project Hierarchy

The following diagram summarises the project hierarchy, recognising that the ESC will answerable to the Government through the Minister for Health and Wellbeing. The roles and responsibilities are described in general terms below and set out in detail in section 4.



3.3. Project Direction

The project direction group is responsible for directing the progress of the project. It makes most decisions that are substantive to the outcome of the project. Within the direction group, there are two committees, the Executive Steering Committee (ESC) and Integrated Management Team (IMT):

- **Executive Steering Committee.** The Executive Steering Committee is made up of senior executive members of the key stakeholder organisations. All strategic decisions for the project are made by the ESC within the approvals of Cabinet. These decisions include overall plan and vision for the hospital and represent the 'big picture' for the project. Examples of decisions taken by the ESC include approval of the vision, business cases (incorporating, scope, budget and schedule for the project), changes to the overall model of care, services to be provided (particuarly with respect to sharing of services with the Royal Adelaide Hospital operator), operations, project quality, etc. The ESC monitors the prectical implenmtation of the project by the Integrated Management Team (IMT).
- **Integrated Management Team.** Tactical decisions involving the establishment of key initiatives to achieve the overall strategy for the project are the responsibility of the Integrated Management Team ('IMT'). The IMT will review, approve and monitor the plans, tasks and procedures that need to be carried out for successful implementation of the project. It would be expected that the vast majority of design decisions would be approved by the IMT, with only those decisions which have a material impact on the budget, timing, risk or service outcomes of the project being escalated to the ESC. The IMT is charged with the management of the delivery of the project and as such makes recommendations to the ESC on significant design decisions, large value procurement and mitigation of strategic risks, and acts on the outcome of those decisions by way of instruction to the Project Team. The Chair of the IMT will formally present a comprehensive progress report ('IMT Report') to the ESC on a monthly basis.

3.4. Project Management

The managment of the project is undertaken by the Project Team. The Project Team is responsible for working with the stakeholder groups to develop design, planning and construction options for consideration by the IMT or ESC as appropriate. In the implementation phase, the Project Team is responsible for the management of construction, building commissioning and handover. The project team prepares most project deliverables and is responsible for the outputs of the project. In order to efficiently deliver the project, some decisions which do not materially impact the scope, timing or cost of the project will need to be taken by managers in the project team.

3.5. Stakeholder Group

The stakeholder group is arranged into working groups, user groups or advisory groups based on the interest of the included stakeholders in the functional aspects of the hospital and the level of input required. The input group provide the project team with the detail of the functional requirements for the hospital beyond those specified in the project objectives, clinical services plan and functional design brief.

4. Governance Arrangements

The project governance arrangements for the new WCH will be enacted through the Terms of Reference, which are set out over the following pages. These Terms of Reference should be distributed to each group at the start of a Project once the project specific requirements are considered and incorporated.

4.1. Terms of Reference - Executive Steering Committee (ESC)

The ESC provides strategic direction and leadership on all project activities. The ESC comprises of senior executives from those stakeholders responsible for setting the project scope and delivering the project within the agreed scope. It provides strategic direction on all aspects of the project and monitors the practical implementation of those strategies by the IMT.

Cabinet is the ultimate decision making authority within the project governance structure and ESC is the primary decision-making authority within the Cabinet approval set. Risks and issues that cannot be resolved and/or are above the delegation of the IMT must be escalated to the ESC.

The ESC is responsible for monitoring achievement of project deliverables (including adherence to project scope) and endorsing project deliverables prior to submission to the Government through the Minister for Health and Wellbeing.

The ESC is also responsible for providing strategic advice to the project related to:

- Whole of government issues and policies
- Political, social or relevant regional commentary around sentiment towards the project
- Strategic long-term considerations and evaluation of broader redevelopment issues

Planning and Development of Final Business Case	Role of ESC
Services Procurement Plan	Support
Project Implementation Plan	Support
Risk Management Plan	Support
Financial Impact Statement	Support
Economic Appraisal	Support
Communications and Consultation Strategy	Support
Operational Commissioning Strategy	Support
ICT Strategy	Support
Workforce Development Strategy	Support
Functional Design Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Approve
Final Business Case	Endorse for Cabinet Approval

Guide Design Development	Role of ESC
Project Implementation Plan	Support
Risk Management Plan	Support
Variations to AusHFG	Approve
Procurement Strategy	Endorse for Cabinet Approval
Financial Impact Statement	Support
Economic Appraisal	Support
Communications and Consultation Plan	Support
Operational readiness plan	Support
Workforce Development Strategy	Support
Systems and Equipment including FFE, MME and ICT	Informed of IMT Approval
Facilities Management Strategy	Support

Project Implementation	Role of ESC
Project Implementation Plan	Support
Procurement Strategy	Approve
Developed Design Documentation including Room Data Sheets	Approve
Major variations to approved project scope	Endorse for sign off by MfH
Variations to AusHFG	Approve
Tender evaluation and engagement of preferred tenderer and award contract	Endorse for Cabinet Approval
Post Tender Review Report to Department of Treasury and Finance	Informed
Finalise design	Approve
Communications and Consultation Plan	Support
Operational Readiness Plan	Support
Workforce Development Plan	Support
Systems and Equipment including FFE, MME and ICT Strategy	Informed of IMT Approval
Operational Commissioning and Facilities Management Plan	Support
Construction Management Plan	Informed
Building Commissioning and Project Completion Plan	Informed of IMT Approval
Certify construction complete	Approve
Handover facility	Approve
Finalise operational commissioning – Move Logistics and Decant Plan	Approve

All phases	Role of ESC
Schedule	Approve changes and monitor
Cost/Budget	Approve changes and monitor

All phases	Role of ESC
Gateway Reviews	Endorse prior to release to Infrastructure SA Review Team
Resource procurement	Approve
Contract management of construction	Informed of issues

Standard Membership	ESC
Chief Executive Officer of SA Health	Chair (Member)
Deputy Chief Executive Officer of SA Health	Member
CEO WCHN	Member
Board Chair WCHN	Member
Executive Director Infrastructure	Member
Department of Treasury and Finance Representative	Member
DPTI Representative	Member
Independent Project Planning and Delivery Advisor (as required)	Invited
Infrastructure new WCH Project Director	Invited
Executive Director, Corporate Services, WCHN	Invited
WCHN Consumer representative(s)	Invited

Quorum

Chief Executive of SA Health (Chair), Executive Director Infrastructure and CEO WCHN.

Frequency

Minimum quarterly but typically monthly and should be determined on project need.
Meetings will occur monthly during development of the Final Business Case.

Support

The Infrastructure Project Secretariat will record and circulate minutes, action items and maintain a decision register.

4.2. Terms of Reference - Integrated Management Team (IMT)

The IMT is responsible for monitoring and directing on all aspects of the project, including the activities of the Project Team and stakeholder groups (including adherence to project scope and parameters, making decisions consistent with their level of delegation, providing direction and advice to other governance structures). The IMT is the primary decision making body during the planning, design and implementation of the project and is responsible for endorsing project deliverables prior to submission to the ESC.

During the planning phase, the IMT oversees and approves the development of the design, implementation strategies and project plans.

During implementation the IMT is responsible for overseeing construction and commissioning, providing direction and advice to the Project Team, monitoring and reporting to the ESC on project progress and making decisions consistent with their level of delegation.

The IMT monitors overall program and project requirements within budget, time and scope as well as the implementation of the strategies and project plans.

During the Planning Phase the Chair of the IMT will rotate between Infrastructure and the WCHN, reflecting the equal roles of each organisation for the definition of requirements and co-development of the design.

During implementation, the Chair of the IMT will be the Executive Director of Infrastructure, reflecting the primacy of Infrastructure in the delivery of the hospital.

Planning and Development of Final Business Case	Role of IMT
Services Procurement Plan	Approve
Project Implementation Plan	Approve
Risk Management Plan	Approve
Financial Impact Statement	Approve
Economic Appraisal	Approve
Communications and Consultation Strategy	Approve
Operational Commissioning Strategy	Approve
Options Development	Approve
Workforce Development Strategy	Approve
Functional Design Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Endorse for ESC to consider
Final Business Case	Endorse for ESC to consider

Design Development	Role of IMT
Project Implementation Plan	Approve
Risk Management Plan	Approve
Variations to AusHFG	Endorse for ESC to consider
Procurement Strategy	Endorse for ESC to Consider
Financial Impact Statement	Approve
Economic Appraisal	Approve
Communications and Consultation Plan	Approve
Operational readiness plan	Approve
Workforce Development Plan	Approve
Systems and Equipment including FFE, MME and ICT Strategy	Approve
Facilities Management Strategy	Approve

Project Implementation	Role of IMT
Project Implementation Plan	Approve
Procurement Strategy	Endorse for ESC to consider
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Endorse for ESC to consider
Major variations to approved Project Scope	Endorse for ESC to consider
Variations to AusHFG	Endorse for ESC to consider
Tender Evaluation and engagement of preferred tenderer and Award Contract	Endorse for ESC to consider
Post Tender Review Report to Department of Treasury and Finance	Approve
Finalise Design	Endorse for ESC to consider
Implementation of Communications and Consultation Plan	Approve
Implementation of Operational Commissioning Plan	Approve
Implementation of Workforce Development Strategy	Approve
Systems and Equipment including FFE, MME and ICT Strategy	Approve
Facilities Management Strategy	Approve
Construction Management Plan	Approve
Building Commissioning and Project Completion Plan	Approve
Certify Construction Complete	Endorse for ESC to consider
Handover Facility	Endorse for ESC to consider
Finalise Operational Commissioning – Move Logistics and Decant Plan	Endorse for ESC to consider

All Phases	Role of IMT
Schedule	Monitor, endorse changes for ESC to consider
Cost/Budget	Monitor, endorse changes for ESC to consider
Gateway Reviews	Endorse for ESC to consider
Resource Procurement	Endorse for ESC to consider
Contract Management of Construction	Monitor and resolve escalated issues

Standard Membership	IMT
Executive Director Infrastructure	Chair (Member)
Chief Executive WCH	Co-chair during planning (Member)
Executive Director, Corporate Services, WCHN	Member
Chief Operating Officer, WCHN	Invited
Director, Engagement and Commissioning, WCHN	Member
DPTI Representative	Member
Infrastructure new WCH Project Director	Member

Independent Project Planning and Delivery Advisor	Member
Infrastructure Consultant Project Manager	Invited
Architect (Consultant)	Invited
Cost Manager (Consultant)	Invited
Manager, Capital Works Communications	Invited

Quorum

Chair and 50% of members.

Frequency

Monthly or as determined based on project need.

Support

The Infrastructure Project Secretariat will record and circulate minutes, action items and maintain a decision register.

4.3. Terms of Reference - Project Team

The Project Team is responsible for the day to day management of the project from the outline business case through to handover to the WCHN. The Project Team prepares the option analysis, design, implementation plan, business cases and reports for consideration by the IMT. It includes WCHN Capital Project team members, Director of Engagement and Commissioning, DHW Infrastructure Project team members, Infrastructure's new WCH Project Director , Department of Planning, Transport and Infrastructure team members, the consultant Project Manager, the design team and the contractors (as required).

Membership will be determined by the expertise required to meet the terms of reference and deliverables of project Team.

During the project planning phase, the Project Team is responsible for operational planning and design to facilitate the achievement of project objectives as defined in the Outline Business Case. The role of the PT includes engaging with Project Working Groups (PWGs), Advisory Groups (AG), Project User Groups (PUGs), and managing and/or implementing key operational and clinical strategies which support the design development and planning including risk management, building commissioning (including non-clinical support services, systems and equipment). The Project Team will support the WCHN during the development of the Operational Commissioning Strategy and Plan (including operational policies and models of care) and the Communication Strategy.

During the implementation phase, the Project Team manages the construction and commissioning of the works and reports to the IMT. The Project Team also supports the WCHN on the implementation of Operational Commissioning, communication and finalisation of operational commissioning (Move Logistics and Decant Plan).

