



Education and Health Standing Committee

Managing the transition?

The report of the inquiry into the transition and operation of services at Fiona Stanley Hospital

Report No. 6
November 2015

Legislative Assembly
Parliament of Western Australia

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Presented by

Dr G.G. Jacobs, MLA

Laid on the Table of the Legislative Assembly on 26 November 2015

Chairman's Foreword

In April 2014, the Committee reported on its inquiry into the information and communication technology challenges associated with commissioning Fiona Stanley Hospital. Following the opening of the hospital in October 2014, media and patient reports emerged of alleged failings in the operation of the hospital. The Committee decided that it was important to undertake a further inquiry to determine whether the alleged failings were just teething problems or indicative of more systemic problems, and whether there were associated costs to taxpayers and/or risks to patient health and safety. To review the operations at Fiona Stanley Hospital, the Committee needed to understand the contractual and operational relationship between the Department of Health and Serco as the facilities manager. I encourage you to read the report to gain a better understanding of these arrangements.

The Committee found that aspects of transitioning patients and services to Fiona Stanley Hospital from other hospitals did cause risks to patient care. The Committee was also disappointed to find that poor planning for the reconfigured South Metropolitan Health Services resulted in Fremantle Hospital being underutilised. Conversely, the level of some services at Fiona Stanley Hospital was underestimated, putting pressure on the hospital's emergency department, cleaning services and help desk services. Additional staffing was needed in these areas to ensure an adequate level of service was provided, leading to contract management considerations about whether the additional services fell under the facilities management contract, or whether these services were outside the contract and contract variations would be needed, and therefore additional costs incurred. There is currently one active contract variation under consideration by the Department relating to the cleaning service.

The role of porters at Fiona Stanley Hospital is unique in the Western Australia healthcare system and has caused some confusion about the extent of their duties. As porters perform a limited role in comparison to orderlies at other hospitals, Fiona Stanley Hospital had to engage a cohort of 'assistants-in-nursing' to undertake duties which the porters do not perform in accordance with the facilities management contract. There has been a significant cost to Western Australian taxpayers associated with these additional staffing requirements.

There are two primary considerations in the operation of a contract such as the one signed with Serco to manage services at Fiona Stanley Hospital. The first relates to patient safety. Serco must deliver services in a way that ensures that patient safety is never put at risk. Where there is doubt about Serco's ability to do so, it is incumbent upon the Department to aggressively enforce the provisions of the contract in order to protect patients undergoing treatment at the hospital. Although the Committee and I are of the view that Serco should never have been given responsibility for running the

sterilisation service, the Department's strong response to the shortfalls associated with Serco's performance was reassuring. It is to be hoped that this response sets a precedent for how future similar problems will be resolved.

The second consideration relates to ensuring that value for money is achieved throughout the life of the contract. This will require the Department to closely monitor Serco's performance and to enforce contract provisions where the view is formed that Serco's performance falls short of contractual obligations. The Department will primarily rely upon Serco's own self-reporting of its performance in order to carry out this monitoring. The Committee has written to the Auditor General requesting that his office audit this self-reporting and the Department's contract management more generally.

I would also like to extend my thanks to Professor Bryant Stokes, who acted as the Department of Health's Director General from April 2013 to August 2015. Professor Stokes has had a long and distinguished career in medicine and health administration in Western Australia. During his time as Acting Director General, governance arrangements for Fiona Stanley Hospital saw significant improvement and, together with Dr David Russell-Weisz, he was able to lead the organisation through the difficult task of opening a new hospital.

Finally, I would like to thank the staff at Fiona Stanley Hospital – those employed by the Department and by Serco alike – for their professionalism and commitment to patient care. There is no doubt that the first 12-months of operations at Fiona Stanley Hospital have been challenging, but their dedication to the patients has never been in doubt.

A handwritten signature in black ink, appearing to read 'G.G. Jacobs', with a large, stylized flourish above it.

DR G.G. JACOBS, MLA
CHAIRMAN

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Executive Summary

Fiona Stanley Hospital is the biggest health infrastructure project ever undertaken in the State of Western Australia. It represents a significant investment by the State with the intent of providing affordable, efficient and effective healthcare for Western Australians, particularly in the south metropolitan area.

The Education and Health Standing Committee has previously inquired into the commissioning of Fiona Stanley Hospital prior to its opening in October 2014. This inquiry identified a number of challenges associated with the organisational management of the project. Since its staged opening began in October 2014, completed in February 2015, the media highlighted concerns about difficulties relating to patient care, Serco's delivery of non-clinical services and the quality of the building fabric. The Committee resolved to undertake a further inquiry into the transition to, and operation of services at, the hospital.

Overall, whilst there is still room for improvement in many of the areas of concern outlined in this report, the Committee is satisfied that action has been taken, and continues to be taken, to rectify the issues identified resulting in satisfactory operations at the hospital.

Transition Management

Throughout this inquiry, the Committee reviewed a number of areas of ongoing concern in relation to governance and contract management, information technology, information management, and facilities management.

In its earlier inquiry, the Committee identified an absence of rigorous governance in the management of the commissioning project. For the most part, the Committee is satisfied that improved arrangements introduced in 2013 have continued and provide the level of governance required for such a complex project. The greater role assumed by the FSH Commissioning and Major Hospitals Transition Taskforce (Taskforce), regular attendance of a representative from the Office of the Minister for Health at Taskforce meetings and regular status reports provided by the Department of Health's Acting Director General to the Minister for Health all contributed to faster identification and resolution of transition issues.

Aspects of the patient transition since the facility's staged opening were not well managed, with delays in patient records being transferred between sites meaning a treating clinician had limited information on which to base his or her consultation. The Department of Health has advised of subsequent significant improvements in transferral, and the Committee recommends that this process is monitored into the future.

Initial problems with information technology and information management systems were caused by aspects of the project being significantly behind schedule, failures in technology and lack of user training and awareness. Ongoing upgrades in technology and process have improved reliability and the Committee considers that the digital records management systems have the capacity to significantly improve information management processes, particularly by comparison with technology available at other hospitals.

However, the Committee notes with concern that there is currently no mechanism for confirming delivery of electronic discharge summaries and recommends a system upgrade to incorporate a delivery receipt or similar notification confirming successful delivery.

Serco services

The decision in 2011 to outsource non-clinical services to a facilities manager has resulted in ongoing scrutiny of the performance of these services by Serco, and also of the oversight of the contract by the Department of Health.

Serco provides portering services to transport patients around the hospital. Porters have a more limited role than orderlies in other hospitals and do not participate as companions/static guards; turning teams; nor in patient positioning. Approximately 120 additional assistants-in-nursing were employed to undertake these duties, costing taxpayers millions to initially train and educate staff, and then fund ongoing salary costs.

Serco staff undertake different types of cleans, most of which are covered under the Facilities Management Services Contract. A particular type of clean, an 'isolation clean' requested and approved by clinical staff, incurs an additional cost per clean. The Committee is concerned that the number of isolation cleans being undertaken is significantly in excess of forecasts, and therefore resulting in additional payments to Serco, and recommends that the Department of Health investigate this area further.

Failures in the sterilisation of hospital equipment were well publicised in the media. The Committee considers that the Department of Health should never have outsourced these services to Serco, considering the clinical nature of this service and its lack of experience in this service. The Committee is satisfied that the Department of Health made the appropriate decision to extract these services from the Facilities Management Services Contract given potential risks to patient safety.

The Committee has written to the Auditor General requesting that his office undertake a performance audit of Serco's self-reporting and the Department of Health's assurance processes around that reporting.

Ministerial Response

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

Findings and Recommendations

Finding 1

Page 10

The improved governance processes introduced after March 2013 were continued and strengthened. The Committee noted that the Minister for Health arranged for a representative from his office to attend meetings of the Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce.

Finding 2

Page 14

To achieve the savings envisaged by establishing Fremantle Hospital as a low complexity, high volume site, patient flows to the hospital will need to be better managed as will the allocation of surgical resources.

Finding 3

Page 19

The transfer of patient records following the opening of Fiona Stanley Hospital was poorly managed by the Department of Health and put patients at risk.

Recommendation 1

Page 19

That the Minister for Health provides an update on the status of the transfer of medical records for patients attending Fiona Stanley Hospital from other hospitals in Western Australia.

Recommendation 2

Page 20

That the Minister for Health report to the Parliament on the adoption of digital medical record (DMR) systems, including BOSSnet, across the rest of the health system, including (as at the time of the response):

- The extent to which DMR has been adopted in other Western Australian hospitals;
- The extent to which a DMR created at Fiona Stanley Hospital is updatable, useable, or otherwise accessible by or for other public hospitals in Western Australia; and
- The timeline and estimated cost for rolling-out a DMR system at other tertiary and general hospital sites in Western Australia.

Finding 4

Page 22

The Digital Medical Record in place at Fiona Stanley Hospital represents a significant improvement on existing paper-based records systems. Ongoing upgrades will help to address some useability issues, including the level of integration with other clinical Information Technology systems. As user familiarity improves the Committee expects increased acceptance of the system by clinical users.

Finding 5**Page 23**

The Committee is of the view that relying upon hardcopy distribution to the patient of the discharge summary is insufficient as a failsafe and that the Department should have internal systems of their own to ensure that treating clinicians receive discharge summaries.

Recommendation 3**Page 23**

That the Department of Health implement an upgrade to the Notification and Clinical Summaries (NaCS) application and the Clinical Governance Management System (CGMS) to provide for a delivery receipt or other similar notification upon the successful delivery of a discharge summary to the receiving clinician or their office.

Finding 6**Page 25**

The Department of Health acknowledged that higher than expected wait times for medications from the pharmacy would improve upon full implementation of the Closed Loop Medication Management System and other elements of the pharmacy automation system.

Recommendation 4**Page 25**

That the Minister for Health report to the Parliament regarding the status of the roll-out of the Closed Loop Medication Management System and the current wait times for dispensation of medication experienced by patients upon discharge.