Planning and Development of Final Business Case	Role of Project Team
Services Procurement Plan	Prepare and implement
Project Implementation Plan	Prepare and manage
Risk Management Plan	Prepare and manage
Financial Impact Statement	Support development and endorse
Economic Appraisal	Prepare

Planning and Development of Final Business Case	Role of Project Team
Communications and Consultation Strategy	Support development and endorse
Operational Commissioning Strategy	Support development and endorse
Options Development	Prepare
Workforce Development Strategy	Informed
Functional Design Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Prepare and update
Final Business Case	Prepare

Design development	Role of Project Team
Project Implementation Plan	Update and manage
Risk Management Plan	Prepare and manage
Variations to AusHFG	Regularly review and support preparation by WHCN
Procurement Strategy	Prepare report and implement
Financial Impact Statement	Support development and endorse
Economic Appraisal	Prepare report
Communications and Consultation Plan	Endorse
Operational readiness plan	Support development and endorse
Workforce Development Plan	Informed
Systems and Equipment including FFE, MME and ICT Strategy	Prepare report
Facilities Management Strategy	Support and endorse

Project Implementation	Role of Project Team
Project Implementation Plan	Update and manage
Procurement Strategy Report and Method	Prepare and implement
Developed Design Documentation including Room Data Sheets – consistent with intent of Schematic Design	Prepare (Designers) and review (Project Manager)
Tender Documentation	Prepare and approve
Request for Tender	Manage and report
Variations to approved Project Scope	Prepare recommendations and implement decisions
Variations to AusHFG	Prepare recommendations
Tender Evaluation and engagement of preferred tenderer and Award Contract	Manage and prepare report
Post Tender Review Report to Department of Treasury and Finance	Prepare

Other Specialist Consultants	Member
Contractor's Representative (Implementation Phase)	Member
Manager, Capital Works Communications	Invited

Quorum

Chair and 50% of members.

Frequency

Weekly or as determined based on project need.

Support

The Infrastructure Project Secretariat will record and circulate minutes, action items and maintain a decision register.

4.4. Terms of Reference - Project Working Group(s) (PWGs)

PWGs report to the Project Team or WCHN (dependent on the deliverable). They have responsibility for providing the Project Team or WCHN with expert advice on the development of project strategies and plans. These include communication and consultation, Operational Commissioning, overarching operational policy development, capital and recurrent cost estimates and economic appraisals.

The type and number of PWGs will be developed in accordance to the needs of the project and to address issues that are complex and require resolution or require co-ordination across clinical or functional areas within the facility or WCHN.

Membership will be determined by the expertise required to meet the terms of reference and deliverables of the PWGs.

Typical Working Groups may include:

- FFE Scheduling & Procurement
- Communications and Consultation
- Strategic Service Delivery Work Groups
- Operational Commissioning
- ICT
- Workforce
- Cost Control Group
- Commissioning and Operational Planning
- Systems and Equipment – Major Medical
- Move Logistics and Decant

Quorum

Chair and 50% of members.

Frequency

As determined based on User Consultation Schedule.

Support

The WCHN representatives will provide secretariat support and will record and circulate minutes.

Project Implementation	Role of Project Team
Finalise Design if D&C or DD&C	Prepare (Designers) and review (Project Manager)
Communications and Consultation Strategy	Informed
Operational Commissioning Strategy	Informed (support where specified in operational readiness plan)
Workforce Development Strategy	Informed
Systems and Equipment including FFE, MME and ICT Strategy	Implement
Facilities Management Strategy	Informed
Construction Management Plan	Prepare (Contractor), endorse (Project Manager) and implement
Building Commissioning and Project Completion Plan	Prepare (Contractor), endorse (Project Manager) and implement
Certify Construction Complete	Prepare (designers) and endorse (Project Director and Project Manager)
Handover Facility	Support
Finalise Operational Commissioning – Move Logistics and Decant Plan	Support

All Stages	Role of Project Team
Schedule	Prepare, manage and report
Cost/Budget	Prepare, manage and report
Gateway Reviews	Prepare reports, manage process and implement outcomes
Resource Procurement	Support
Contract Management of Construction	Manage and report

Standard Membership	Role
Infrastructure new WCH Project Director	Chair (Member)
Project Manager	Member
DPTI Representative	Member
Director, Engagement and Commissioning, WCHN	Member
Manager, Major Capital Projects	Member
Clinical Lead, Major Capital Projects	Member
Other Project Team members	Member
Clinical Planner (Consultant)	Member
Architect (Consultant)	Member
Engineer(s) (Consultant)	Member
Cost Planner (Consultant)	Member

4.5. Terms of Reference - Executive Advisory Group (EAG)

The EAG is responsible for overseeing the Advisory Groups, and relevant Work Group process. This includes receiving reports, endorsing recommendations, and resolving issues escalated by these groups. The EAG ensures alignment of design briefs with Clinical Services Plan (CSP), Statewide policies, WCHN and Facility operational policies and other project parameters. The EAG is also responsible for endorsing design briefs and design documents prior to submission to the PT or IMT for endorsement. The EAG is responsible for endorsement of project workforce, ICT and operational plans, and costings.

The EAG supports the preparation of all deliverables and is required to endorse the business cases and design documentation.

Standard Membership	Role of EAG
Chief Executive WCHN or representative	Chair (Member)
WCHN Executive members/ representatives including:	
Chief Operating Officer	Member
Executive Director, Corporate Services	Member
Executive Director, Medical Services	Member
Executive Director, Nursing & Midwifery	Member
Executive Director, People & Culture	Member
Executive Lead Allied Health	Member
Chief Finance Officer	Member
Divisional Directors	Member
Non-clinical personnel / operational Directors	Invited
Project members, including:	
Director Engagement & Commissioning	Member
Clinical Lead, Capital Works	Member
Manager, Capital Works	Member
Manager, Communications Major Capital Works	Invited
Infrastructure Project Director	Invited
Consultants (as required)	Invited

Quorum

Chair and 50% of members

Frequency

Monthly, or as determined based on project need

Support

The WCHN Capital Works Secretariat will record and circulate minutes.

4.6. Terms of Reference - WCHN Advisory Groups (AG)

An AG is chaired by the WCHN Executive or Senior Leader and convened as required to provide expert advice on clinical and service delivery matters to the EAG or PT. This group is responsible for the

strategic operational planning and resolution of issues escalated from PUGs and ensuring consistency across the PUGs relevant to their specific Terms of Reference.

Membership will be determined by the expertise required to meet the terms of reference and deliverables of the AG. At minimum the AG will have a consumer representative, WCHN Executive member, and be multidisciplinary.

4.7. Terms of Reference Project User Group(s) (PUGs)

PUGs report to the AGs as required and refer matters for resolution to the EAG. PUGs are responsible for developing the inputs for the Strategic Service Delivery, and Functional Design Briefs for health planning units (HPUs). A key requirement is to ensure these briefs are aligned with the endorsed CSP, local, area and state-wide operational policies and other Project parameters.

The PUGs generate and provide clinical and operational planning input, provide feedback on health service delivery matters and non-clinical factors as they impact the design and operational implementation. The PUGs consider and moderate the interests of the broader workforce and work collaboratively to ensure that the facility user requirements both in the short and long term are accurately reflected in the project brief and design documentation.

The PUGs support the preparation of all deliverables and are required to endorse the business cases and design documentation.

Membership will be determined by the expertise required to meet the terms of reference and deliverables of the PUG. At minimum the PUG will have a consumer representative, Clinical or Corporate lead (dependent on the TOR), and be multidisciplinary.

Quorum

Chair and 50% of members

Frequency

As determined based User Consultation Schedule

Support

WCHN Major Capital Works Team will record and circulate minutes for PUGs that support WCHN Work Groups.

Clinical Services Planner (Consultant) will record and circulate minutes (Functional Design Brief).
Architect secretariat will record and circulate minutes (design).

4.8. Primary responsibilities for deliverables and activities

The following tables sets out the entities primarily responsible for producing each of the deliverables, and the organisations responsible from which endorsement or approval is required.

The role of each group with respect to each deliverable is set out in the terms of reference for each group below.

Final Business Case Deliverables	Responsible Entity
Services Procurement Plan	Approve
Project Implementation Plan	Project Team
Risk Management Plan	Project Team
Financial Impact Statement	WCHN

Final Business Case Deliverables	Responsible Entity
Economic Appraisal Report	Project Team
Communications and Engagement Plan	WCHN
Operational Commissioning Strategy	WCHN
Workforce Development Strategy	WCHN
Functional Design Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Project Team
Final Business Case	Project Team

Design Development Deliverables	Responsible Entity
Proposals for variations to AusHFG	WCHN
Proposals for variations to the project scope	Project Team
Procurement Strategy	Project Team
Financial Impact Statement	WCHN
Economic Appraisal	Project Team
Communications and Engagement Plan	WCHN
Operational readiness plan	WCHN
Workforce Development Plan	WCHN
Systems and Equipment including FFE, MME and ICT Strategy	Project Team
Facilities Management Strategy	WCHN
Design Reports	Design Consultants

Project Implementation Deliverables	Responsible Entity
Tender Documentation	Project Team
Post Tender Review Report	Project Team
Final Design Report	Design Consultant or Managing Contractor
Operational Commissioning and Facilities Management Plan	WCHN
Construction Management Plan	Design Consultant or Managing Contractor
Building Commissioning and Project Completion Plan	Design Consultant or Managing Contractor
Completion certificate	Project Team
Facility handover certificate	Project Team

The group responsible for the implementation of each activity is set out in the table below.

Activity	Responsible Entity
Request for Tender	Project Team
Finalise design	Design Consultant or Managing Contractor
Schedule management	Project Team
Cost/Budget management	Project Team
Progression of Gateway Reviews	Project Team
Resource procurement	WCHN
Contract administration of construction	Project Team
Implementation of Communications and Engagement Plan	WCHN
Implementation of Operational readiness plan	WCHN
Implementation of Workforce Development Plan	WCHN
Final selection of systems and equipment including FFE, MME and ICT Strategy	Project Team
Implementation of Operational Commissioning and Facilities Management Plan	WCHN
Implementation of Construction Management Plan	Design Consultant or Managing Contractor
Implementation of Building Commissioning and Project Completion Plan	Design Consultant or Managing Contractor
Testing and certification	Project Team
Handover facility	Project Team
Finalise operational commissioning – Move Logistics and Decant Plan	WCHN

4.9. Declaration of Conflict of Interest

All Project Committee, Team and Working Group members are obligated to formally declare an actual or potential conflict of interest that may arise through the normal course of their involvement in the Project. Should any member think that they may have an actual or potential conflict of interest, they must discuss it with the Chair of their Project Committee, Team or Working Group to confirm whether it fits the criteria of an actual or potential conflict. Conflict of Interest Registers must be established and maintained by the Project to record and assist in proper management of actual and potential conflicts of interest.

Should a conflict of interest exist, the Chair of the Project Committee, Team or Working Group should apply one of the following strategies to ensure the integrity of official functions of the Project:

- Restrictions are placed on the member's involvement in the matter.
- A disinterested third party is appointed to oversee part or all of the processes that deals with the matter.
- The committee, team or working group member does not participate in the matter.
- The private interest concerned is relinquished.

All information regarding the conflicts of interest can be found in SA Health Policy Directive PUBLIC-I1-A1, Conflict of Interest – Declaration and Management Policy Directive July 2016.

5. Limits of authority

5.1. Introduction

The purpose of a limits-of-authority policy is to define and document the policies and procedures that restrict the approval of transactions (by financial value, decision type and/or contract duration) to specific individuals to ensure consistent good business practices and governance. These procedures identify who is delegated to approve specified financial transaction amounts, as well as who can be assigned temporary authority in the event a manager is unavailable.

5.2. Application

This policy applies to all staff involved in the tender and procurement process as well as those members of the ESC, IMT or Project Team that have been delegated any aspect of financial oversight or decision making capability for the development and delivery of the project.

Where decision making capability is delegated to a group, the delegation vests in the chair or most senior member of that group, except where the terms of reference require decisions to be made by a vote of the members.

5.3. Policy

The limits of authority are determined based upon the staff member's position and may be revoked at any time by the ESC.

The Schedule of Delegations, set out below, represents the written delegation of authority by the ESC. This schedule will be confirmed annually by the ESC and filed with Department for Health and Wellbeing Finance Group. The Schedule of Delegations may be amended at any time by the ESC.

The Department for Health and Wellbeing Finance Group will maintain an up-to-date Schedule of Limits Authority, with a list of the approved delegates, for the purpose of verification of expenditure authority.

This Limits of Authority Policy also applies to transactions that do not involve a monetary amount, but nonetheless legally commit the Department for Health and Wellbeing or incur liabilities for the Department. For example, approval of a variation of scope which is likely to have a functional impact.

5.4. Authority

Authorities may be delegated to other staff members if this delegation is formally recorded and authorised by the ESC. However, signing authority for contracts is reserved only for those staff identified in the Schedule of Delegations set out below. The general requirements regarding signing authority are:

- A delegation of authority, whether it is contract signing authority or other financial or spending authority, may not be made unless it is detailed in the Schedule of Delegations Authority set out below.
- All delegations relate to the delegate's position, not to the individual in that position.
- A delegation of authority under this policy may be wholly or partially withdrawn or restricted (either permanently or temporarily) at any time by the ESC.
- No delegations may be made to non-staff members.
- A delegate's manager may exercise the same level of authority as the delegate (that is to say, levels of authority are hierarchical through relevant lines of responsibility).

Notwithstanding these delegations, delegates should keep their managers informed of significant initiatives and projects, even if the cost of those initiatives and projects are below the delegated amount.

5.5. Schedule of Delegations

The following set out the key delegations for each of the major phases of the project –functional design brief, business case, detailed design and construction. These reflect the sorts of decisions to be made in each phase and the materiality of those decisions to the project. As a general principle, deviation from designs approved in previous stages will require approval by the ESC, whilst refinement of design within these parameters can be approved by the IMT.

Pre-Business Case

Prior to the approval of the final business case, the budget is yet to be finalised, so the delegation of approval allows some flexibility within the project parameters approved in previous phases.

Decision to be considered	ESC	IMT	Project Team
Design changes which are not compliant with requirements[1]	Approve	Endorse	Prepare
Design changes which impact on RAH[2]	Approve	Endorse	Prepare
Any schedule, staging or design options which will extend the predicted operational date for the hospital	Approve	Endorse	Prepare
Any schedule, staging or design options which will impact on the schedule but not the operational date for the hospital	Inform	Approve	Prepare
Shortlisting of planning or design options to be presented	-	Inform	Approve
Design changes valued **<$100,000 (A monthly cap** is to be considered)	Inform	Approve	Prepare
Design changes valued **>$100,000**	Approve	Endorse	Prepare
Release of design contingency	Approve	Endorse	Prepare
Approval of options which will increase the hospital workforce requirements	Approve	Endorse	Prepare
Approval of system selection with high operating costs[3]	Inform	Approve	Prepare
Approval or modification of project strategies[4]	Approve	Endorse	Prepare

[1] Requirements include the project vision, project objectives, AusHFG, other statutory requirements, clinical services plan, functional design brief, previously approved design reports

[2] Impact on RAH includes proposals for shared services, proposal which will require a modification to the operator's contract or proposals which will require physical modifications to the hospital building or infrastructure

[3] Approval is required for the specification and selection of systems including HVAC, fire, security, BMS, nurse call, communications

[4] Project strategies include all documents setting out the high level approach to project delivery, including, but not limited, the procurement strategy, workforce strategy, handover and operational commissioning strategy, communication strategy and industrial relations strategy

Decision to be considered	ESC	IMT	Project Team
Approval or modification of project plans[5]	Inform	Approve	Prepare
Approval of the design reports	Approve	Endorse	Prepare
Approval of the business case	Approve	Endorse	Prepare

Contractor Procurement

Decision to be considered	ESC	IMT	Project Team
Approval of procurement strategy	Approve	Endorse	Prepare
Approval of contractor EOI documents	-	Inform	Approve
Shortlisting of contractors	Inform	Approve	Prepare
Approval of contractor RFT documents	-	Inform	Approve
Approval of negotiation plan	Inform	Approve	Prepare
Approval to enter into contract with preferred contractor	Endorse for Cabinet Approval	Endorse	Prepare

Design Finalisation

The project scope and budget is finalised with the approval of the business case. Therefore, the ability of the Project Team to make fundamental changes to the design or to increase scope is limited and will require ESC approval.

Decision to be considered	ESC	IMT	Project Team
Design changes which are not compliant with requirements	Approve	Endorse	Prepare
Design changes which impact on RAH	Approve	Endorse	Prepare
Schedule, staging or design options which will extend the predicted operational date for the hospital	Approve	Endorse	Prepare
Schedule, staging or design options which will not impact on the operational date for the hospital	Inform	Approve	Prepare
Shortlisting of planning or design options to be presented		Inform	Approve
Design changes valued **<$100,000** (A **monthly cap** is to be considered)	Inform	Approve	Prepare
Design changes valued **>$100,000**	Approve	Endorse	Prepare

[5] Project plans includes all documents setting out the detailed approach to project delivery, including, but not limited to, detailed implementation plans for the project strategies, project management plan, scheduling and staging plan, risk management plan, issue management plan, interface management plan, information management plan and subordinate specifications for project systems, reporting framework, contract administration plan, decanting plan and WCH operational plans.

Decision to be considered	ESC	IMT	Project Team
Release of design contingency	Approve	Endorse	Prepare
Approval of options which will increase the hospital workforce requirements	Approve	Endorse	Prepare
Approval of system selection with high operating costs	Inform	Approve	Prepare
Approval or modification of project strategies	Approve	Endorse	Prepare
Approval or modification of project plans	Inform	Approve	Prepare
Approval of the design report	Approve	Endorse	Prepare

Construction

The delegation of approvals in the construction phase focusses on the administration of the construction contracts, within the approved budget, with no further design changes expected except to resolve site issues. The ESC and IMT approve the Senior Responsible Officer, with the appropriate delegation, to action variations and EOTS within the approved cost plan and program.

Change to be approved	ESC	IMT	Project Team
Approval of, or modification to, the subcontractor packaging plan	Inform	Approve	Prepare
Approval of subcontracts up to $200,000	-	Approve	Prepare
Approval of subcontracts greater than $200,000 up to $2M	Inform	Approve	Prepare
Approval of subcontracts greater than $2M	Approve	Endorse	Prepare
Approval of EOTs which will extend the operational date for the hospital	Approve	Endorse	Prepare
Approval of EOTs which will not extend the operational date for the hospital	Inform	Approve	Prepare
Variations **< $100,000 (A monthly cap** is to be considered)	Inform	Approve	Prepare
Variations **> $100,000**	Approve	Endorse	Prepare
Release of construction contingency	Inform	Approve	Prepare
Acceptance of practical completion	Approve	Endorse	Prepare

5.6. Transactions

A delegate identified under this policy has the designated authority to take an action or sign a document necessary to give effect to a transaction. Any such action or signature must comply with necessary legal and financial approvals related to the specific transaction, such as the contract approval process for contracts.

Any delegation to incur expenditure must be exercised within the limits of the relevant approved budget.

A delegate can only exercise authority with respect to the total transaction value, which includes related and integrated transactions.

If there is any increase in the cost of a transaction, then:

- the delegate who approved the original transaction must approve that variation; or
- if the sum of the variation and the original cost of the transaction exceed the delegate's limit of authority for that type of transaction, a delegate with the appropriate level of authority must approve that variation.

All contracts must be processed in accordance with the contract approval process.

5.7. Compliance and Breaches

The Department for Health and Wellbeing may commence applicable disciplinary procedures if a person to whom this policy applies breaches this policy.

C

Project Controls

6. Project reporting

6.1. Overview

Effective reporting is central to the governance of complex construction projects such as the new WCH. Progress and performance status awareness is critically important to achieving objectives and realising benefits – enabling the Executive Steering Committee to evaluate issues, proactively address shortfalls, and confidently communicate the project status to the Minister for Health and Wellbeing.

High quality, relevant, credible, insightful and timely reports instil confidence in key stakeholders and create the clear message that the Project Team has a strong understanding of performance status and is in control of progress.

An effective reporting framework ensures that the right information is provided to the right people at the right time, contributes to managing customer expectations, is responsive to customer needs, and captures all elements of the project objectives. In complex projects such as the new WCH, an effective reporting framework is crucial to maintaining situational awareness around the risks, issues and opportunities across the project. It also includes insight and analysis so that the information has meaning and answers the questions that the Executive need answered.

Developing a more effective reporting framework, backed by data management and analysis, and tailored to the needs of key stakeholders, will enhance the reputation of DHW Infrastructure, facilitate proactive decision making and drive improved performance and financial outcomes.

6.2. Key principles

The following principles should be applied to project reporting:

Principle 1: Fully align the reporting framework with the project objectives and operational planning

The ultimate purpose of a performance measurement framework is to focus key stakeholders on making decisions which improve the performance of the project. As the performance of the project will ultimately be measured in terms of the project objectives and the operational efficacy of the hospital, the project report and the metrics that are measured should be grounded in these areas.

Principle 2: Simplicity of design

The reporting framework must provide key stakeholders with the information and insights that they need to make effective decisions which improve the performance and outcomes of the delivery of services under the contracts.

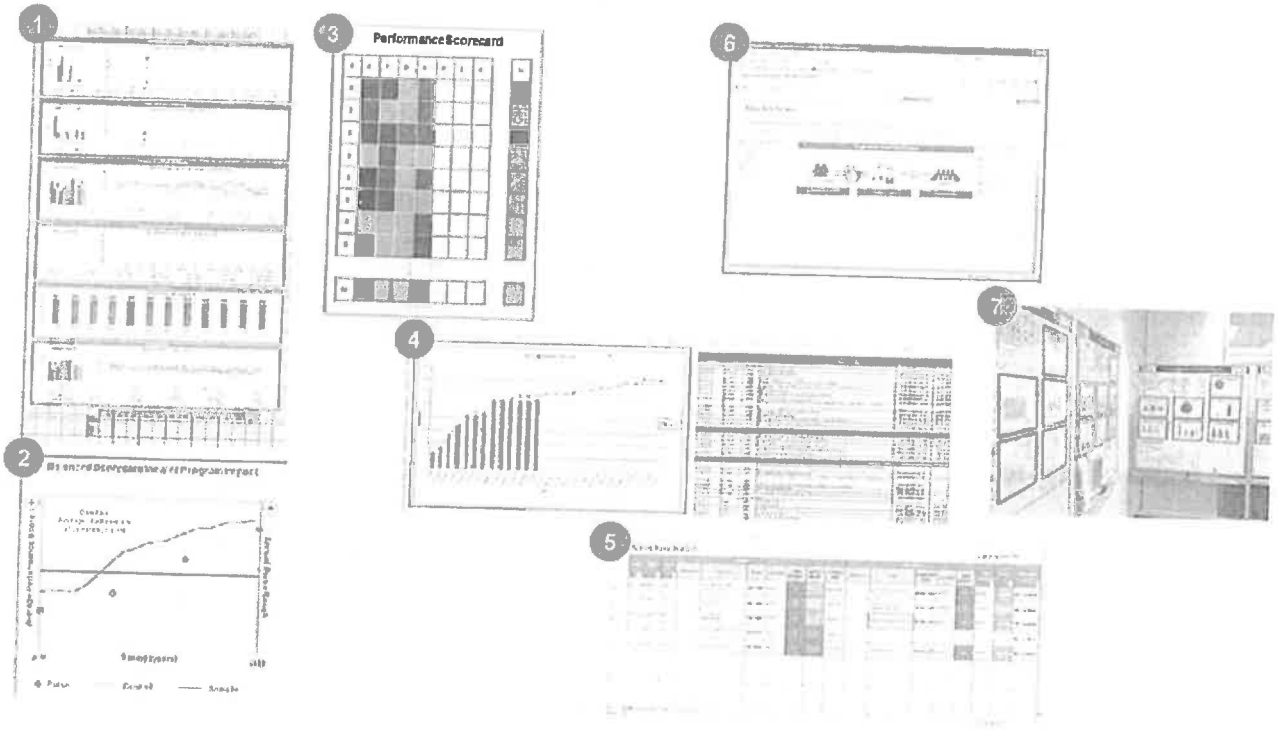
Effective reports don't simply provide information because it's available, leaving it to stakeholders to derive relevance or meaning – they demonstrate understanding and management of project performance, raise awareness of risks and issues and present options or actions that can be implemented in a timely manner. They are succinct and well-structured so that the required information is easy to find, free of jargon and simple to understand and supported by visual representation of data rather than pages of text.

The table overleaf summarises the key design objectives for the reporting framework.