Recommendation 5**Page 26**

That the Minister for Health report to the Parliament on the reliability of the paging system in use at Fiona Stanley Hospital for the three month period following the tabling of this report, including:

- The uptime of the system;
- The dates, times and lengths of any outages;
- The extent of the outages (i.e. localised to individual departments or hospital-wide); and
- The abatement and/or failure points incurred by Serco as a result of any outages.

Finding 7**Page 29**

The Committee is of the view that the problems encountered with the Information and Communications Technology systems at Fiona Stanley Hospital were a direct consequence of the scheduling and project management problems experienced in the lead-up to the opening of the hospital. The Department of Health has attempted to recover the time lost due to these schedule failings, but have not been able to avoid:

- Delays to the hospital commissioning;
- Increased costs; and
- Problems with the interface between the service providers.

Finding 8

Page 30

The Committee was concerned that the Department of Health did not always provide materially relevant information in the answers to some of the questions put to it regarding the performance of the Information and Communications Technology systems at the hospital.

Finding 9

Page 36

Despite having a reduced range of functions in comparison to the orderlies found in other Western Australian public hospitals, 50 additional internal logistics staff were required to meet contract obligations and demand for services following the commencement of phase 3 operations in February 2015. Serco confirmed that, subsequent to a small reduction, the numbers remain above the initial staffing levels.

Recommendation 6

Page 36

That the Minister for Health provide a report to the Parliament at quarterly intervals for the remainder of the 39th Parliament containing the number of internal logistics service staff employed by Serco at Fiona Stanley Hospital. The report should include:

- The number of permanent, casual or agency staff; and
- The role that the staff provide (i.e. waste management, portering, etc.).

Finding 10

Page 37

Once the Department of Health realised the impact of Serco's portering model, which did not include all of the traditional orderly duties, Fiona Stanley Hospital was required to engage an additional 170 Assistants-in-Nursing staff. The Department of Health estimated a cost of \$1.82 million to educate and train the Assistants-in-Nursing. Additional ongoing salary costs would also be incurred.

Recommendation 7

Page 38

The Minister for Health reports to the Parliament the annual costs arising from the employment of Assistants-in-Nursing at Fiona Stanley Hospital.

Finding 11

Page 40

The Committee is not convinced the reporting processes are robust and that the guidelines are consistent between both Serco and the Department of Health. The self-

reporting concept is essentially flawed and the Department of Health has neither the expertise nor the energy to implement a comprehensive audit system of its own.

Finding 12

Page 43

The number of isolation cleans being requested by clinical staff is significantly above the forecast amount, and has been occurring since the hospital commenced operations in October 2014. The Committee's view is that this disparity likely reflects a lack of confidence amongst clinical staff in the adequacy of the general cleans being performed.

Recommendation 8

Page 44

That the Minister for Health determines the reasons for the excessive number of isolation cleans being performed and report to the Parliament on the outcome of the investigation.

Finding 13

Page 46

Serco has lodged a variation to the contract for cleaning services. The variation is on the basis that Serco is currently performing cleaning services that it was not originally contracted to deliver. The Committee notes that Serco was significantly more willing to outline the basis for its variation proposal than the Department of Health had been.

Recommendation 9

Page 46

The Minister for Health reports to the Parliament the outcome of Serco's contract variation proposal, including – should the variation proposal be successful – full details of Serco's altered cleaning responsibilities and the estimated annual cost to the Department of Health.

Finding 14

Page 47

The Department of Health has responded to patient concerns and improved Linen Services at Fiona Stanley Hospital. As the linen service is not a service with a fixed-price component, the improvements to the linen service will result in extra payments to Serco arising from the increased volume of linen.

Finding 15

Page 50

Although the Committee accepts that the quality of Serco's self-reporting has improved, the Committee is of the view that the problems were common to most services provided by Serco and were not, in many cases, of the standard required for the Department of Health to effectively manage the contract and monitor Serco's performance.

Finding 16**Page 55**

The Supplies Management Service is currently being jointly managed by the Department of Health and Serco as a result of deficiencies associated with Serco's management of the service.

Finding 17**Page 56**

Given the inclusion of the Sterilisation Service in the Facilities Management Services Contract, the Committee questions the level of scrutiny applied to the contract by the Minister when he signed it. It should have been obvious that this service required the expertise of the Department of Health in delivering patient-centric care.

Finding 18**Page 57**

The Acting Director General, Professor Bryant Stokes, and Chief Executive Officer of Fiona Stanley Hospital Commissioning, Dr David Russell-Weisz, made the right and only choice in transferring the Sterilisation Service from Serco back to the Department of Health, given risks to patient safety.

Finding 19**Page 57**

The Committee was not convinced that all measures were adopted to reassure post-surgical patients at Fiona Stanley Hospital that they were at no risk to exposure from poorly sterilised instruments.

Finding 20**Page 60**

The significant financial implications of the operation of the Facilities Management Services Contract at Fiona Stanley Hospital by Serco calls for accuracy of reporting by Serco, and rigorous contract management by the Department of Health.

Recommendation 10**Page 60**

That the Minister for Health supports the Committee's request to the Auditor General that his office carries out an audit of the management of the Facilities Management Services Contract.

Chapter 1

Introduction

The inquiry

Background

Fiona Stanley Hospital (FSH) opened its doors to patients for the first time in October 2014 with the relocation of the State Rehabilitation Service from Shenton Park to a new purpose-built facility at the FSH campus. Over the period of the following four months, FSH progressively introduced increasingly complex medical specialities, culminating with the relocation of the heart and lung transplant service from Royal Perth Hospital (RPH) in February 2015.

Commencing operations at FSH involved significantly more than simply opening the doors of a new hospital. It involved reconfiguration of hospital activity across the South Metropolitan Health Service (SMHS).

Unfortunately, media reporting soon emerged of difficulties at the hospital relating to patient care, the adequacy of Serco's delivery of non-clinical services and the quality of the building fabric – particularly following floods in April and July 2015.

FSH represents a significant investment for the State of Western Australian and is crucial for the continued delivery of effective and affordable healthcare to a significant proportion of the State's population. Given FSH's importance, and given the ongoing media speculation and public interest surrounding the hospital's performance, the Committee resolved to conduct an inquiry into the transition to and operation of services at the hospital.

The inquiry focus

The Terms of Reference for the inquiry are relatively straightforward, and give emphasis to two complementary elements as they relate to clinical risks to patients and financial risks to the State. Firstly, in relation to the clinical services delivered by the Department of Health (the Department) and, secondly, in relation to the management by Serco of the services it is contracted to deliver.

As with the earlier inquiry undertaken by this Committee examining the management of the FSH project, internal reporting on the status of the hospital was provided by the Department. The extent and amount of evidence received as part of this process was, however, considerably less than in the previous inquiry. Nonetheless, it was sufficient

Chapter 1

for enabling an understanding of the project and for giving balanced consideration to the issues that had been highlighted by those raising concerns about the hospital.

The Committee also took evidence from a range of stakeholders, including unions representing the hospital's workforce, as well as Serco in its role as the hospital's facilities manager.

The Committee's consideration of the evidence

During the course of the inquiry, a range of concerns or allegations were made relating to the operation of FSH. The Committee's approach to handling these allegations has been consistent throughout the inquiry process. In the first instance, the Committee sought documents from the Department that would either confirm or rebut the allegation. Where documentation did not clarify the issue, the Committee put questions directly to the Department or, where appropriate to do so, to Serco.

The veracity of the allegations were, wherever possible, assessed against the Department's responses including primary source documents.

Towards the end of the inquiry process, the Committee provided Serco with information about several issues that are contained in this report, but which had not been put directly to Serco at hearing or otherwise placed into the public record. A copy of the Committee's letter to Serco and Serco's response to that letter are provided in full in Appendix 6.

The Fiona Stanley Hospital

Hospital infrastructure and services

With 783 beds, FSH is the southern metropolitan area's major tertiary hospital. The hospital provides tertiary services for the population of SMHS and general and specialist hospital services for the residents of the local government areas of Canning, Cockburn, East Fremantle, Fremantle and Melville. The hospital is a campus-style development, consisting of a main hospital building and buildings for education and pathology, the State rehabilitation service, mental health and administration. The Western Australian Institute of Medical Research, built in conjunction with universities, is co-located on the site.

FSH offers a full range of emergency, acute medical and surgical services including: a trauma service; cardiothoracic surgery, including the advanced heart failure and lung failure service and heart and lung transplantation, renal transplantation and dialysis services; an adult mental health unit with a secure wing and mother and baby unit; obstetrics and neonatal; and paediatrics services. FSH provides a comprehensive cancer service, being one of two major cancer centres in the State, and includes radiotherapy treatment facilities, medical oncology and haematology.

FSH houses the State-wide adult burns service and hyperbaric and tertiary rehabilitation services. It provides facilities for pathology, biomedical engineering and cell tissue manufacturing. In line with recommendations made by the Clinical Cluster Advisory Committee, the State's major adult trauma centre remains at RPH.¹

The Commissioning project

In the Committee's previous report examining the circumstances surrounding FSH's delayed opening, the phrase 'commissioning project' was referred to as an abbreviated descriptor for the various elements required to have the hospital ready for operation. The commissioning project consisted of the following:

- SMHS reconfiguration
- Information and Communications Technology
- Workforce
- Clinical Commissioning
- Facilities Management
- Infrastructure
- Corporate

The focus of this inquiry has been on the period after the hospital commenced operations; however, the phrase 'commissioning project' has been used in much the same context in this report as it was in the earlier one.

Serco and the Facilities Management Services Contract

When the Facilities Management Services Contract (FMSC) was signed in 2011, Serco was contracted to provide a total of 29 services at FSH. Since then, the Sterilisation Service has been the subject of a 'take out' notice and is now being provided directly by The Department, although Serco continues to provide support services for the Sterilisation Service. The Child Care, Health Records Management and Clinical Coding service and the Scheduling and Billing service were removed from the contract by the Department in the months leading up to the hospital's opening. These latter two services were never fully costed or included in the original estimates for the total cost of the contract:

They were services that were placed in original scope but it was not entirely clear at the time of contract signing how those services would

¹ The preceding paragraphs were adapted from the Fiona Stanley Hospital Clinical Services Plan, pp. 10–12.