Aspect of Report	Standard Reporting	Objective
Length	Very long (50+ pages) with many sections, superfluous information and excessive writing. Historical data is retained regardless of whether it is still relevant or meaningful.	Concise, to the point, targeted, with few sections.
Terminology	Esoteric terms, extensive use of acronyms, high level of assumed knowledge.	Straightforward and jargon-free. Use simple language to tell the story.
Relevance	Largely ignored as no-one has the time to read it in full. Aggregates all of the data rather than focusing on what is relevant.	As the information is targeted and concise, used extensively to guide discussion.
Scope	Narrow. Whatever is easiest to report.	Well bound and defined, with further detail where required, demonstrating layered understanding.
Data	Simplistic, averages, no history or forecasting. Many manual adjustments.	Rich, meaningful data from an authoritative source. Supported by analytics.
Efficiency	Slow and time consuming to produce, requiring multiple iterations and checks.	Right first time, with automatic population of sections and targeted analysis.
Formatting	Poorly and inconsistently formatted, making it difficult to write and read.	Content is planned and consistent from month to month so that the required information is always in the same place. Tables, graphs and graphics are integrated throughout.

The diagram overleaf shows some artefacts that could be used as part of a comprehensive reporting framework. Note that the focus is on presentation of data with supporting narrative, rather than on a lengthy narrative with limited data.

Sample reporting tools



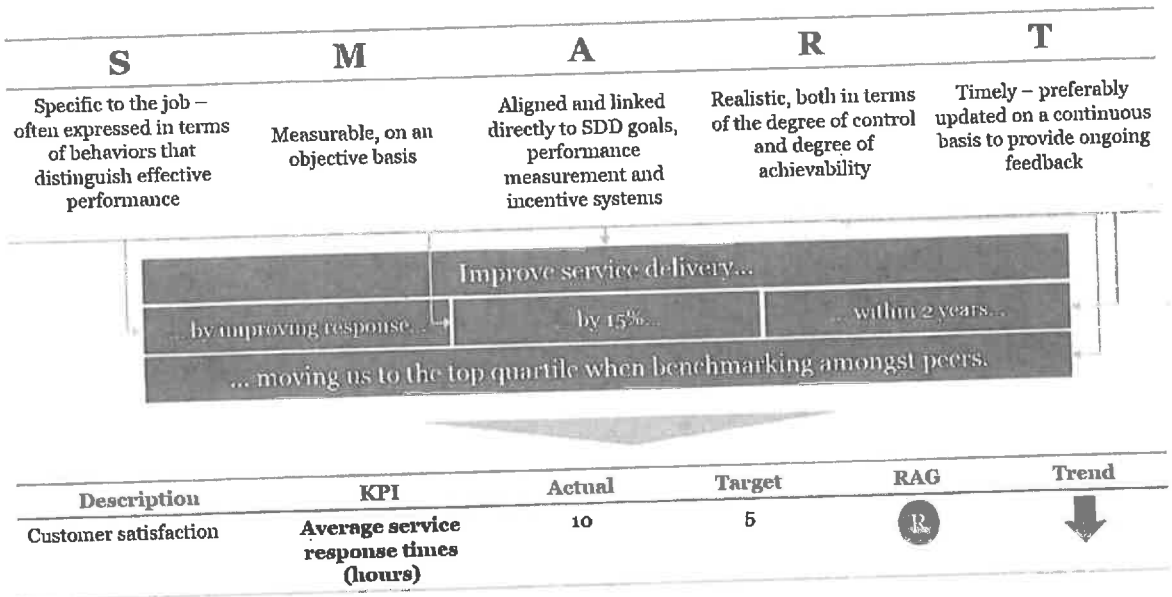
Legend:

1 – Benefits Tracker
2 – Key Performance Metric Tracker
3 –Performance Scorecard
4 – Integrated Milestone Tracker
5 – Action Item Tracker
6 – Reporting Portal (SharePoint)
7 – Visual Management boards

Principle 3: Apply the Principles of 'Good Metrics'

Strategic objectives should be cascaded throughout the project, including to the contractor and subcontractor KPIs, ensuring the Project Team is aligned and working towards common goals and outcomes. Whilst granularity of data increases the further down you go, the overall content, structure and design remain the same.

For metrics to be meaningful and offer performance review and decision support they need to be specific to the business decision, measurable to be able to compare, aligned to a target, realistic to ensure it can be achieved and timely so is can be monitored within a specific timeframe. The below diagram illustrates the approach to the nature of the hypotheses development and resulting KPIs and measures.



Effective contract performance measurement information is focused on prioritised metrics that are varied and balanced across a number of dimensions (e.g. Past vs. Future, Leading vs. Lagging, External vs. Internal, Quantitative vs. Qualitative etc.).

Many of the KPIs used in the project management context are quantitative and lagging (e.g. schedule status, current cost plan status, number of defects). In this context, they provide insight into issues which were caused by prior actions or omissions. Developing predictive KPIs which make use of qualitative assessments provides insight into the actions the executive can take to mitigate risks and ensure strategic outcomes are achieved.

Principle 4: Minimise Production Effort

Time spent preparing and collating reports uses resources and time that could be dedicated to important tasks such as issue resolution or stakeholder engagement. The design of the reporting framework should therefore give due consideration to minimising the resource burden across the Project Team. Specifically, the reporting framework should seek to:

- minimise additional data collection effort to only those areas which are critical to performance
- minimise the content and analysis required to be consolidated within the final outputs, to the key areas required by stakeholders for decisions
- fully articulate the process through which outputs are produced so it is well understood and efficient
- automate data collection, analysis, and report production, to the greatest extent possible.

The result for the new WCH will be a reporting framework which enhances project performance, but does not create an impost on staff causing them to resist its implementation.

6.3. Minimum Requirements

Project reports for all project work streams are required to be summarised within the IMT Report for issue to the ESC on a monthly basis. Reports should monitor cost, program and quality while providing a check and balance on project delivery and advice on major issues.

It is recommended that a full Performance Measurement Baseline (PMB) is agreed and used as a by the project managers as a basis for reporting.

The validation process for acceptance of the PMB would cover the following:

- Full definition of all scope requirements and objective included in the project;
- A completed program including all activities necessary to deliver the scope;
- Allocation of all activities to a responsible party;
- Costs allocated to activities in the program at an appropriate level of granularity;
- Visibility of all key risks;
- Allocation of mitigation actions to responsible parties; and
- Inclusion of appropriate time and cost contingencies commensurate with unmitigated risk

The PMB should be formally accepted by all key parties – any exceptions being reported and treated as risks.

Once the PMB has been formally accepted it should be used as a means of reporting performance – generally this will be done monthly.

Reporting should include:

- Comparisons of work performed vs. planned – both in terms of work volume and the status and expected completion dates for program milestones;
- Cost performance against plan;
- Any approved changes of scope affecting program or budget;
- Status of cost and time contingency;
- Current status of key risks; and
- Health and Safety and Quality statistics

This information supported by a high level narrative should be sufficient to identify program status and should be validated from time to time to ensure accuracy.

6.4. Executive Steering Committee reports

The ESC will proactively look toward the future to identify Project opportunities. The report presented to the ESC will be in a standard monthly project report format. This report will be a summarised version of the IMT Report and will include the following:

- approvals required from the ESC
- an update of the risk register for the project;
- a project schedule update including reporting against any defined time contingency;
- key financial management aspects of the project including:
  - budget issues, and
  - forecast and actual expenditure.
- an update on key people issues;
- a review of any contract administration matters which require ESC attention; and
- an update of progress against other key project performance indicators (e.g. meeting legislative or licensing requirements)

The ESC Report should be prepared and circulated by the Infrastructure Project Director, endorsed by Co-Chairs IMT and circulated at least three working days before the ESC Meeting. It should provide updated data relevant to the project performance measures being addressed and conclude with any recommended course(s) of action. The ESC report will be submitted to the ESC on a monthly basis.

6.5. Monthly IMT Reports

The Project Team is required to produce a monthly IMT Report. The report will include updates on program and progress, design status, procurement and contracts status/issues, project cost and budget status, client issues and actions, and lay risks and mitigation strategy.

At a minimum the monthly project report should be structured to cover the following and should include consistently photographed areas of the project to demonstrate progress:

- Introduction;
- Executive summary;
- Authorities;
- Work Health and Safety;
- Design;
- Construction;
- Cost v Budget;
- Program;
- Interfaces;
- Risks; and
- Recommendations.

Monthly progress reports from project consultants and contractors should be an annexure to the IMT Report.

6.6. Project Systems

Major complex projects such as the new WCH generate enormous amounts of data. If managed correctly, this data can be analysed to provide a valuable decision support tool that will assist the Project Team, IMT and ESC to better manage the project and deliver a better outcome.

A comprehensive project information system will allow project team members to create, securely store, find, track, analyse and collaborate on data such as schedule, cost plan, quality requirements, risk, issues, project plans, user requirements, project benefits, management of interfaces, stakeholder engagement activities, community relations, design and construction activities, work health and safety, and industrial relations, amongst others.

6.7. Information System Components

A typical project information system would be expected to include the following compatible components (noting that some software packages may serve multiple purposes:

- A business information layer to collate and present data for reporting purposes
- An auditable project communication system for contract notices, RFIs, directions and other project communications

- A document management system for storage and retrieval of business cases, approvals, design reports and other project documentation
- A building information management database for the design
- Scheduling software
- Budget management software
- Payment management software
- Risk management software

The Project Team is to develop the specification for the project information systems and procure the software where appropriate.

6.8. Compliance and audits

All projects should be audited internally by the Project Team to check that the project is complying with the governance process. The project information system must be easily auditable to meet these requirements.

7. Project cost and budget management

7.1. Introduction

The purpose of the project cost management process is to be able to place responsibility on those in charge of any aspect of the project to perform their respective roles and responsibilities within the prescribed limits (e.g. Agreed cost allowances, budgets or contracts). Project cost management may be defined as:

- The process of placing responsibility on the project's designers and implementers to manage the cost of delivering the project
- The collecting of actual cost data in a suitable format
- Comparing that to corresponding budget data
- Taking corrective action as necessary

The cost plan will be prepared a cost planner working as part of the design team.

Cost management, and review of the cost plans included in the business cases, must be undertaken by an independent cost planner reporting to the consultant Project Manager.

The Project Manager has responsibility for managing and reporting cost performace to the Project Director, IMT and ESC.

7.2. Management and approval of the project budget during the Planning Phase

The project budget is approved as part of each business case in accordance with the approval requirements of the Department for Health and Wellbeing.

The cost of delivering the project must be estimated by the cost planner and included in each design report and the business cases.

During the planning phase, the cost planner must also estimate the impact of any changes made as part of the design development as part of each monthly report. This report is to be used by the Project Team to ensure the estimated cost of the project does not exceed the budget approved in the previous business case.

Any design or planning changes must be approved in accordance with the Schedule of Delegation in section 5.

Any change which is likely to increase the estimated cost of delivering the project so that it exceeds the project budget must be approved by the ESC.

7.3. Management of financial transactions

The IMT, with the Department of Treasury and Finance, must develop a policy for the management and approval of financial transactions. The policy must be in accordance with SA Government policy. The policy should include processes and delegations for:

- Monitoring and controlling the assessment and payment of invoices to consultants and contractors
- Payment of authority fees and other ad hoc costs

- A regular internal auditing program for project payments

Approval of financial transactions must be in accordance with Departmental financial delegations.

7.4. Cost reporting

An important part of the new WCH governance is cost reporting and monitoring. The Project Director is responsible for providing monthly progress reports to the ESC that will report on the status of the project financially.

The report will be incorporated into the IMT and ESC reprot. It should be concise and succinct focusing on key indicators such as original budget and anticipated final cost. The monthly progress report is also required to cover both historical and forecast expenditure, proposed changes and committed cost. Typically the cost report will cover the following:

- Description;
- Budget for the item;
- Contract value;
- Contract package reference no;
- Contingency;
- Anticipated variations;
- Approved variations;
- Committed costs; and
- Anticipated final cost

7.5. Whole of life costing

Whole of life costing must be undertaken by an independent Whole of Life Cost Planner reporting to the WCHN.

A report detailed the estimated whole of life cost of the assets and recommending changes to reduce the whole of life cost must be produced as part of each design report and included in the business cases.

The Project Manager must prepare a report responding to each recommendation of the Whole of Life Cost Planner, to be included in the relevant design report or business case.

7.6. Changes to project budget and management of contingencies

Any change to the project budget must be approved by the ESC.

Utilisation of the contingencies must be approved in accordance with the Schedule of Delegations.

8. Schedule management

8.1. Overview

To assess the project effectively requires confidence in the reliability and accuracy of the execution status of the project program.

8.2. Responsibilities

During the planning and design of the project, the Project Manager is responsible for developing, and reporting on, the planning and design schedule and the outline implementation schedule.

During implementation, the contractor is responsible for preparing and updating the construction schedule. The Project Manager is responsible for reviewing and reporting on the schedule.