Chapter 1

be delivered and what technology would be used and, as a result, there were uncosted and unconfirmed services.²

The initial contract period is 10 years, now covering 25 services, and included three years of pre-operations and transition services during which time Serco was required to take necessary actions to ensure that it was able to commence providing services once the hospital was originally scheduled to open in April 2014. The contract includes two options for five-year extensions, the first in 2021 and the second in 2026.

In broad terms, the services that Serco performs at the hospital fall into the following categories:

- Management, procurement and integration services: Although the contract with Serco includes the provision of 25 individual services Serco will be expected to deliver the services in a seamless and integrated fashion. In effect, this means that one of the services that Serco is being contracted to provide is its experience in managing complex service contracts.
- Hard facilities management (FM) services: Serco is responsible for maintaining the fabric of the built environment. Examples of hard FM services include maintenance of lifts, plumbing and electrical systems and general building maintenance.
- Soft facilities management services: Serco is responsible for providing patient catering, cleaning services and other soft services at the hospital.
- Information and Communication Technology (ICT) services: Serco is responsible for delivering an integrated ICT solution at the hospital, ranging from providing Wi-Fi access through to managing all physical ICT infrastructure at the hospital, including paging devices and desktop computers.

The health care funding environment

The cost of providing hospital services in Western Australia exceeds the national average, and has done so for some time. Its rate of growth is also above the national average, meaning that the gap between the national average and the actual cost in Western Australia is growing rather than converging. Since at least the 2013–14 State Budget it has been the stated aim of the State Government to narrow – and then eventually eliminate – the gap between national average and the actual cost of health service delivery in Western Australia. The *2015–16 State Budget* explained that:

The key budget strategy for WA Health is to achieve convergence between the cost of delivering public hospital services in the State's

² Mr Joseph Boyle, Former Transition Project Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 7.

*health system and the projected national average cost of hospital services within the timeframe for completion of the WA Health Reform Program (i.e. by 2020-21).*³

Notwithstanding the continued changes to the manner in which the Commonwealth Government provides funds to the States for health care, achieving convergence is important because the national average cost is used in order to determine the Commonwealth's contribution to hospital funding. The introduction of FSH and the reconfiguration of services in SMHS should have represented an opportunity to significantly develop a path for convergence. The Committee was told that the contract was negotiated without consideration of these issues. Furthermore, the fixed nature of the payments to Serco each month means that any cost efficiencies at the hospital will need to come from savings in clinical service delivery, or in linen, catering, waste and isolation cleans which are largely consumption based.

³ Department of Treasury (WA), *Budget Paper No. 3*, p. 81.

Chapter 2

Transition Management

Governance

Sound governance is the basis for accountability to the Parliament

The Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce (the Taskforce) was established following a recommendation made in the review of FSH commissioning completed by the University Hospitals Birmingham (UHB). The review team drew on their experience to identify the most important factors determining successful project delivery:

It is the experience of this team that the successful implementation of a Program of this nature requires clear governance structures, clear role definitions, detailed integrated planning and clear critical path milestones. It requires integration across all streams and financial control. A high level of risk management and mitigation skills are required with a well developed process and clear responsibilities and accountabilities allocated from the outset.⁴

The UHB Report went on to outline the ways in which the governance structures in place at the time that the review occurred fell short of their expectations. The Taskforce was an important first step in providing significantly improved governance arrangements for the project; however, as the Committee outlined in its previous report on FSH, it took several months – and the appointment of a new Director General of Health – before the Taskforce was able to fulfil its promise.

Ultimately, good governance is essential if risks are to be identified and appropriately managed. In thinking about risks associated with government service or infrastructure delivery, it is natural to concentrate on the financial risks – that the project might be late, or over-budget, for example – but there are more fundamental risks that can arise as a result of poor governance. These risks relate to the very nature of accountability in our Westminster-style responsible government and they touch on the role of the Parliament – as elected representatives of the people – in holding the government to account. The High Court of Australia, in its judgment in *Egan v Willis* observed that:

A system of responsible government traditionally has been considered to encompass 'the means by which Parliament brings the Executive to

⁴ University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 12.

Chapter 2

account' so that 'the Executive's primary responsibility in its prosecution of government is owed to Parliament'. The point was made by Mill, writing in 1861, who spoke of the task of the legislature 'to watch and control the government: to throw the light of publicity on its acts'. It has been said of the contemporary position in Australia that, while 'the primary role of Parliament is to pass laws, it also has important functions to question and criticise government on behalf of the people' and that 'to secure the accountability of government activity is the very essence of responsible government'.⁵

Departments have a responsibility to effectively manage projects under their control, and to implement robust governance processes. Not only does good governance provide the most effective means through which projects can be delivered on time and on budget, accountability to the Parliament and the operation of responsible government relies upon it. There are many lessons to be learned from the challenges encountered by the commissioning project, but none are more fundamental than the basic requirement that government departments and agencies keep their responsible ministers informed of all material matters impacting upon agency performance.

Significant improvements were made to governance post March 2013

In its earlier report on the commissioning project, the Committee observed that '[given] the extent and complexity of the commissioning project, we would have expected that a well-developed governance structure was in place that encompassed the entire scope of the project.'⁶ Ultimately, the Committee found that the absence of rigorous governance from the management of the commissioning project made it 'almost impossible to gain an accurate understanding of the true status of the project'.⁷ The Committee acknowledged that significant improvements were made to project governance and that the Taskforce assumed a dominant role in overseeing the project post March 2013.

Obviously, in conducting this second inquiry into FSH, the Committee was keen to see that the strengthened governance arrangements introduced in 2013 were continued and improved upon.

For the most part, the Committee was satisfied that the improved arrangements provided the level of governance assurance required of an undertaking as complex as

5 *Egan v. Willis* [1998] HCA 71, 158 ALR 527, [103] (McHugh J), [150], [154]-[155] (Kirby J), [194] (Callinan J).

6 Education and Health Standing Committee, *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning the Fiona Stanley Hospital*, Report No. 2, April 2014, p. 17.

7 Education and Health Standing Committee, *More than Bricks and Mortar: The report of the inquiry into the organisational response within the Department of Health to the challenges associated with commissioning the Fiona Stanley Hospital*, Report No. 2, April 2014, p. 24.

the commissioning project. In particular, the Committee was reassured that the Minister for Health had a representative at each meeting of the Taskforce after March 2013. The presence of this representative effectively addresses the concerns that the Minister was not sufficiently engaged in the overall management of the commissioning of the hospital. It also reinforced the requirement for government agencies to keep responsible Ministers informed of material matters impacting upon agency performance.

Furthermore, the Acting Director General of the Department for the period 18 April 2013 to 2 August 2015 gave evidence to the Committee that he spoke to the Minister for Health at least weekly in relation to the status of the commissioning project. During those discussions, the Minister was kept ‘totally informed’ with issues associated with the hospital.⁸ Significantly, the Taskforce met weekly and issues impacting upon the transition of services were quickly escalated for Taskforce consideration.⁹

The Go/No-Go process

An important element of the improved governance arrangements for the commissioning project was the adoption of the Go/No-Go process as the basis for the assessment of the readiness of the FSH Commissioning and SMHS Reconfiguration. The Go/No-Go assessment (the GNG assessment) took place in two stages ahead of each of the hospital’s three opening phases. The process was endorsed by the Taskforce and Cabinet was advised of the adoption of the GNG assessment process in July 2014 as part of the Taskforce’s regular Cabinet updates.¹⁰ The key consideration of the GNG assessment was ‘the delivery of safe, quality patient care at FSH, without compromise to the quality of care at reconfiguring SMHS hospitals.’¹¹ The Taskforce’s role in the GNG assessment was to provide a recommendation to the Director General who would then, in turn, provide his own recommendation to the Minister for Health.

According to Professor Stokes, the GNG assessments were a ‘very, very deep piece of work’¹² and it is clear from the range of documentation made available to the Committee that the Department attempted to identify and then assess the complete range of factors impacting upon the ability of the hospital to open.

8 Professor Bryant Stokes, Acting Director General (former), Department of Health, *Transcript of Evidence*, 19 October 2015, p. 4.

9 Professor Bryant Stokes, Acting Director General (former), Department of Health, *Transcript of Evidence*, 19 October 2015, p. 3.

10 FSH Taskforce Decision Summary: Phase 3 Go/No-Go Assessment Part 1, 11 December 2014; in Submission No. 15 from the Department of Health, 21 August 2015.

11 FSH Taskforce Decision Summary: Phase 3 Go/No-Go Assessment Part 1, 11 December 2014; in Submission No. 15 from the Department of Health, 21 August 2015.

12 Professor Bryant Stokes, Acting Director General (former), Department of Health, *Transcript of Evidence*, 19 October 2015, p. 3.

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Finding 1

The improved governance processes introduced after March 2013 were continued and strengthened. The Committee noted that the Minister for Health arranged for a representative from his office to attend meetings of the Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce.

South Metropolitan Health Service Reconfiguration

Although much of the public focus has been on the operation of FSH since it first opened, FSH itself is part of a broader health system known as the South Metropolitan Health Service. The hospital's introduction heralds a significant disruption to the way in which health services are delivered in the south metropolitan region; managing that disruption has been an important element of the process to safely open FSH.

Prior to the commencement of operations at FSH, SMHS consisted of two tertiary hospital sites at RPH and Fremantle Hospital, plus general hospitals at Rockingham and Armadale in addition to the Peel Health Campus and Murray Districts Hospital. Following the opening of FSH, Fremantle Hospital no longer operates an emergency department and is instead classified as a large general hospital. RPH has retained its emergency department, but has lost a number of beds. The reconfigured bed numbers for both Fremantle Hospital and RPH are provided in Table 2.1.