The IMT is responsible for directing actions to manage schedule delays or risks, acting on recommendations by the Project Team.

8.3. Schedule development

The Project Manager must prepare a schedule for the planning and design of the project immediately after engagement. The schedule for the planning and design of the project must include:

- All design activities
- Stakeholder engagement activities, including workshops
- Approval timeframes
- Site investigations
- Business case requirements

As part of each design report, the Project Manager must prepare a schedule for the implementation of the project which includes:

- any approval required to commence a stage of the project, and the timeframes for acquiring any resource, financial, engineering or other logistic upon which the program for delivering the works specifically relies
- any constraints outside the Project Team's control that may affect the timing of the implementation
- a detailed breakdown of all construction processes for each stage of the project including:
  - all procurement activities
  - any enabling activities
  - approvals
  - site establishment
  - decanting and demolition of facilities to clear the site
  - installation of temporary infrastructure
  - installation or upgrade of site services
- all construction activities broken down by stage and then by subcontractor

- dependencies between activities
- critical path activities
- staging requirements and constraints
- contingency for each activity or stage
- the required date for completion
- the expected date of completion
- all commissioning activities and certifications
- ICT installation
- operational commissioning and user relocation activities
- DLP and financial closure activities

The contractor's program for the implementation phase must meet the above requirements.

8.4. Independent assurance

The schedule must be reviewed by an independent scheduling consultant prior to each design milestone, after engagement of the contractor and on a quarterly basis during implementation. It is important that the schedule is assessed to provide the IMT with a level of independent assurance that:

- The control systems used in the management of the project are appropriate;
- The status of the project is being accurately communicated;
- There is complete visibility of key risks and their current mitigation status; and
- Mitigation plans for key activities are verified as working

8.5. Schedule reporting requirements

The contractor is required to provide monthly schedule updates and progress reports detailing the implementation status of the project. These reports should be included in the ESC Report and presented at the monthly ESC by the PD. The report must include the following:

- detailed description of activities planned for the coming reporting period
- schedule risks, including management strategies and contingency plans
- analysis of critical path activities
- analysis of critical resources and impact on the schedule if the resource is lost
- alternatives for scheduling the construction work
- contingencies allowed for critical activities
- opportunities for fast-tracking the construction
- schedule constraints
- any activity deletions or additions since the previous schedule update
- an assessment of the performance of the construction against the schedule to date, including an assessment of trends with respect to the contingency remaining for each stage over time
- other details as required by the Project Manager in writing

The Project Manager is to review each report and provide commentary on each aspect of the report for consideration by the IMT.

8.6. Work breakdown structure

The schedule structure typically should be set up to clearly break down the delivery of the project at different levels.

Schedule levels are created in the form of a Work Breakdown Structure (WBS) or levels within the schedule which breaks the project scope down to increased levels of granularity to facilitate management focus on individual work elements.

8.7. Program risk escalation

Where a significant adverse condition is identified the ESC will be notified of this through the reporting mechanisms with recommendation and request that actions are taken in response to ensure the project can adequately protect against and adverse risks. Risks are to be escalated in accordance with section13.

9. Work Health and Safety and Environmental Management

9.1. Overview

The Department for Health and Wellbeing recognises it has a responsibility for health, safety and the environment.

The new WCH project will be managed strictly in accordance with the *Work Health and Safety Act* 2012 (South Australia) and Code of Practice on how to manage work health and safety risks (South Australia).

9.2. WHS Responsibilities

The main contractor is responsible for work health and safety on the site. The contractor is to prepare and implement the Work Health and Safety (WHS) plan for the project and report on the WHS performance of the project on a monthly basis.

The Project Manager is responsible for reviewing the Work Health and Safety plan and conducting regular audits of its implementation at a cadence to be agreed with the Project Director. The outcomes of the audit are to be reported to the IMT, Project Director and Contractor.

There is an open and transparent policy for recording all accidents or near misses and these should be included in the IMT report and brought to the attention of the ESC. Executive Director Infrastructure and Unit Manager Building Projects Department of Planning Transport and Infrastructure must be made aware of any serious safety breach or injury within 24 hours and kept abreast of the corrective action or treatment.

9.3. Safety in Design

The architect is responsible for leading the safety in design process. This process is to be conducted in accordance with Model Code of Practice for the Safe Design of Structures[6].

The WCHN is responsible for providing the data and lessons learnt required by the code of practice.

The Project Manager is responsible for overseeing the safety in design process and reporting the outcomes to Project Director and IMT.

9.4. Environmental policy and controls

The Department for Health and Wellbeing is dedicated to the responsible stewardship of the environment and sustainable development.

The project is to be managed strictly in accordance with ISO14001:2016 Environmental Management Systems.

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[6] Available at https://www.safeworkaustralia.gov.au/doc/model-code-practice-safe-design-structures

The architect is responsible for leading the sustainable design and ensuring compliance with the South Australian government's SASP targets.

The Project Team is to include a report on the sustainable design of the buildings in each design report for review and approval by the IMT.

The contractor is responsible for the preparation and implementation of the Construction Environmental Management Plan.

10. Design development

10.1. Design reports

The Project Team must prepare Design Reports at each design milestone which provide user groups with supporting information relating to the design for each Stage.

Each Design Report must meet the following requirements:

- The Design Report must document the design and design process leading up to the relevant Design Milestone
- Design Reports must be capable of being used as a briefing document for User Groups in their own right
- Design Reports must comply, where appropriate, with the AusHFG
- Design Reports must be stand-alone documents. They must contain all relevant design documentation and information without the need to refer or cross reference to other information
- Design Reports must be structured to reflect the requirements of the user groups reviewing the document – information regarding each element, department or stage must be consolidated in separate sections
- Design Reports must be collated in a way that is logical, clear and concise. They must use tabulated data and illustrations where appropriate
- A transmittal advice listing the documents provided as part of or in addition to a Design Report must accompany the submission
- A brief statement outlining any changes introduced to the documents must accompany the Design Report

Each Design Report must address the following:

- Background to the design and design milestone
- Clear definition of the Project objectives and how they will be achieved through the Works
- Location and siting
- A description of the clinical planning process and how it has been incorporated into the design
- Outline each element or stage, including:
  - objectives and requirements
  - how the design meets the objectives and requirements
  - design intent, philosophies, assumptions and methodologies
  - summary of options considered, major design issues, background to the evaluation of options and solutions
  - illustrations of preferred scheme with floor plans, elevations and sections
  - estimate of the cost for the delivery of the element or stage
- Assessment of options of methods and material for construction
- Compatibility of the architectural and urban design (if applicable) with any proposed or existing developments on the site and achievement of the requirements of this Brief

- Details on how the requirements of the contract, functional design brief and clinical services plan are achieved
- Outcomes of risk management and value management workshops and how they have been incorporated into the design documentation
- Physical security design approach (if applicable) to achieving the required level of physical security for the facility
- Description of how the engineering design satisfies the requirements of AusHFG, relevant Australian Standards, Statutory Requirements and the existing site infrastructure conditions and requirements
- How the Works incorporate ESD Principles and WOL Objectives
- Environmental and heritage issues and considerations (including social issues, drainage, clearing and erosion control)
- Summary of WOL cost analysis undertaken
- Design information to support the determination of facilities operating costs, utilities costs, ICT and other hospital operational costs
- Future expansion options considered in the design and relevant engineering services strategies required to achieve these options
- Approach to fire engineering and how the design satisfies relevant Australian Standards and other Statutory Requirements
- Requirements for mechanical systems to meet clinical standards
- Identification of all Statutory Requirements and relevant Australian Standards adopted together with clear indication of the extent and field of application
- The adequacy of technical systems and materials selected for the design with respect to cost effectiveness and fitness for purpose
- Details of Safety in Design (SiD) Workshops with relevant stakeholders, including meeting minutes and demonstration of how the SiD outcomes have been incorporated into the design
- Details of proposed dispensations including completed dispensation applications
- Outcome and evidence of Stakeholder discussions including planning approvals, local fire, utilities, and communications external providers. Identification of any operational procedures required to be implemented by future users as a result of the design
- A record of all User Group comments (if any) on the previous Design Report along with the proposed response
- Description of initiatives/practices to be used to ensure the required construction process does not exceed the capacity and abilities of the local construction industry
- Design verification documentation, demonstrating evidence of independent peer review

10.2. Design approval process

The ESC must have approve the design at each design milestone in accordance with the Terms of Reference.

Design reports are required at five stages:

1. Masterplan and Functional Design Brief
2. Concept Development

3. Schematic Development
4. Detailed Development
5. Final construction documentation

The Project Manager must coordinate review of each design report by the stakeholder groups. Comments are to be consolidated and provided, along with a summary of the Project Manager's own review, to the IMT for endorsement and the ESC for approval.

10.3. Design validation

Each design report is to be reviewed by an independent peer reviewer. The scope of the independent peer review is to be developed by the Project Manager and must be based on a risk assessment of the design. The Independent Peer Reviewer is to produce a report on the design, which will be forwarded to the designers for a response, and if necessary, updates to the design and report.

The Project Manager will consider the comments and responses of the peer review, as well as conducting their own review, and prepare a Design Validation Report for consideration by the IMT.

The IMT will consider the reports and endorse the Design Report for approval by the ESC.

11. Dispute Resolution Framework

11.1 Overview

Issues identified during the development of the Full Business Case, provide an opportunity to inform the document as well as identify project risks early to ensure effective mitigation measures are in place to manage those risks.

Identification of issues can improve the contribution to the Full Business Case when:

- The Project direction and management groups use issue and dispute information to improve and facilitate decision-making.
- The Project direction group are quickly notified of all issues and/or disputes with significant or severe risk and action is taken.
- Policies and practices about issue and dispute management are regularly reviewed with stakeholders to ensure that they are effective.

A coordinated, consistent and effective approach to managing and reporting issues and disputes are essential components of effective risk management and quality control. Identifying and managing issues effectively can also prevent issues and disputes from arising or becoming intractable, and help to ensure that issues are promptly identified and analysed.

To be effective, an Issue and Dispute Resolution Framework should support responsive issue and dispute management including:

- responding promptly and sensitively to issues and disputes including communicating timeframes;
- assessing all issues and disputes to determine appropriate issue and dispute management responses;
- resolving issues and disputes in a timely manner;
- communicating and informing disputants of the progress and/or decision of the issue or dispute even when there is 'no news' or 'no change.'

11.2 Issue or Dispute Management

An issue or dispute can be identified by any member of the project direction, project management and stakeholder group however it is important that communication and reporting of the issue or dispute follows the escalation process as defined in the project direction, project management and stakeholder group ToRs

Once an issue is identified it is logged by the Infrastructure Project Secretariat, by use of an Issue or Dispute Form (IF). The Issue or Dispute Form (IF) details the description and impact of the issue in terms of design, cost and program. Once these details are known, the issue can be forwarded to the Project Team, IMT or the ESC for consideration and a decision. All Issues or Disputes are to be recorded in the Issue and Dispute Resolution Register.

The Issue or Dispute Form (IF) should include the following information:

- Details of the issue or dispute, reasons and by whom;

- Cost impact, existing budget and basis of cost estimate (quote, estimate etc.);
- The effect this issue will have on the current project program;
- Any secondary impacts to be considered; and
- Recommendation

Once completed the Issue or Dispute Form is then reviewed by project stakeholders and presented to the Project Team or IMT.

11.3 Issue or Dispute Escalation Process

The issue management process for effective decision or issue escalation are included in the Terms of Reference for ESC, IMT, the Project Team and stakeholder working, user and advisory groups.

Issue resolution processes commonly adopted by the project team in the development of the Full Business Case include: [7]..

- Risk workshops at project commencement to define and agree:
  - project risk areas
  - methods best suited to mitigating and managing those risks
  - key performance indicators for success across the major project outcomes, including personnel job satisfaction.

- Each member of the project direction and management groups are charged with identifying issues as soon as they become apparent for solution. Project direction and management group members are to work in a cooperative, best-for-project and timely manner without disruption to the development of the Full Business Case.

An escalation process is established to ensure the senior executive members of the Project Direction group become aware of issues in time to take the necessary steps or decisions to minimise unnecessary cost and/or schedule damage and/or to provide advice regarding a sensible resolution of the issue that does not impact adversely on the relationship with the other members of the project team. It is emphasised that success depends principally on cooperative, constructive attitudes of all members of the project team.