Table 2.1: SMHS tertiary beds pre- and post-reconfiguration¹³

Bed type	RPH (30/06/14) ¹	RPH (30/06/15) ¹	Freo (30/06/14) ²	Freo (30/06/15) ²	FSH (30/06/14)	FSH (30/06/15)
Chemotherapy	37	12	11	0	0	26
Dialysis	14	14	0	0	0	12
Medical/Surgical ³	534	350	294	162	0	460
Mental Health	20	20	66	66	0	30
Neonatal	0	0	12	0	0	18
Obstetrics	0	0	0	0	0	43
Paed MS	0	0	21	0	0	24
Palliative	0	0	0	0	0	0
Rehab	17	14	26	26	0	140
Same-day	40	40	46	46	0	30
TOTAL	662	450	476	300	0	783

¹ Shenton Park Campus provided an additional 150 Rehab beds and 58 Medical/Surgical beds at 30/06/14 and 0 beds at 30/06/15 following the reconfiguration.

² Kaleeya Hospital provided an additional 32 Medical/Surgical beds; 13 Obstetrics beds; 18 Rehab beds; and 13 Same-day beds at 30/06/14 and 0 beds at 30/06/15 following the reconfiguration.

³ Medical/Surgical includes ICU beds.

Fremantle Hospital as a specialist hospital

Most activity in tertiary hospital sites comes from emergency departments. This is known as unplanned activity (whereas elective surgery is known as planned activity). At any one time, as much as 85 per cent of inpatient activity at a tertiary hospital will be as a result of the admission of patients following presentation at the emergency department. These patients tend to require high acuity care given the seriousness of their medical conditions and the immediacy of their need for treatment. FSH was always intended to be a high acuity facility; general surgery would account for a low percentage of the overall activity that takes place at the hospital. Given that Fremantle Hospital would no longer have an emergency department, and that FSH would carry the burden of the high acuity care, a decision had to be made about the best way in which to utilise the capacity retained at Fremantle Hospital.

This has resulted in the emergence of Fremantle Hospital as a specialist hospital providing 'high-volume, low-complexity'¹⁴ surgery; predominantly general surgery, orthopaedics, some hand surgery and eye surgery.¹⁵ On average, between three and nine patients are also transferred to Fremantle Hospital from FSH each weekday if their level of acuity has decreased such that they no longer require the level of care available at FSH.¹⁶ The Australian Medical Association told the Committee that there was pressure on clinicians to transfer patients to Fremantle Hospital in order to make space

13 Submission No. 20 from the Department of Health, 6 November 2015.

14 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, *Transcript of Evidence*, 19 October 2015, p. 18.

15 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, *Transcript of Evidence*, 14 October 2015, p. 23.

16 Submission No. 16 from the Department of Health, 23 September 2015, p. 18.

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available at FSH.¹⁷ The Committee is not in a position to make any conclusions on this information; however, it is noted that the number of transferees would appear to be quite low given the capacity at FSH. There is evidence to suggest that inter-hospital transfers have detrimental impacts on the lengths of stay of those transferring patients¹⁸, meaning that the movement of a patient from FSH to open up space at FSH might have an overall negative outcome in terms of the cost of health service delivery in SMHS.

The Department told the Committee that the transfer of patients is longstanding practice and had always been part of the planning for FSH and the reconfiguration of SMHS.¹⁹

Fremantle Hospital is under-utilised

The Australian Medical Association (AMA) told the Committee that Fremantle Hospital was under-utilised; that ‘activity is significantly less than planned’; that the anaesthetic department is under-utilised; that the intensive care unit is under-utilised because ‘there is not enough surgery happening to keep the ICU full and ticking over’.²⁰

The Committee asked the Department about Fremantle Hospital’s utilisation rate following the reconfiguration of services in SMHS:

*Fremantle is underperforming. It is not well utilised, and there are challenges multi-fold in that transferring waiting list, transferring clinics. They are all set up; there is plenty of capacity there; there is plenty of resourcing there.*²¹

Although the Department was not able to offer specific information about the nature or extent of the under-utilisation during the hearing, the following detail was provided:

[...] some specialties are only running at about 60 to 70 per cent of what is projected. The medical workload and the rehabilitation and the mental health: mental health is obviously doing very well; medical is

17 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 7.

18 Discussion Paper for the Minister for Health, prepared by Ms Nicole Feely, 5 December 2011, pp. 3–4.

19 Submission No. 16 from the Department of Health, 23 September 2015, p. 18.

20 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 11.

21 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 21.

*doing pretty well with the transfers from FSH, creating capacities as the acute patients move in; and rehab is going well.*²²

Despite Fremantle Hospital running under-capacity, the Committee was assured that elective surgery activities in SMHS were meeting their targets:

*Across south metro we are on target for our activity, so the activity that has been purchased from the state from south metro is being performed. Is it being performed where we might have anticipated or desired it to perform? Not necessarily [...]*²³

Two primary causes for Fremantle Hospital's under-utilisation were identified during the hearings process. The first relates to the challenge of moving patients from one hospital's waiting list to another:

*There is a lot of administrative burden in doing that. We do have the central referral service, which refers stuff directly down there, but obviously if people have been waiting on the waitlist for a long time, you would like to move them, and clinicians do have an ownership about their patients. They might have been looking after them for some time and that patient might have been going to Royal Perth, or whichever other hospital, for some time, so there is a process to move each and every one of those, and that takes time.*²⁴

The other has to do with the challenges associated with managing staff across multiple locations.

*One of the challenges comes about when you are splitting staff across so many sites and where they get pulled back to when there is sickness leave [...] and that creates an impact.*²⁵

Dr Robyn Lawrence, the Acting Chief Executive of SMHS, also explained that workforce availability was also having an impact on cementing Fremantle Hospital's new role as an elective surgery centre:

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- 22 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 17.
- 23 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 21.
- 24 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 19.
- 25 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, *Transcript of Evidence*, 14 October 2015, p. 21.

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*The challenge has been around re-establishing [...] elective flows. Part of that is workforce and having the workforce available to be at Fremantle as well as supporting FSH and supporting Royal Perth.*²⁶

Finding 2

To achieve the savings envisaged by establishing Fremantle Hospital as a low complexity, high volume site, patient flows to the hospital will need to be better managed as will the allocation of surgical resources.

There are cost implications

Paying for an under-utilised asset in a system experiencing significant pressure to reduce costs is unsustainable in the longer term. Under the SMHS reconfiguration, Fremantle Hospital was intended to become a general surgery specialist. As a non-tertiary facility, Fremantle Hospital costs less to operate than RPH or FSH:

*Ideally, you want to get your high-volume, low complexity stuff together. That was the concept of Fremantle, so for a better price, you would get more patients done, essentially.*²⁷

Unfortunately, more elective surgery is taking place at RPH than had been planned for, leaving Fremantle Hospital under-utilised.²⁸ SMHS' senior leadership acknowledges that it will need to ensure that the activity shifts back to Fremantle Hospital away from RPH, but there was also acknowledgment that it was possible that there was 'too much general surgery capacity' and that there was a 'need to bring it down'.²⁹

The introduction of FSH into the SMHS health system should result in lower costs overall and a more efficient mode of health service delivery for two important reasons. Firstly, because new health facilities tend to be cheaper to operate than older infrastructure and, secondly, because the capacity introduced by FSH enables a reconfiguration of service delivery that allows appropriate care in the appropriate setting at an appropriate cost. This is consistent with the principles established in the Reid Review.

The challenge for the Department in coming years will be to ensure that service delivery models can be established that take advantage of the efficiencies that potentially exist following the introduction of FSH. In particular this means ensuring

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- 26 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 17.
27 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 18.
28 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 21.
29 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 23

that surgical activity is taking place at the right hospital given the level of care needed. This is a challenge that the Department acknowledges; to that end, Dr Lawrence told the Committee that she would like 'to see some ongoing rearrangement of our services so that we can get them in a cost-effective manner in the right place.'³⁰

The Inflammatory Bowel Disease Unit

Fremantle Hospital was the location for the Inflammatory Bowel Disease Unit (IBDU), which was a specialist service that sat within the gastroenterology service. The IBDU employed three nurses for a total of 2.3 Full Time Equivalent (FTE) staff, including one full time specialist nurse coordinator, a 0.7 FTE research nurse and a 0.6 FTE nurse responsible for coordinating patient education and follow-up treatment, including Pharmaceutical Benefits Scheme (PBS) coordination. The Department's internal documents reveal awareness that the PBS coordination role would save FSH pharmacy approximately \$4.3 million each year via directing patients to the PBS scheme.

The funding for these nurses was sourced from clinical research moneys, which meant that the positions were not included in the nursing 'workforce build' for FSH.

Furthermore, in a briefing prepared for the Minister for Health, the Department reported that:

*A significant portion of the [IBDU nurses'] work was administrative, non-nursing functions. This was partially the impetus for a gastroenterology [clinical nurse specialist]. Whilst their skills are indeed invaluable, in a financially constrained ABF environment, FSH needs to ensure resource allocation is appropriate and evenly distributed.*³¹

Eventually, in recognition of the cost savings associated with pharmacy services, the 0.6 FTE nurse that had been coordinating PBS activities was offered a six month contract at FSH. The view offered by the Department in internal briefings was that the newly created Gastroenterology Clinical Nurse Specialist would be:

*instrumental in ensuring that the appropriate paperwork is completed for PBS medications, in collaboration with the Pharmacy Department, in addition to ensuring oversight for those patients that require admission to the day medical procedures unit.*³²

On 14 January 2015, the Minister for Health signed a briefing note containing the quote above with the instruction that the Department 'ensure that the quality of service is

30 Dr Robyn Lawrence, Acting Chief Executive, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 21.

31 Department of Health, Briefing Note to the Minister for Health, 2 December 2014, p. 2.

32 Department of Health, Briefing Note to the Minister for Health, 9 January 2015, p. 2.

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not diminished'.³³ Finally, in April 2015, in response to an update on the IBDU at FSH, the Minister instructed the Department that:

*I require this unit be returned to its former standard, noting that there are now additional patients from RPH. I am also of the view that a specific IBD unit be re-established.*³⁴

The Department provided the Committee with updated staffing numbers for the service:

Table 2.2: Current IBDU structure at Fiona Stanley Hospital³⁵

Role	FTE
Acting Clinical Nurse Specialist	1.0
Clinical Nurse	0.6
Clinical Nurse	1.0
Administrative Assistant	1.0
Clinical Research Nurse	0.475
Total FTE	4.075

Patient bookings following the shift of patients to Fiona Stanley Hospital

The Committee is aware of a number of instances where patients were left confused or otherwise unsatisfied by the process of transferring their outpatient care from RPH or Fremantle Hospital to FSH. This was an issue examined in some detail in the *Review of operational clinical and patient care at Fiona Stanley Hospital* by MMK Consulting and the Australian Commission on Safety and Quality in Health Care (the Operational Review). In particular, the Operational Review highlighted instances where patients and their records and booking information were lost in the system. The Operational Review noted that these complaints were corrected following subsequent visits, suggesting that the problems were a consequence of the early challenges associated with the commencement of operations at the hospital.