11.4 Issue or Dispute Resolution using Independent Third Party Facilitators

The underlying principles of effective issue resolution should be included in all project contracts. They may be reduced to five key points [8]:

- ensure that contracts embody processes to resolve issues at the lowest appropriate level;
- if necessary, issues are escalated for resolution to more senior and if need be, the most senior, executives in each organisation;
- employ every endeavour to resolve issues by negotiation before the involvement of lawyers;
- consider utilising skilled engineers, contractors or negotiators to assist in resolving issues;

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[7] [8].Guide to Leading Practice for Dispute Avoidance and Resolution
Available at http://www.construction-innovation.info/images/pdfs/DAR_Guide.pdf

- if formal dispute resolution is inevitable, select the most appropriate method to achieve an early, economical and non- disruptive project solution.

Contracting parties may wish to include a short clause in a project contract clarifying the issue resolution position for the parties. For greater certainty the parties may wish to include a structured reactive dispute resolution clause to apply as a fall-back position in the event the parties are unable to resolve an issue.

There are two main categories of issue resolution strategies that can be implemented:
- issue resolution managed directly by the project direction group ;
- issue resolution using independent third party facilitators such as Dispute Resolution Boards or Project mediation

Dispute Resolution Boards (DRBs)

The objectives of the DRB concept reflect basic commercial common sense, and include:
- encouraging the parties to articulate issues as they arise;
- promoting discussion and resolution of issues by the parties on the basis of best-for-project and least cost whoever pays while the work is in progress;
- establishing a pre-agreed panel of experts with continuous knowledge of the project and exposure to any issues while the work is in progress to provide a quick and simple method of resolving ongoing issues.

The DRB concepts are flexible, readily adaptable to most project procurement strategies and can be readily used by small, medium and large projects.

Project Mediation

The objective of project mediation is to help support the successful delivery of a project by identifying and addressing problems before they turn into disputes about payment and delay.

Project mediation is designed to promote successful project delivery by identifying potential problems early, and addressing them before they impact on payment, delay the work or otherwise have an adverse effect on the relationships of the parties.
Under the project mediation model, typically two project mediators are appointed for the project – one technical and one legal. The project mediators are not facilitative or transformative mediators, but experts bringing their experience and professional judgment to the project. There are then three distinct elements to project mediation.

The first is a risk workshop, convened by the project mediators, and attended by all interested parties. This will usually be the owners and their representatives, contractors, key subcontractors and may extend to financiers and insurers. The risk workshop is ostensibly for the parties to establish lines of communication and levels of authority, and to discuss risks for the project, and potential areas of conflict going forward. For high risk projects, it is also an opportunity to establish and work through the risk register for the project.

The second element focuses on dispute avoidance, by allowing access to the project mediators during the project. This will involve attendance on site from time to time to discuss progress and to identify potential problems, and direct discussion between mediators and the parties to prevent disputes arising, or to clarify information requirements which need to be addressed before settlement discussions take place. In this role, the project mediators are more alternative and more involved than traditional disputes boards; however this reduced level of formality and more flexible approach to dispute avoidance allows the mediators to bring their respective skills to bear.

The final element of project mediation is to formally mediate any disputes which then arise, before they are referred for final determination, whether in court or in arbitration. Again, the mediators will assist the parties in the context of a voluntary and confidential mediation. The mediators will inevitably provide more guidance to the parties on the relative strengths of their positions than many facilitative or transformative mediators would feel comfortable with. However, it is the mediators' experience and judgment which they bring to the process, rather than a theoretically neutral forum for airing grievances.

11.5 Issue or Dispute Decisions

All issue and dispute decisions must be approved in accordance with the Schedule of Delegations set out in Section 5.

11.6 Tracking Issues or Disputes

All issues or disputes will be collated and documented by the Infrastructure Project Secretariat, in an Issue or Dispute Report. The report will show the status of the issue or dispute:

- Initiation;
- Impact Assessment (time, cost, quality)
- Submitted for consideration
- Decision

The Issue or Dispute Resolution Register will be updated on an ongoing basis and be included in the monthly IMT report.

11.7 Cost Control

Issue or Dispute decisions that have a cost effect on the project will be included in the project cost report.

Issue or Dispute decisions that have a change impact within the project, the impact will be logged on the Change Register

12. Change control

Change Control procedures are required whenever there is deviation on a project from the agreed project scope.

12.1. Change Request Process and Form

Any increase to a project budget must be approved prior to being instructed/implemented using a change request form.

The change process on a project should be clearly outlined and the levels of change, typically by value, should be detailed in the Project Delivery Plan.

12.2. Change control management

A change can be identified by any member of the project team however it is important that a clear process is detailed.

Once a change is identified it is logged by the Cost Planner by use of a Change Request Form (CRF) and the impact of the change in terms of design, cost and program is to be established. Once these details are known the change request can be forwarded to either the IMT or the ESC (subject to the projects limits of authority) for approval.

Contingency sums should not to be used to accommodate scope changes as the contingency amount is to be used for unforeseen expenditure caused by events which could not have been covered at the start of the project.

The change request form should include the following information:

- Details of the change, reasons for change requested and by whom;
- Cost impact, existing budget and basis of cost estimate (quote, estimate etc.);
- The effect will this change have on the current project program;
- Any secondary impacts to be considered; and
- Recommendation
- Once completed the CRF is then reviewed by project stakeholders and presented to the IMT.

Once approved the CRF acts as the internal change authorisation within the project and the impact is logged on the Change Register.

12.3. Change requests

The Project Team will be responsible for raising change requests and obtaining the relevant authorisation.

12.4. Change approvals

All changes must be approved in accordance with the Schedule of Delegations set out in section 5.

12.5. Tracking changes & status

All change items will be collated and documented by the Project Team in a Change Control Report. The report will show the status of the change:

- Initiation
- Impact Assessment (time, cost, quality)
- Submitted for authorisation
- Approved/Rejected

The change register will be updated on an ongoing basis and be included in the monthly IMT report.

12.6. Cost control

Approved change requests that have a cost effect on the project will be included in the project cost report.

The Change Control Report will be updated monthly by the Cost Planner and assisted by the Project Manager is included in the IMT report.

13. Risk management

13.1. Overview

Risk Management is key element of correct planning and the delivery of the project. A risk assessment has been undertaken as part of the Outline Business Case. Risks were initially identified by DHW and further developed by PwC. Risks were also sought from the PwC Health team who are highly experienced in the planning and delivery of major complex health projects across WA, NSW, QLD and VIC. This reinforced the initial WCH risk assessment. The risks identified were documented within a risk register and presented and updated at the workshop. The risk register is intended to be a live document which is reviewed at key stages of the project.

13.2. Risk Process

The risk management process and the framework adopted for WCH is based on the Australian Standard AS/NZS 31000:2018 – *Risk Management Principles and Guidelines*. The process undertaken underpins and supports gateway reviews of Business Cases across various jurisdictions.

Risk workshops should be held prior to major design and construction milestones and no less than quarterly. The purpose of risk workshops is to review and update the risk register, incorporating the perspectives of a wide range of stakeholders to the project. Risk workshops should include a mixture of senior and junior personnel from all of the key organisations responsible for the delivery and operation of the hospital, including, at a minimum:

- Representatives from the EAG
- Representatives of the organisations represented on the IMT
- Representatives of all members of the Project Team
- On-site construction staff, including site managers and representatives of key trades
- Departmental representatives from WCH
- Facility management staff
- RAH interface staff and PPP operator

Risks should also be reviewed in accordance with the schedule below at ESC meetings, IMT meetings, Project Team meetings and site meetings.

For each risk review or workshop, the risk management process for WCH should involve the following steps:

- Identify risk;
- Analyse and establish risk context;
- Evaluate risk; and
- Mitigate the risk.

The risk register must be updated with outcomes of the risk review or workshop within 3 days.

The Project Manager is responsible for managing the implementation of mitigation actions in the register. The Project Manager must hold a risk meeting within the Project Team once a month to review the risk register, ensure risk severity rating are still current and that risk mitigations are being implemented.

13.3. Reporting of risks

Risks with a severity score greater than 20 following mitigation are to be reported immediately to the Chair of the ESC, who will detail ongoing reporting and management requirements.

Risks with a severity score greater than 15 following mitigation action must be reported to the ESC at each ESC meeting.

Risks with a severity score greater than 12 following mitigation must be reported to the IMT at each IMT meeting.

All other risks will be managed by the Project Team in accordance with the risk process above.

13.4. Definition of risks

Before starting any risk management process it is vital that all the participants involved clearly understand how to define a risk and the differences between a risk and an issue.

Risk is defined as the uncertainty of outcome of actions or events. A risk is something that has the potential to occur but has not yet occurred, e.g. there is a risk of the project overrunning on cost due to potential increases in the price of steel.

A statement of a risk should encompass the cause of the impact, and the impact to the objective ("cause and consequence") which may arise. Care should be taken to avoid:

- Confusing potential impacts with risks;
- Stating risks which do not impact on objectives; or
- Defining risks by simply stating the opposite of the objective

Issues are managed separately to risks. An issue is an event that has happened and will definitely have an impact on an element of a project or a program in terms of time, cost or quality.

An issue could have been previously noted on the risk register and been subsequently realised or could have been an unforeseen event, e.g. A project has significantly overrun on cost due to an increase in the price of steel.

13.5. Risk categories

The following risk categories have formed the basis of risk management in the outline business case. Further categories may be added if deemed appropriate and approved by the IMT:

- Business Case
- Cost – Capital
- Cost – Operational
- Design
- Environmental
- Existing Site/Infrastructure
- Leadership & Management
- Political
- Precinct Planning
- Procurement
- Program
- Scope
- Stakeholder Consultation
- Strategic Planning

13.6. Risk analysis

The Risk Criteria Matrix below is designed to help the project team assess the risks that have been raised during the identification process. Each risk is rated on a basis of 'Severity' and 'Likelihood';

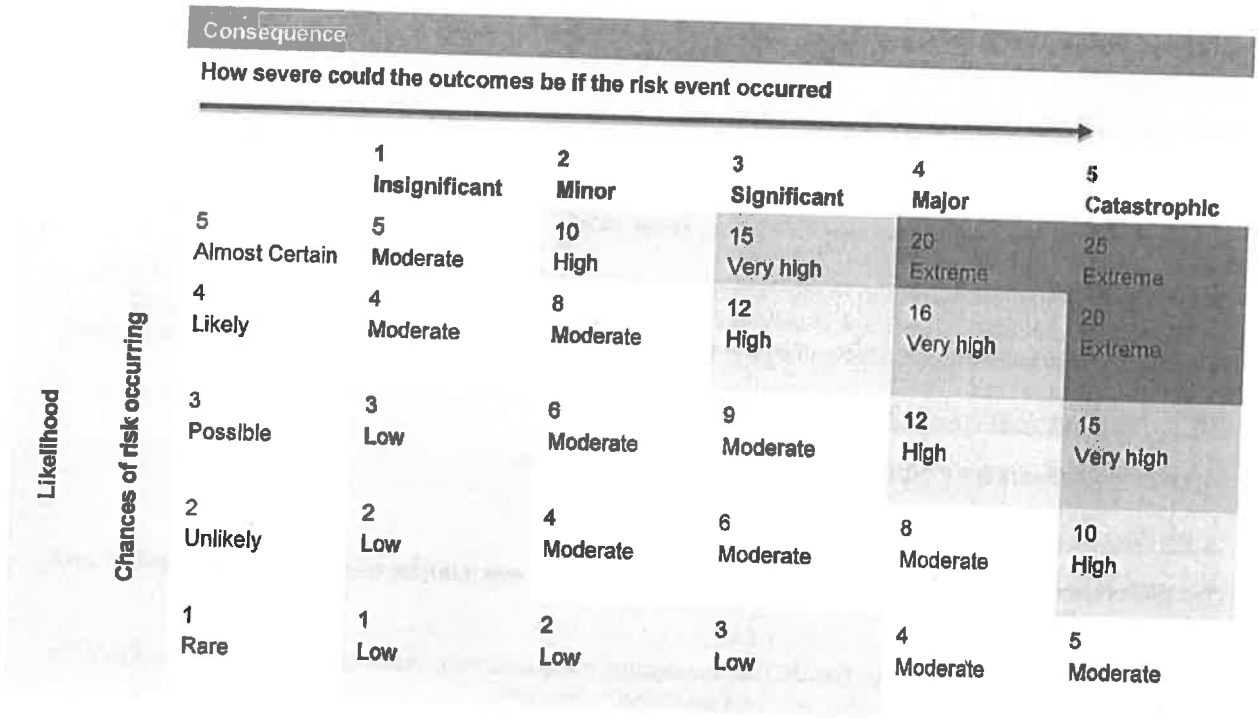
- The severity rating is given across 5 severity types with the highest rating defaulting as the 'severity rating; and
- The severity and likelihood ratings combine to give an 'Overall Risk Rating'.