It is also important to note that, as originally envisaged, Serco was to have provided all scheduling services at the hospital, including bookings for outpatient services and elective surgery theatre appointments. In April 2014, the decision was made to bring those services back 'in house' in order to 'ensure that the quality of patient care is maximised' and to enable WA Health to 'deliver a truly seamless healthcare experience'.³⁶ Although the reasoning may have been sound, there have clearly been difficulties with the process following the decision to provide the service in house. Given that the decision to carry out these services directly was only made in April 2014,

33 Department of Health, Briefing Note to the Minister for Health, 9 January 2015, p. 3.

34 Department of Health, Briefing Note to the Minister for Health, 9 January 2015, p. 3.

35 Submission No. 17 from the Department of Health, 14 October 2015, p. 15 (Attachment B).

36 Submission No. 17 from the Department of Health, 14 October 2015, p. 12 (Attachment B).

it is not difficult to imagine that many of the problems subsequently encountered have been as a result of the lateness of the decision relative to the hospital's opening date.

The Committee sought further information on how the Department had responded to these concerns and the recommendations contained in the Operational Review. The Department told us that:

- FSH has undertaken a review of outpatient booking processes to maximise the timeliness of notifications.
- FSH is monitoring Did Not Attend (DNA) rates, identifying trends and developing further strategies to decrease the number of outpatient DNAs.
- FSH is continuing to refine outpatient booking arrangement to accommodate urgent referrals.
- FSH is currently reviewing the supervision of the procedural waitlists to ensure compliance with relevant WA Health Operational Directives.
- South and North Metropolitan Health Services are reviewing the need and feasibility of shared on-call rosters either within SMHS tertiary hospitals or across the metropolitan area with RPH and SCGH.³⁷

Patient records following the shift of patients to Fiona Stanley Hospital

The Operational Review also raised concerns about the transfer of patient records from existing hospitals to FSH, particularly for those patients receiving cancer treatments. Similar – though more damningly expressed – concerns about oncology patient records were also raised in the *2015 WA Adult Cancer Taskforce Report* (the Cancer Report):

*This has resulted in fragmented patient care, patients not receiving timely adjuvant treatment and very poor access to patient records resulting in numerous clinical incidents - no patient notes when a patient comes to theatre, no information available for the MD [multi-disciplinary] team meeting discussion, no information of prior chemotherapy treatment when attending for therapy, very frequent lack of notes available when a patient attends outpatient clinics. In addition, considerable expensive and scarce specialist time is being inefficiently utilised to try to manage this situation.*³⁸

In response, the Department told that the Committee that the problems were mostly a result of the initial transfer of patients to FSH from other hospital sites. When

³⁷ Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment B).

³⁸ Report of the 2015 WA Adult Cancer Care Taskforce, 16 June 2015, p. 5

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outpatient services at FSH initially commenced the paper medical record and paper referral were required in order to see previous patient treatment. If the paper record was not available at that time, then the treating clinician had only limited information on which to base his or her consultation. The Department assured the Committee that, over time, as patients have been seen at FSH, the required information has become available within the digital medical record at FSH.³⁹

The Department acknowledged that there were delays in transferring patient records from originating sites due to the volume of transferring patients and that on some occasions the records were not available when patients presented for scheduled appointments.⁴⁰ According to the Department, measures were implemented to remedy the situation including onsite storage for complex patients with chronic conditions, timelier file requests and review of upcoming clinic lists to ensure records had been received in advance.

Although the Department has assured the Committee that significant improvements were seen within a month of opening as a result of the remedies, many of those remedies seem like processes that should have been in place ahead of the hospital's opening. Similarly, the Department should have had some idea of the volume of transferring patients as they were individuals already in the system receiving treatment at other sites. Adequate resources therefore should have been made available to ensure that the volume of transferring patients did not swamp the capacity of the records transfer process. It does seem, again, that the late decision to remove some clerical services relating to patient records and bookings from Serco back to the Department may have had an impact on the level of preparedness for the hospital once it opened. The Health Services Union (HSU) reported to the Committee that:

Just prior to the hospital opening, the Serco contract was altered to move some ward clerk and other like clerical positions out of the scope of Serco and back into health scope. Because that happened quite close to the opening of the hospital, there were no processes or systems established for those staff when they started in their roles, and they are moving from an environment where a particular set of technology and services were provided, to a new technology environment with absolutely no processes or systems. Things like referral processes from one specialist service to another were entirely broken, initially.⁴¹

39 Submission No. 17 from the Department of Health, 14 October 2015, p. 10 (Attachment B).

40 Submission No. 17 from the Department of Health, 14 October 2015, p. 10 (Attachment B).

41 Ms Melissa Wagner, Senior Organiser, Health Services Union of Western Australia, *Transcript of Evidence*, 23 September 2015, p. 12.

Finding 3

The transfer of patient records following the opening of Fiona Stanley Hospital was poorly managed by the Department of Health and put patients at risk.

Recommendation 1

That the Minister for Health provides an update on the status of the transfer of medical records for patients attending Fiona Stanley Hospital from other hospitals in Western Australia.

The Digital Medical Record generally

During the course of the inquiry, the Committee has received various reports about the effectiveness of the Digital Medical Record (DMR) system in use at FSH. On the one hand, the AMA told the Committee that that the DMR had '[caused] a significant reduction in efficiency [...] and it does not interface, as it is installed now, with the other applications, and it frequently crashes or freezes on users.'⁴² The HSU the following information about the DMR:

*We have outer hospitals unable to receive medical records electronically because they are not operating on the same systems. Even within Fiona Stanley, we are told that the patient record created within the intensive care unit cannot simply be sent to the ward when a patient is transferred. It then requires a manual intervention in terms of creating that record and getting it to the ward.*⁴³

The Operational Review expressed concerns about the general lack of integration of the DMR system; currently not all of the relevant records are accessible through the DMR software (known as BOSSnet) and must instead be accessed through separate windows and tabs. Of more particular concern was the reported length of time required to load the various pieces of software required for admitting patients or, in an outpatient setting, to manage a patient's notes.⁴⁴

There is considerable variability in the commentary provided to the Committee about the effectiveness of the DMR system. For example, the Department provided the Committee with a response to the concerns raised at hearing by the AMA. The Department reported that:

BOSSnet (also referred to as the DMR) has been delivering significant benefits including the visibility of medical records across FSH

⁴² Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 2.

⁴³ Mr Dan Hill, Secretary, Health Services Union of Western Australia, *Transcript of Evidence*, 23 September 2015, p. 4.

⁴⁴ Review of operational clinical and patient care at Fiona Stanley Hospital, p. 28.

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*(simultaneously by multiple users) and other sites (the record can be read at [Fremantle Hospital] and RPH), notes are legible, date and time accurately recorded and access to the record is auditable.*⁴⁵

Other witnesses, however, told the Committee that the medical records were not accessible at other hospitals. This does seem to be another example of an issue where the expectations on either side are not in alignment. The Committee understands that medical records are accessible at the other major hospitals in SMHS, but that smaller general hospitals do not yet have access. Similarly, no hospital in the North Metropolitan Health Service is able to electronically access a medical record created at FSH. In many respects, the approach taken by the Department in this instance is entirely reasonable – given that FSH must operate in coordination with the other major hospitals in SMHS, the decision to limit DMR access to those major hospitals is appropriate given the limitations of time and resources encountered in the lead-up to FSH’s opening. Ideally, the medical record system would be rolled-out across the State, but the reality of limited budgets and IT capabilities means that the solution so far implemented is appropriate in the circumstances.

The Committee certainly expects to see the DMR further rolled-out across all health services in Western Australia in order to further improve the quality of patient care and efficiency in the health system. It is not clear whether or not the BOSSnet DMR will be rolled-out to other sites or whether it will remain solely in use at FSH.

Recommendation 2

That the Minister for Health report to the Parliament on the adoption of digital medical record (DMR) systems, including BOSSnet, across the rest of the health system, including (as at the time of the response):

- The extent to which DMR has been adopted in other Western Australian hospitals;
- The extent to which a DMR created at Fiona Stanley Hospital is updatable, useable, or otherwise accessible by or for other public hospitals in Western Australia; and
- The timeline and estimated cost for rolling-out a DMR system at other tertiary and general hospital sites in Western Australia.

Although the DMR system would clearly benefit from further integration, it is clear that the system as it currently exists is a vast improvement compared to existing paper-based systems. It is the Committee’s understanding that improvements to BOSSnet’s level of integration have taken place since the system first went live, and that a number of documents now publish directly into the medical record including discharge

⁴⁵ Submission No. 16 from the Department of Health, 23 September 2015, p. 3.

summaries, ProcRep, Cardiobase and eReferrals.⁴⁶ The Committee witnessed this first-hand during a tour of the hospital and accompanied a number of clinicians on ward rounds using ‘workstations on wheels’ in order to access patient information – including radiography and other imaging scans – directly at the bed side. Furthermore, the DMR is not a static build; it will experience progressive upgrades that should address many of the early concerns so far expressed. The most recent upgrade was scheduled to occur in mid-October 2015 and should have resulted in the ability to copy from PDF files in other applications and then paste directly into BOSSnet.⁴⁷ A simultaneous upgrade was intended to address an issue that reportedly accounts for at least 70 per cent of the incidents reported for BOSSnet—namely problems arising from print requests for radiology.⁴⁸

The DMR system’s reliability has also been the source of some concern. Given the technical nature of the issues involved, the Committee is not in a position to provide definitive commentary on the matter; however, it is important to place on the public record the Department’s response to these complaints:

*Issues with the network and infrastructure at FSH, managed by Serco/ BT have impacted the performance of BOSSnet and have resulted in often inaccurate reports of BOSSnet failure. These issues also impact the performance of BOSSnet DMR which again results in negative reports from clinicians.*⁴⁹

The Department also provided the Committee with the following information about the 40 BOSSnet failures experienced since 1 January 2015:

- 10 related to the radiology print function mentioned above
- 4 related to servers
- 11 related to storage space meeting capacity
- 2 issues which ‘resolved themselves’ – either user or network issue on site at FSH
- a user tried to print an exceptionally large report
- issue was with remote access not BOSSnet
- 1 caused by Windows patching
- 2 issues from HIH impacting BOSSnet

46 Submission No. 16 from the Department of Health, 23 September 2015, p. 3.

47 Submission No. 17 from the Department of Health, 14 October 2015, p. 9 (Attachment B).

48 Submission No. 17 from the Department of Health, 14 October 2015, p. 9 (Attachment B).

49 Submission No. 17 from the Department of Health, 14 October 2015, p. 9 (Attachment B).

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- 2 related to DC1 issues
- issues were related to BOSSnet partition control
- 3 related to non-Production (test) environments⁵⁰

Finding 4

The Digital Medical Record in place at Fiona Stanley Hospital represents a significant improvement on existing paper-based records systems. Ongoing upgrades will help to address some useability issues, including the level of integration with other clinical Information Technology systems. As user familiarity improves the Committee expects increased acceptance of the system by clinical users.

Electronic discharge summaries

During the early stages of the inquiry, the Committee was approached by Mr Philip Olsen who reported to the Committee the circumstances surrounding the death of his son, Jared, following treatment for an Inflammatory Bowel Disease related complaint at FSH. The Committee greatly appreciated Mr Olsen's willingness to come forward and share his story. The Committee advised Mr Olsen that it would be unable to investigate the individual circumstances surrounding his son's death, although the Committee was interested in any systemic issues that had been uncovered. As the circumstances surrounding Jared's death will be the subject of a coronial inquiry, the Committee will limit its commentary to an issue relating to the electronic discharge summary produced by FSH upon Jared's discharge.

In Jared's case, the summary contained important information about the necessity for additional blood tests to be carried out in order to confirm that the drugs Jared had started taking in hospital were not toxic to him. Unfortunately, FSH's database had the wrong address for Jared's doctor, meaning that the discharge summary never arrived anywhere and Jared's doctor was never able to follow-up with him the importance of having that second round of blood tests.

The Department told the Committee that there is no capacity in the electronic discharge summary system to receive a 'delivery receipt' once a discharge summary has been sent. This means that the clinician generating the summary has no means of confirming whether it has reached its destination. As Jared's case demonstrates, discharge summaries will often contain important information about the continuing care needs of those discharged from the hospital. The Department told the Committee that there is no system currently in use in Australia that provides the type of delivery receipt that may, in some cases, prove the difference between life and death.

50 Submission No. 17 from the Department of Health, 14 October 2015, p. 10 (Attachment B).

The promise of technology in the health care system must be that it can help to improve outcomes for patients. Merely replacing the traditional mail-based delivery of discharge summaries with its electronic equivalent does not improve patient outcomes, especially when the additional functionality available in electronic systems, such as delivery receipts, is not incorporated.

Finding 5

The Committee is of the view that relying upon hardcopy distribution to the patient of the discharge summary is insufficient as a failsafe and that the Department should have internal systems of their own to ensure that treating clinicians receive discharge summaries.

Recommendation 3

That the Department of Health implement an upgrade to the Notification and Clinical Summaries (NaCS) application and the Clinical Governance Management System (CGMS) to provide for a delivery receipt or other similar notification upon the successful delivery of a discharge summary to the receiving clinician or their office.

The Intensive Care Unit Clinical Information System

The AMA reported that there had been significant difficulties with the implementation of the Intensive Care Unit's (ICU's) Clinical Information System (CIS), whilst the HSU indicated that the ICU CIS was not compatible with the systems in use on the general wards. According to the HSU, this meant that patient's records must be printed and scanned when they transfer from the ICU to a general ward. The system does not currently provide the ability to export ICU medical records to BOSSnet, although this is an upgrade that is being considered. This manual paper-based process was confirmed to the Committee during its visit to the hospital.

An ICU treats critically ill patients who have the highest dependency on medical devices and staff resources. Treatment of patients is time critical and dependent on the assimilation of multiple data outputs at the bedside in order to constantly regulate, moderate or monitor treatment. In this unique environment, intricately calibrated medical devices are necessary to manage and monitor critically ill, often unconscious patients. Vast amounts of clinical information and physiological data are collected and, in traditional hospital settings, transcribed manually onto paper charts from medical devices, computer monitoring systems and other hospital databases (e.g. laboratory and radiological) to support clinical decision making. It is estimated that ICU clinicians manage 1,700 measurements a day for an average patient, as opposed to 32 measurements a day for an average ward patient.

Manually transferring this amount of clinical information, fundamental to safe and effective patient care, to a paper based record system, is time consuming and can

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result in illegible entries, transcription and omission errors and incomplete clinical records. Implementing an electronic solution to this process is therefore clearly of significant clinical benefit and allows for the introduction of efficiencies in the delivery of care.⁵¹

The Committee spent an extended period of time discussing the ICU CIS with clinicians in the ICU on its tour of the hospital. It was clear that the system had introduced significant improvements, although there was acknowledgement that the system's roll-out had been more difficult than anticipated. The Committee was particularly impressed by the ability of consultants to log-in to the system from home in order to monitor physiological parameters in real-time from an external location. This should obviously reduce the requirement for out-of-hours call outs for ICU consultants.

The Closed Loop Medication Management System

Closed Loop Medication Management Systems (CLMMS) involve a clinical system that includes electronic prescribing, automated medication units at ward level, smart carts for administration of medicines and an electronic medication chart. Automated medication units at ward level are linked to the pharmacy information system and may also be linked to a robot that stores and picks the drugs in the pharmacy. Automation allows hospitals to track drug usage and improve safety through bar-coding and decision support. It also reduces theft and the need for manual recording of transactions for S8 and S4R drugs.⁵²

CLMMS was an area that the Committee reported on quite extensively in its earlier inquiry into the commissioning of FSH. This was primarily because a range of documentation made available to the Committee as part of that inquiry made it clear that delays in making a decision about CLMMS contributed to the overall delay in opening the hospital. Ultimately, FSH did not open with CLMMS in place; however, the system is expected to go live through the remainder of 2015 and into 2016.⁵³ It was not implemented at the time of hospital opening because it was felt that implementing the process changes necessary whilst simultaneously opening the hospital would have introduced unnecessary clinical risks.⁵⁴

The Operational Review reported that a number of patients had complaints about the length of time required in order to receive pharmaceuticals on discharge.⁵⁵ The

51 Preceding paragraphs adapted from: Department of Health, Internal Memorandum prepared by Mr Alan Piper for MS Nicole Feely, 1 June 2012.

52 Preceding paragraph adapted from: Department of Health, Internal Memorandum prepared by Mr Alan Piper for MS Nicole Feely, 14 June 2012

53 Submission No. 17 from the Department of Health, 14 October 2015, p. 2 (Attachment B).

54 Dr Hannah Seymour, Medical Co-Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 14 October 2015, p. 18.

55 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 11.

Committee initially considered whether these delays were as a result of the failure to implement CLMMS at the hospital upon opening; however, in detailed answers to questions posed by the Committee it seems that the delays stemmed from multiple sources, including uncertainty involving prescriptions from patients transferring from other hospitals.⁵⁶ Additional staffing was also made available to manage pharmacy processes pre-automation.⁵⁷

Finding 6

The Department of Health acknowledged that higher than expected wait times for medications from the pharmacy would improve upon full implementation of the Closed Loop Medication Management System and other elements of the pharmacy automation system.

Recommendation 4

That the Minister for Health report to the Parliament regarding the status of the roll-out of the Closed Loop Medication Management System and the current wait times for dispensation of medication experienced by patients upon discharge.

Paging and Communications

The AMA told the Committee that '[the] out-of-hours team is often resorting to walkie-talkies, two-way radios, because the mobile system does not work, the duress system does not work, the paging system is down for repatching, rebooting et cetera.'⁵⁸

The HSU reported something similar, although it provided additional information about the nature of the mobile communications systems used by staff at the hospital:

*The staff at Fiona Stanley have phones that are somewhat like older style mobile phones and they require wireless connectivity if they carry with them. If they are not connected appropriately, the phone simply does not ring, so it rings out if you are trying to ring somebody, which is problematic in a hospital setting.*⁵⁹

The problems with the pagers are separate from the widely reported existence of a mobile phone black spot within the hospital. The pagers and other internal communications devices given to staff run on the internal FSH network, and do not require connection to a GSM mobile network to operate.

56 Submission No. 17 from the Department of Health, 14 October 2015, p. 4 (Attachment B).

57 Submission No. 17 from the Department of Health, 14 October 2015, p. 4 (Attachment B).

58 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 6.

59 Ms Melissa Wagner, Senior Organiser, Health Services Union of Western Australia, *Transcript of Evidence*, 23 September 2015, p. 4.