Once risks have been identified and assessed they need to have mitigation plans agreed and owners assigned. The risk register sets out the key information required for the mitigation plan and ownership of that plan. Once agreed, progress against the action will be tracked using the expected completion dates and Current Risk Rating field.

Rating	Consequence or impact
5 – Catastrophic	Outcomes which will result in failure to meet the project objectives, cause long-term, significant impacts to the WCH, death or permanent disability
4 – Major	Outcomes which have a significant impact on the overall success of the project
3 – Significant	Outcomes which are significant but will not prevent the overall success of the project
2 – Minor	Outcomes which have no permanent impact
1 – Insignificant	Outcomes which are minor in nature

Descriptor	% Probability	Detailed Description
Almost Certain	76 – 100%	Risk has a high likelihood of occurring even if mitigation is implemented
Likely	51 – 75%	Risk has a high likelihood of occurring
Possible	26 – 50%	Risk has a moderate likelihood of occurring
Unlikely	11 – 25%	Risk is considered unlikely to occur
Rare	0 – 10%	Risk will occur in rare circumstances

Risk Criteria Matrix



13.7. Risk scoring and ranking

The risks are to be scored by multiplying likelihood with impact and ranked accordingly.

Risk Score Likelihood*Impact	Risk Ranking
>20	Extreme
≥ 15 & ≤ 19	Very High
≥ 10 & ≤ 14	High
≥ 4 & ≤ 9	Moderate
≤ 3	Low

The current project risk matrix is included in the Outline Business Case risk report.

14. Operational readiness

14.1. Overview

The operational readiness plan is the key document governing the handover and operational commissioning of the hospital. It should enable the WCHN and hospital executive to understand the context in which the operational commissioning takes place.

The process of commissioning an acute services building relates not only to the management of time, costs, supplies, equipment and the quality of buildings, but also to the management of people and services to ensure that the facility is utilised effectively and patient, staff and visitor safety is maintained.

14.2. Operational Commissioning governance

<To be developed prior to approval of the Final Business Case>

14.3. Responsibilities

The WCHN is responsible for preparing the operational readiness plan for endorsement by the IMT and approved by ESC.

The Project Team should assist the WCHN to prepare the operational readiness plan, endorse it prior to approval by the IMT and undertake any role specified in the plan.

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New Women's and Children's Hospital Project

EXECUTIVE STEERING COMMITTEE

TERMS OF REFERENCE

1. BACKGROUND

The South Australian Government (the government) has committed to a range of initiatives to improve how health is delivered in SA. *A Strong Plan for Real Change* (2018) includes a commitment to deliver best practice health services for women and children by building a new Women's and Children's Hospital (new WCH) co-located with the Royal Adelaide Hospital (RAH). The new Women's and Children's Hospital Project ('project') includes the development of the Final Business Case, planning, design, development and the delivery of the new WCH building.

The new WCH Project will be delivered in accordance with SA Government guidelines for the development and delivery of capital projects.

2. PURPOSE

The Executive Steering Committee (ESC) provides strategic direction and leadership on all project activities. All strategic decisions for the project are made by the ESC within the approvals of Cabinet. The ESC comprises of senior executives from those stakeholders responsible for setting the project scope and delivering the project within the agreed scope. The ESC monitors the practical implementation of the project by the Integrated Management Team (IMT).

3. ROLE AND RESPONSIBILITIES

Cabinet is the ultimate decision making authority within the project governance structure and the ESC is the primary decision making authority within the Cabinet approval set. Risks and issues that cannot be resolved and/or are above delegation by the Integrated Management Team (IMT) must be escalated to the ESC.

The ESC is responsible for monitoring achievement of project deliverables (including adherence to project scope) and endorsing project deliverables prior to submission through to the Government.

The ESC is also responsible for providing strategic advice to the project related to:

- Whole of government issues and policies.
- Political, social or relevant regional commentary around sentiment towards the project.
- Strategic long-term considerations and evaluation of broader redevelopment issues.

3.1 Scope

Planning and Development of Final Business Case	Role of ESC
Services Procurement Plan	Support
Project Implementation Plan	Support
Risk Management Plan	Support
Financial Impact Statement	Support
Economic Appraisal	Support
Communications and Consultation Strategy	Support
Operational Commissioning Strategy	Support
ICT Strategy	Support
Workforce Development Strategy	Support
Functional Design Brief including: Models of Care Functional Relationships Operational Policies Workforce Requirements Schedules of Accommodation	Approve
Final Business Case	Endorse for Cabinet Approval

Guide Design Development	Role of ESC
Project Implementation Plan	Support
Risk Management Plan	Support
Variations to AusHFG	Approve
Procurement Strategy	Endorse for Cabinet Approval
Financial Impact Statement	Support
Economic Appraisal	Support
Communications and Consultation Plan	Support
Operational readiness plan	Support
Workforce Development Strategy	Support
Systems and Equipment including FFE, MME and ICT	Informed of IMT Approval
Facilities Management Strategy	Support

Project Implementation	Role of ESC
Project Implementation Plan	Support
Procurement Strategy	Approve
Developed Design Documentation including Room Data Sheets	Approve
Major variations to approved project scope	Endorse for sign off by MfHW
Variations to AusHFG	Approve
Tender evaluation and engagement of preferred tenderer and award contract	Endorse for Cabinet Approval
Post Tender Review Report to Department of Treasury and Finance	Informed
Finalise design	Approve
Communications and Consultation Plan	Support
Operational Readiness Plan	Support
Workforce Development Plan	Support
Systems and Equipment including FFE, MME and ICT Strategy	Informed of IMT Approval
Operational Commissioning and Facilities Management Plan	Support
Construction Management Plan	Informed
Building Commissioning and Project Completion Plan	Informed of IMT Approval
Certify construction complete	Approve
Handover facility	Approve
Finalise operational commissioning – Move Logistics and Decant Plan	Approve

All phases	Role of ESC
Schedule	Approve changes and monitor
Cost/Budget	Approve changes and monitor
Gateway Reviews	Endorse prior to release to Infrastructure SA Review Team
Resource procurement	Approve
Contract management of construction	Informed of issues

3.2 Out of Scope

- Sustainment works for Women's and Children's Hospital.

4. REPORTING LINES

- The ESC is accountable to the Government and will report through to the Minister for Health and Wellbeing on a regular basis. Attachment 1 summarises the new WCH project governance.
- The Report presented to the ESC will be in a standard monthly project report format. The ESC Report will summarise status of the program and progress,

design status, procurement and contracts status/issues, project cost and budget status, client issues and actions, and lay risks and mitigation strategy.

- Decisions are to be made by consensus (i.e. members are satisfied with the decision even though it may not be their first choice). Where consensus cannot be reached by the ESC, the item will be referred for decision by the ESC Chair or Minister for Health and Wellbeing if required.

5. LIMITS OF AUTHORITY

- With reference to the WCH Project's draft *Governance Manual* (May 2019), the Limits of Authority Policy (Attachment 1) defines and documents the policies and procedures that restrict the approval of transactions (by financial value, decision type and/or contract duration) to specific individuals to ensure consistent good business practices and governance.
- The limits of authority are determined based upon the staff member's position and may be revoked at any time by the Executive Steering Committee (ESC).
- The Schedule of Delegations represents the written delegation of authority by the ESC. This schedule will be confirmed annually by the ESC and filed with Department for Health and Wellbeing Finance Group. The Schedule of Delegations may be amended at any time by the ESC.
- The Department for Health and Wellbeing Finance Group will maintain an up-to-date Schedule of Limits Authority, with a list of the approved delegates, for the purpose of verification of expenditure authority.
- This Limits of Authority Policy also applies to transactions that do not involve a monetary amount, but nonetheless legally commit the Department for Health and Wellbeing or incur liabilities for the Department. For example, approval of a variation of scope which is likely to have a functional impact.

6. OPERATIONAL MATTERS

6.1 Membership

- Membership of the ESC is representative of the key Project stakeholders and includes:
  - Department for Health and Wellbeing (DHW);
  - Women's and Children's Hospital Network (WCHN);
  - Department of Treasury and Finance
  - Department of Planning, Transport and Infrastructure (DPTI)

- The Chair of the ESC will be Chief Executive Officer of SA Health.

Standard Membership	ESC
Chief Executive Officer of SA Health	Chair (Member)
Deputy Chief Executive Officer of SA Health	Member
CEO WCHN	Member
Board Chair WCHN	Member
Executive Director Infrastructure	Member
Department of Treasury and Finance Representative	Member

Standard Membership	ESC
DPTI Representative	Member
Independent Project Planning and Delivery Advisor (as required)	Invited
Infrastructure new WCH Project Director	Invited
Executive Director, Corporate Services, WCHN	Invited
WCHN Consumer representative(s)	Invited

- Proxies will be allowed if they are appropriately informed to ensure continuity in decision making during the life of the ESC. ESC members will be kept informed with comprehensive reports.

6.2 Consultation and Communication

- Ensure that there is consultation undertaken with clinicians and their professional and industrial organisations, consumers, and state and local Government Planning and Infrastructure, to inform the decisions regarding the new WCH Project.
- Ensure that appropriate consultation occurs with Chief Executives of SALHN, NALHN, CALHN, and the Country LHNs and State-wide Services.
- Ensure that an appropriate communications and consultation plan is developed to inform all key stakeholders of the progress of the Project.

6.3 Reports

- Project reports for all project work streams are required to be summarised within the IMT Report for issue to the ESC on a monthly basis.
- The ESC will proactively look toward the future to identify Project opportunities. The Report presented to the ESC will be in a standard monthly project report format. This report will be a summarised version of the IMT Report and will include the following:
  - approvals required from the ESC;
  - an update of the risk register for the project;
  - a project schedule update including reporting against any defined time contingency;
  - key financial management aspects of the project including:
    - budget issues, and
    - forecast and actual expenditure.
  - an update on key people issues;
  - a review of any contract administration matters which require ESC attention; and
  - an update of progress against other key project performance indicators (e.g. meeting legislative or licensing requirements).
- The ESC Report should be prepared by the Infrastructure new WCH Project Director, endorsed by Co-Chairs IMT and circulated at least three working days before the ESC Meeting. It should provide updated data relevant to the project performance measures being addressed and conclude with any recommended course(s) of action.
- The ESC Report will be submitted to the ESC on a monthly basis.

6.4 Meetings

- The Chair of the ESC will be Chief Executive Officer of SA Health.
- Executive Support will be provided by the Infrastructure Project Secretariat.
- The Minutes will be distributed within 5 working days after the meeting and the Agenda will be distributed electronically at least 3 working days prior to the scheduled meeting.
- Actions arising from the meeting are to be communicated to the applicable team member in the relevant organisation(s) by the appropriate ESC member within two working days of the meeting.
- Any agenda items to be forwarded to Infrastructure Project Secretariat for the consideration of the Chair for inclusion on the agenda.
- Frequency of meetings will be monthly or as determined based on project need.
- A meeting quorum comprises of the Chair and 50% of members.
- Meetings will be held at Citicentre, 11 Hindmarsh Square, and/or at the Women's and Children's Hospital.

6.5 Declaration of Conflict of Interest

- ESC members are obligated to formally declare an actual or potential conflict of interest that may arise through the normal course of their involvement in the Project. Should an ESC member think that they may have an actual or potential conflict of interest, they must discuss it with the Chair of the ESC to confirm whether it fits the criteria of an actual or potential conflict. Conflict of Interest Registers must be established and maintained by the Project to record and assist in proper management of actual and potential conflicts of interest.
- Should a conflict of interest exist, the Chair of the ESC should apply one of the following strategies to ensure the integrity of official functions of the ESC:
    - Restrictions are placed on the committee member's involvement in the matter.
    - A disinterested third party is appointed to oversee part or all of the processes that deals with the matter.
    - The committee member does not participate in the matter.
    - The private interest concerned is relinquished.
- All information regarding the conflicts of interest can be found in SA Health Policy Directive PUBLIC-I1-A1, Conflict of Interest – Declaration and Management Policy Directive July 2016.