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In August 2014, a 'gateway review' identified potential problems with the hospital's network infrastructure, in particular its ability to support the number of devices that would be active across the campus at any particular time. Given that the paging system relies upon the Wi-Fi network, any potential weaknesses would have a detrimental impact upon communications across the site. In response to the findings made in the gateway review, the Department commissioned an independent consultant to review the system and a number of recommendations have subsequently been implemented in order to ensure that the system is more robust than it would otherwise have been.⁶⁰

In relation to the use of two-way radios during outages, the Department reported that:

- *Interruptions to any software or hardware that supports the delivery of the paging service to notify and activate the Medical Emergency Team (MET) response is managed through the deployment and use of hand-held two-way radios. In circumstances where the paging service is offline, the Medical Emergency Team members are individually notified by mobile phone and requested to attend to pick up a two-way radio. Whilst the paging service experiences any interruption, the MET Team are activated and managed via the two-way radio. It is critical for any hospital to have backup for paging down time.*
- *Two way radios allow all members of the MET team to be advised of an emergency at the same time.*⁶¹

Recommendation 5

That the Minister for Health report to the Parliament on the reliability of the paging system in use at Fiona Stanley Hospital for the three month period following the tabling of this report, including:

- The uptime of the system;
- The dates, times and lengths of any outages;
- The extent of the outages (i.e. localised to individual departments or hospital-wide); and
- The abatement and/or failure points incurred by Serco as a result of any outages.

⁶⁰ Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

⁶¹ Submission No. 16 from the Department of Health, 23 September 2015, p. 4.

Reliability and stability of ICT applications

The AMA raised concerns with the Committee about the reliability and stability of ICT applications at the hospital. In particular, concern was expressed in relation to the frequency of outages and the limited notice given prior to the commencement of planned outages.⁶² The ICT environment at FSH is complex and is managed jointly by Serco and its subcontractors (principally British Telecom (BT)) and the Health Information Network (HIN).

Serco is responsible for providing all ICT equipment behind FSH's outer firewall, including:

- Servers (application, database, web and file and print);
- Storage and backup systems;
- Desktop/laptop/thin client PCs;
- Mobility devices (smartphones, tablets and Cisco paging);
- Multi-function devices (including printers);
- FSH corporate Wi-Fi networks;
- Corporate IP Telephony system;
- Corporate audio visual and Patient Entertainment System infrastructure and devices; and
- Real Time Location Services network infrastructure and devices.⁶³

The Department's responsibility extends to providing the corporate network that connects FSH to the wider Health network in addition to all of the clinical applications needed in the hospital including BOSSnet, WebPAS, etc.⁶⁴

In its response to the AMA's evidence, the Department reported that:

[Serco] has FSH application uptime targets of 99.8% for Class A, 99.5% for Class B and 98% for Class C applications. These performance targets have only been breached for an application three times since

62 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 3.

63 Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

64 Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

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*October 2014 – with all these breaches occurring early in the period since opening.*⁶⁵

There is evidence, however, that the Department was unhappy with the level of ICT service being provided by Serco in the period up to May 2015. When asked about this, the Department told the Committee that:

*The State considers that the ICT service is being provided by the FM at a satisfactory standard and whilst there were some availability challenges in early months, the last three months (June '15 – August '15) has seen no Service Failure Points incurred with regard to non-clinical applications.*⁶⁶

The Department also provided a lengthy explanation for some of the difficulties associated with the implementation of the ICT systems at the hospital:

*As background, ICT at FSH was a greenfield environment four years ago and in that time, an ICT capability has been built that supports some 5,000 users and 6,500 devices. Of the many complexities in developing a greenfield facility, an initial hurdle in the early stages was identifying and establishing relationships with key stakeholders and ICT delivery partners such as Health Information Network (HIN). The issue was compounded by the fact that FSH was reliant on HIN for access to the DoH WA corporate network and systems, along with access to clinical applications for installation, testing and user provisioning purposes. It also became clear during the build and test phase of ICT at FSH, that systems weren't performing to design specification for reasons such as increased loads and volumes above the forecasted levels which was a shared responsibility of the FM, various ICT vendors, FSH ICT and HIN (to some degree) to resolve.*⁶⁷

The Department has acknowledged that there are a number of ICT project initiatives that remain outstanding, although these projects are 'being managed through to successful implementation'.⁶⁸ On the question of Serco's overall performance, the Department expresses the view that:

The FM has progressively improved their performance in running ICT now that the hospital has moved into the operational phase and given

65 Submission No. 16 from the Department of Health, 23 September 2015, p. 5.

66 Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

67 Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

68 Submission No. 17 from the Department of Health, 14 October 2015, p. 13 (Attachment A).

*there are less project initiatives and associated changes impacting ICT systems.*⁶⁹

The answer is entirely consistent with the notion that the performance of Serco was not especially sound in the early periods following the hospital's opening, but that it has improved since.

Finding 7

The Committee is of the view that the problems encountered with the Information and Communications Technology systems at Fiona Stanley Hospital were a direct consequence of the scheduling and project management problems experienced in the lead-up to the opening of the hospital. The Department of Health has attempted to recover the time lost due to these schedule failings, but have not been able to avoid:

- Delays to the hospital commissioning;
- Increased costs; and
- Problems with the interface between the service providers.

The Committee sought information about the impact – if any – on clinical activities at the hospital arising from ICT failures or under performance. In relation to Serco's performance, the Department reported that 'the State considers this unlikely, given many of the ICT Key Performance Indicators (KPIs) reflect a positive, stable and consistent level of ICT service.'⁷⁰ However, the Department's comment in relation to the performance of HIN provided ICT services was less reassuring:

*FSH has been impacted a number of times over recent weeks by Department of Health managed clinical ICT systems which may have potentially impacted clinical services.*⁷¹

Unfortunately, the Department did not provide additional information about the problems or their potential impact upon clinical care in its response. Given the nature of the Committee's question, it would have been of greater assistance if the answer had outlined the nature of the ICT problems that were impacting on FSH and whether they were impacting upon the delivery of clinical services.

It is entirely possible that the problems encountered were minor, and that their impact on clinical service delivery was insignificant, but the answer in no way assures the Committee that this is the case. It is representative of an approach that the Committee commented on its earlier FSH report; namely, the provision of materially relevant

69 Submission No. 17 from the Department of Health, 14 October 2015, p. 14 (Attachment A).

70 Submission No. 17 from the Department of Health, 14 October 2015, p. 14 (Attachment A).

71 Submission No. 17 from the Department of Health, 14 October 2015, p. 9 (Attachment B).

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information – whether it is to the Minister, this Committee or Parliament more generally – should not be reliant upon the receipt of the ‘right’ questions from the requesting body.⁷² The Committee’s intent was clear given the nature of the question and its context within this inquiry examining the transition to and operation of services at the hospital.

Finding 8

The Committee was concerned that the Department of Health did not always provide materially relevant information in the answers to some of the questions put to it regarding the performance of the Information and Communications Technology systems at the hospital.

⁷² The Committee discusses the provision of information to responsible Ministers and the existence of information asymmetry between Ministers and their agencies at pages 101 and 102 of its report *More than Bricks and Mortar*.

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Serco Services

Ensuring value for money

The decision to award Serco the contract to provide non-clinical services at FSH has attracted significant controversy since the contract's announcement in 2011. Much of the discussion has been underpinned by differing philosophical and political positions relating to the appropriateness of contracting-out arrangements. The Committee is obviously aware of these views, but this inquiry is not a broader examination of the role or effectiveness of the delivery of public services by the private sector. Instead, when it comes to Serco's role at FSH, the Committee has been solely focussed on two key elements:

- Whether Serco is delivering services to the standard required of them under the contract; and
- Whether the Department, in its management of the contract, is enforcing Serco's contractual obligations via close monitoring of the company's performance.

In the United Kingdom, that country's national audit office observed that contractors will 'seek to pass risk back to the taxpayer if [agencies] do not meet their obligations or enforce the contract'.⁷³ Ensuring that value for money is achieved for the State and taxpayers will therefore depend almost exclusively on the Department's performance in managing the contract.

The contract upon signing was estimated to be worth \$4.3 billion over 20 years. Given the change in the number of services and other contract variations, the Committee sought an update on the current value of the contract and estimated savings. In response, the Department reported that a 'full revision of the Estimated Contract Value cannot be accurately completed at this point of time'.⁷⁴ In response to the same question, Serco told the Committee that the revised estimated total value of the contract for the first 10-year period was \$1.35 billion.⁷⁵

The Department has budgeted \$164.8 million for the 2015–16 financial year as the estimated cost of the contract with Serco. It should be noted that in 2011 Serco

⁷³ UK National Audit Office, *Performance and Management of Hospital PFI Contracts*, June 2010, p. 29.

⁷⁴ Submission No. 18 from the Department of Health, 5 November 2015, p. 1.

⁷⁵ Submission No. 19A from Serco, 10 November 2015, p. 1.

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reported that its annual revenue from the full operation at the hospital would be \$160 million; this was before the loss of some services from the contract.

During the course of the inquiry, the Committee was made aware of a number of areas of potential shortfall in terms of Serco's performance. The information was either provided by FSH stakeholders in evidence to the inquiry or as a result of the internal reporting that the Department made available to the Committee. Where these potential shortfalls were deemed sufficiently serious, the Committee raised them directly with the Department. The following pages contain a brief summation of the outcome of that process for several of the services provided by Serco.

Portering

What are porters?

At FSH the movement of patients around the facility is a service provided by Serco under its Internal Logistics management role. The Internal Logistics Service Specification requires Serco to 'transport patients around the site', including:

- (1) escorting ambulant Patients throughout the Hospital; and*
- (2) by using Internal Transport Equipment that is appropriate given each Patient's individual health requirements and status,*

In a manner that:

- (i) is courteous and polite;*
- (ii) ensures each Patient's health and medical care is not compromised;*
- (iii) respects the dignity and privacy of each Patient; and*
- (iv) is culturally appropriate to each Patient.⁷⁶*

In addition to the movement of patients, the Internal Logistics Service is also responsible for the movement of materials around the hospital site. Materials can include pharmacy items; patient X-ray films and other results; portable medical equipment and furniture and other equipment. Some materials, including catering and linen, are also moved around the site autonomously via automated guided vehicles.⁷⁷

Serco employees engaged to provide these internal logistics services are known as porters. The role of porter is new to WA Health and is unique to FSH. The position has essentially been imported from Serco's operation of hospital services in the United

⁷⁶ Submission No. 17 from the Department of Health, 14 October 2015, p. 1 (Attachment A).

⁷⁷ Submission No. 17 from the Department of Health, 14 October 2015, p. 1 (Attachment A).