6.6 Meeting Frequency

- Meetings will occur monthly during development of the Final Business Case, on the 3rd Thursday of the month for 1 hour or as required. IMT will meet on the 2nd and 4th Tuesdays of the month.

6.7 Support for Executive Steering Committee

- The Infrastructure Project Secretariat will record and circulate minutes, action items and maintain a Decision Register.

7 ADOPTION AND AMENDMENT OF THE TERMS OF REFERENCE

The Terms of Reference shall be reviewed regularly and shall be altered only with the approval of the CE Health and/ or Minister for Health and Wellbeing.

Terms of Reference were adopted on .....day of .....2019.

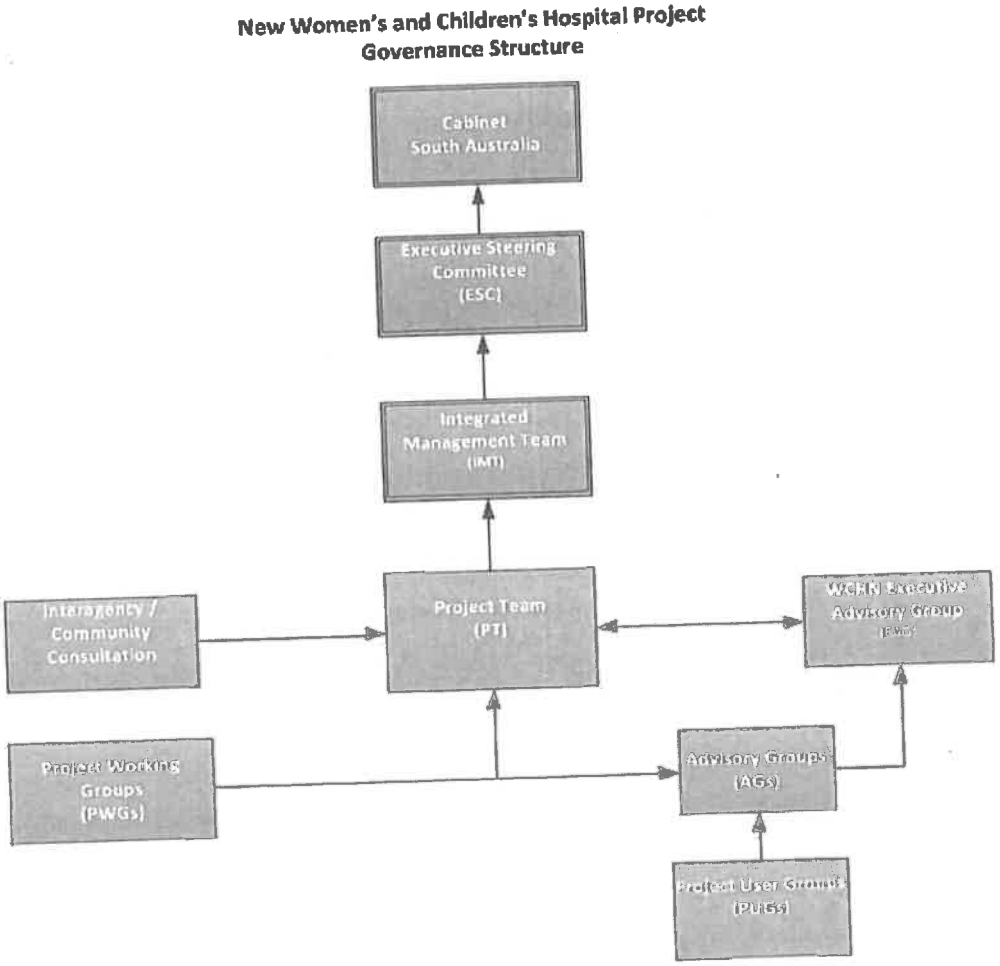
.....
Chair - Chief Executive – SA Health

.....
Minister for Health and Wellbeing

ATTACHMENT 1

New Women's and Children's Hospital Project - Governance

The following diagram summarises the project governance, recognising that the ESC will be answerable to the Government through the Minister for Health and Wellbeing.



ATTACHMENT 2

New Women's and Children's Hospital Project – Limits of Authority Policy (Draft)

1. Introduction

The purpose of a limits-of-authority policy is to define and document the policies and procedures that restrict the approval of transactions (by financial value, decision type and/or contract duration) to specific individuals to ensure consistent good business practices and governance. These procedures identify who is delegated to approve specified financial transaction amounts, as well as who can be assigned temporary authority in the event a manager is unavailable.

2. Application

This policy applies to all staff involved in the tender and procurement process as well as those members of the ESC, IMT or Project Team that have been delegated any aspect of financial oversight or decision making capability for the development and delivery of the project.

Where decision making capability is delegated to a group, the delegation vests in the chair or most senior member of that group, except where the terms of reference require decisions to be made by a vote of the members.

3. Policy

The limits of authority are determined based upon the staff member's position and may be revoked at any time by the ESC.

The Schedule of Delegations, set out below, represents the written delegation of authority by the ESC. This schedule will be confirmed annually by the ESC and filed with Department for Health and Wellbeing Finance Group. The Schedule of Delegations may be amended at any time by the ESC.

The Department for Health and Wellbeing Finance Group will maintain an up-to-date Schedule of Limits Authority, with a list of the approved delegates, for the purpose of verification of expenditure authority.

This Limits of Authority Policy also applies to transactions that do not involve a monetary amount, but nonetheless legally commit the Department for Health and Wellbeing or incur liabilities for the Department. For example, approval of a variation of scope which is likely to have a functional impact.

4. Authority

Authorities may be delegated to other staff members if this delegation is formally recorded and authorised by the ESC. However, signing authority for contracts is reserved only for those staff identified in the Schedule of Delegations set out below. The general requirements regarding signing authority are:

1. A delegation of authority, whether it is contract signing authority or other financial or spending authority, may not be made unless it is detailed in the Schedule of Delegations Authority set out below.
2. All delegations relate to the delegate's position, not to the individual in that position.

3. A delegation of authority under this policy may be wholly or partially withdrawn or restricted (either permanently or temporarily) at any time by the ESC.
4. No delegations may be made to non-staff members.
5. A delegate's manager may exercise the same level of authority as the delegate (that is to say, levels of authority are hierarchical through relevant lines of responsibility).

Notwithstanding these delegations, delegates should keep their managers informed of significant initiatives and projects, even if the cost of those initiatives and projects are below the delegated amount.

5. Schedule of Delegations

The following set out the key delegations for each of the major phases of the project –functional design brief, business case, detailed design and construction. These reflect the range of decisions to be made in each phase and the materiality of those decisions to the project. As a general principle, deviation from designs approved in previous stages will require approval by the ESC, whilst refinement of design within these parameters can be approved by the IMT.

5.1 Pre-Business Case

Prior to the approval of the final business case, the budget is yet to be finalised, so the delegation of approval allows some flexibility within the project parameters approved in previous phases.

Decision to be considered	ESC	IMT	Project Team
Design changes which are not compliant with requirements[1]	Approve	Endorse	Prepare
Design changes which impact on RAH[2]	Approve	Endorse	Prepare
Any schedule, staging or design options which will extend the predicted operational date for the hospital	Approve	Endorse	Prepare
Any schedule, staging or design options which will impact on the schedule but not the operational date for the hospital	Inform	Approve	Prepare
Shortlisting of planning or design options to be presented	-	Inform	Approve
Design changes valued <$100,000 (A monthly cap is to be considered)	Inform	Approve	Prepare
Design changes valued >$100,000	Approve	Endorse	Prepare
Release of design contingency	Approve	Endorse	Prepare
Approval of options which will increase the hospital workforce requirements	Approve	Endorse	Prepare

[1] Requirements include the project vision, project objectives, AusHFG, other statutory requirements, clinical services plan, functional design brief, previously approved design reports
[2] Impact on RAH includes proposals for shared services, proposal which will require a modification to the operator's contract or proposals which will require physical modifications to the hospital building or infrastructure

Decision to be considered	ESC	IMT	Project Team
Approval of system selection with high operating costs [3]	Inform	Approve	Prepare
Approval or modification of project strategies [4]	Approve	Endorse	Prepare
Approval or modification of project plans [5]	Inform	Approve	Prepare
Approval of the design reports	Approve	Endorse	Prepare
Approval of the business case	Endorse for Cabinet Approval	Endorse	Prepare

3 Approval is required for the specification and selection of systems including HVAC, fire, security, BMS, nurse call, communications.
4 Project strategies include all documents setting out the high level approach to project delivery, including, but not limited, the procurement strategy, workforce strategy, handover and operational commissioning strategy, communication strategy and industrial relations strategy
5 Project plans includes all documents setting out the detailed approach to project delivery, including, but not limited to, detailed implementation plans for the project strategies, project management plan, scheduling and staging plan, risk management plan, issue management plan, interface management plan, information management plan and subordinate specifications for project systems, reporting framework, contract administration plan, decanting plan and WCH operational plans.

5.2 Contractor Procurement

Decision to be considered	ESC	IMT	Project Team
Approval of procurement strategy	Approve	Endorse	Prepare
Approval of contractor EOI documents	-	Inform	Approve
Shortlisting of contractors	Inform	Approve	Prepare
Approval of contractor RFT documents	-	Inform	Approve
Approval of negotiation plan	Inform	Approve	Prepare
Approval to enter into contract with preferred contractor	Endorse for Cabinet Approval	Endorse	Prepare

5.3 Design Finalisation

The project scope and budget is finalised with the approval of the business case. Therefore, the ability of the Project Team to make fundamental changes to the design or to increase scope is limited and will require ESC approval.

Decision to be considered	ESC	IMT	Project Team
Design changes which are not compliant with requirements	Approve	Endorse	Prepare
Design changes which impact on RAH	Approve	Endorse	Prepare
Schedule, staging or design options which will extend the predicted operational date for the hospital	Approve	Endorse	Prepare
Schedule, staging or design options which will not impact on the operational date for the hospital	Inform	Approve	Prepare
Shortlisting of planning or design options to be presented		Inform	Approve

Decision to be considered	Inform	Approve	
Design changes valued <$100,000 (A monthly cap is to be considered)	Inform	Approve	Prepare
Design changes valued >$100,000	Approve	Endorse	Prepare
Release of design contingency	Approve	Endorse	Prepare
Approval of options which will increase the hospital workforce requirements	Approve	Endorse	Prepare
Approval of system selection with high operating costs	Inform	Approve	Prepare
Approval or modification of project strategies	Approve	Endorse	Prepare
Approval or modification of project plans	Inform	Approve	Prepare
Approval of the design report	Approve	Endorse	Prepare

5.4 Construction

The delegation of approvals in the construction phase focusses on the administration of the construction contracts, within the approved budget, with no further design changes expected except to resolve site issues. The ESC and IMT approve the Senior Responsible Officer as appointed for the construction phase, with the appropriate delegation, to action variations and EOTS within the approved cost plan and program.

Change to be approved	ESC	IMT	Project Team
Approval of, or modification to, the subcontractor packaging plan	Inform	Approve	Prepare
Approval of subcontracts up to $200,000	-	Approve	Prepare
Approval of subcontracts greater than $200,000 up to $2M	Inform	Approve	Prepare
Approval of subcontracts greater than $2M	Approve	Endorse	Prepare
Approval of EOTs which will extend the operational date for the hospital	Approve	Endorse	Prepare
Approval of EOTs which will not extend the operational date for the hospital	Inform	Approve	Prepare
Variations < $100,000 (A monthly cap is to be considered)	Inform	Approve	Prepare
Variations > $100,000	Approve	Endorse	Prepare
Release of construction contingency	Inform	Approve	Prepare
Acceptance of practical completion	Approve	Endorse	Prepare

6. Transactions

A delegate identified under this policy has the designated authority to take an action or sign a document necessary to give effect to a transaction. Any such action or signature must comply with necessary legal and financial approvals related to the specific transaction, such as the contract approval process for contracts.

Any delegation to incur expenditure must be exercised within the limits of the relevant approved budget.

A delegate can only exercise authority with respect to the total transaction value, which includes related and integrated transactions.

If there is any increase in the cost of a transaction, then:

- the delegate who approved the original transaction must approve that variation; or
- if the sum of the variation and the original cost of the transaction exceed the delegate's limit of authority for that type of transaction, a delegate with the appropriate level of authority must approve that variation.

All contracts must be processed in accordance with the contract approval process.

7. Compliance and Breaches

The Department for Health and Wellbeing may commence applicable disciplinary procedures if a person to whom this policy applies breaches this policy.