Kingdom. In other public hospitals within Western Australia most, but not all, functions of a porter are carried out by Orderlies or Patient Care Assistants (PCAs). The role of porters at FSH, however, is distinct because porters are considered to undertake a non-clinical role, whereas Orderlies and PCAs (in particular) may play a role in patient care through limb holding or turning.

The role of porters at Fiona Stanley Hospital

It was of some concern to the Committee that there appeared to be considerable confusion over the extent to which porters employed at FSH could ‘touch’ patients given their limited and expressly defined non-clinical role. The Operational Review reported that ‘[t]he contract with Serco did not allow for porters to physically touch patients’.⁷⁸ It went on to state:

*[g]iven that a significant part of a porter’s role is transferring patients to and from beds, chairs, wheelchairs, operating theatre tables and so on, this created a major difficulty for the hospital to overcome. FSH has subsequently employed 120 Assistants-in-Nursing and Serco has added 70 additional porters to meet the hospital needs.*⁷⁹

The Committee in its early hearings with unions and the AMA sought to confirm whether this was the case. In closed session with United Voice it was suggested to the Committee that whether porters were permitted to touch patients was somewhat of a grey area. This appeared to be supported by evidence given to the Committee by the AMA:

Mr R.F. JOHNSON: ...I find it absolutely extraordinary that porters-cum-orderlies are not allowed to touch patients, to be able to move them from a wheelchair into a bed, or a bed into a wheelchair, or even hold up their arm up or something like that. They are not allowed to touch them. Is that —

Dr Jenkins: That is correct. Essentially, they are not meant to touch them in the ordinary course. Obviously, if there was an emergency they would, like any other citizen, but that is correct.⁸⁰

The Committee’s concern was that the perceived prohibition on porters touching patients had resulted in the employment of additional Assistants-in-Nursing in order to

78 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 26.

79 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 26.

80 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 9.

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assist with tasks which had traditionally been carried out by orderlies at other public hospitals. This was articulated in the Operational Review, which found:

*Clinical staff reported instances where 3 individuals were each required to perform task such as moving a patient from theatre and cleaning the theatre floors that in other jurisdictions would be performed by only 1 person.*⁸¹

The Committee, on its tour of FSH, asked various clinical staff, as well Serco managers and employees, whether porters were permitted to touch patients. The answer varied; some clinicians reported that porters could touch patients whilst some reported the opposite; Serco management and staff, however, confirmed that porters were permitted to touch patients.

In following up this issue, the Committee wrote to the Department posing this question and was advised that:

*[p]orters are not prohibited to touch patients. There are specific patient handling procedures such as pressure care rounds, which involve the regular turning of non-ambulant patients in order to reduce their likelihood of developing pressure sores. These types of patient handling procedures were considered to be a clinical function during the development of the FMSC.*⁸²

In a Committee hearing with the Minister for Health the minister further confirmed that porters were permitted to touch patients:

*In the area of portering, this issue of touching patients [...] they are allowed to help move them, for example, off a chair, off a trolley and onto a chair. They are allowed to physically touch them, but what they are not allowed to do is help with the movement of limbs or turning patients within a bed. That work is the area of the assistants in nursing.*⁸³

It therefore appears that there is some level of confusion within FSH over this issue. It is possible that the confusion arises from the fact that porters are new roles in the WA public health system. Comments from Dr Ian Jenkins of the AMA highlight the cultural change needed in order to fully integrate the portering role into the health care model at FSH. Dr Jenkins told the Committee that 'at Fremantle we had the same orderlies for

81 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 26.

82 Submission No. 17 from the Department of Health, 14 October 2015, p. 2 (Attachment A).

83 Hon Dr Kim Hames, MLA, Deputy Premier; Minister for Health; Tourism, *Transcript of Evidence*, 14 October 2015, p. 12.

20 years [...] they cleaned the floors, made the beds, they knew about the hygiene we needed in intensive care'.⁸⁴ Obviously, the porters will not be in a position to offer such multi-role assistance given the nature of their contractually stipulated roles.

Performance of Porters

Media reporting in February 2015 suggested that a shortage of porters was creating delays in the transfer of patients, with reports that some doctors were required to collect their own patients.⁸⁵ The Minister confirmed to the Committee that 'there were aspects of the employment of Serco that have proved challenging [...] particularly the sterilisation component and, to a lesser extent, the portering component'.⁸⁶

Furthermore, the internal reporting provided to the Committee by the Department seemed to confirm that there were problems with the performance of the portering service. A Portering Project Board consisting of Serco and the Department representatives was established in March 2015 because:

*The Internal Logistics Service experienced some challenges following the Phase 3 opening of the hospital on 3rd February 2015 that impacted on the timely delivery of the Service. This resulted in a joint (State and FM) Project Board being established to provide a central point to manage the issues through to their conclusion, improve work flows and delivery times and provide ongoing education and change management to the wider hospital staff.*⁸⁷

According to the board's terms of reference its aim was to provide:

oversight, governance and leadership of key aspects of the Portering Service during initial business as usual operations, to ensure that the service is delivered efficiently and effectively across all relevant areas. There will be particular focus on portering services provided to critical areas/functions, including (but not limited to) theatres, emergency department, pathology, wards and medical imaging.

84 Dr Ian Jenkins, Chair, Inter-Hospital Liaison Committee, Australian Medical Association, *Transcript of Evidence*, 19 August 2015, p. 8.

85 O'Connor, Andrew, *Serco faces \$60,000 bill for extra staff after equipment sterilisation delays at Fiona Stanley Hospital*, 25 February 2015. Available at: <http://www.abc.net.au/news/2015-02-25/serco-faces-bill-for-fiona-stanley-equipment-delays/6262874>. Accessed on 27 October 2015.

86 Hon Dr Kim Hames, MLA, Deputy Premier; Minister for Health; Tourism, *Transcript of Evidence*, 14 October 2015, p. 3.

87 Dr David Russell-Weisz, Director General, Department of Health, Letter, 14 October 2015, p. 3.

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*The Portering Project Board will place strong emphasis on the identification and management of key risks to patient safety and efficient service delivery.*⁸⁸

The Board ceased operation on 30 June 2015, by which time it had identified and resolved 73 key issues. The Department's internal reporting demonstrates that during the Board's operation it was able to oversight and improve on six areas of repeated failures from the FM relating to attendance times and completion times for emergency, urgent, planned and non-urgent requests. The reporting also shows that additional new porters were employed at FSH during this time in order to meet the level of demand.

Immediately following the commencement of phase 3 operations at the hospital in February 2015, Serco employed additional agency staff on a short term basis in order to meet early operational demands.⁸⁹ At hearing, Serco indicated that it had brought in an additional 50 staff across logistics, waste and linen in order to respond to the 'surge in early February when ED opened.'⁹⁰ Staffing levels have since reduced, but would seem to be above the initial levels available in February 2015.

Finding 9

Despite having a reduced range of functions in comparison to the orderlies found in other Western Australian public hospitals, 50 additional internal logistics staff were required to meet contract obligations and demand for services following the commencement of phase 3 operations in February 2015. Serco confirmed that, subsequent to a small reduction, the numbers remain above the initial staffing levels.

Recommendation 6

That the Minister for Health provide a report to the Parliament at quarterly intervals for the remainder of the 39th Parliament containing the number of internal logistics service staff employed by Serco at Fiona Stanley Hospital. The report should include:

- The number of permanent, casual or agency staff; and
- The role that the staff provide (i.e. waste management, portering, etc.).

The role of Assistants-in-Nursing at Fiona Stanley Hospital

In discussing the use of Assistants-in-Nursing (AINs) at FSH, the Operational Review used language that implied that 120 AINs had been employed arising from the

88 Dr David Russell-Weisz, Director General, Department of Health, Letter, 14 October 2015, p. 3.

89 Submission No. 17 from the Department of Health, 14 October 2015, p. 4 (Attachment A).

90 Mr Andrew Wheble, Operations Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 21.

limitations imposed by the prohibition against porters touching patients.⁹¹ On this issue, the Department informed the Committee:

*The employment of AINs was not in response to 'limitations imposed on the porters'. The recruitment of AINs was planned in the workforce build for FSH and the scope of the role includes assistance with routine patient handling procedures. AINs perform a key role across Fiona Stanley Hospital (FSH) and the wider Western Australian (WA) Health system.*⁹²

These comments were contradicted when the Committee received an internal briefing note from July 2013 which outlined interface issues between Serco and the Department. The Department provided the Committee with a workforce major issues brief dated 23 July 2013 which addressed the:

*Creation of permanent full time employees for ongoing employment of Assistants in Nursing at Fiona Stanley Hospital (FSH) to address workforce functional interface issues between current WA Health Staff and Serco provided services.*⁹³

The briefing confirmed that Serco employees would not be contracted to provide certain roles, including companions/static guards; turning teams; and patient positioning.⁹⁴ The briefing note then went on to outline the requirement to employ AINs in order to ensure that these roles were performed at the hospital.

The Committee understands from this briefing note that the Department only recognised that AINs would be needed once it realised there would be a service delivery gap due to the limited role that Serco's porters would undertake at the hospital. The Department understood that Serco was not contracted to undertake the roles of companions/static guards, turning teams and patient position staff. Approximately 137 FTEs were required across FSH to fulfil the role of AINs, with approximately 170 AINs requiring education and training to meet this requirement at an estimated cost of \$1.82 million.⁹⁵

Finding 10

Once the Department of Health realised the impact of Serco's portering model, which did not include all of the traditional orderly duties, Fiona Stanley Hospital was required to engage an additional 170 Assistants-in-Nursing staff. The Department of Health

91 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 26.

92 Dr David Russell-Weisz, Director General, Department of Health, Letter, 14 October 2015, p. 2.

93 Submission No. 18 from the Department of Health, 5 November 2015.

94 Submission No. 18 from the Department of Health, 5 November 2015.

95 Submission No. 18 from the Department of Health, 5 November 2015.

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estimated a cost of \$1.82 million to educate and train the Assistants-in-Nursing. Additional ongoing salary costs would also be incurred.

Recommendation 7

The Minister for Health reports to the Parliament the annual costs arising from the employment of Assistants-in-Nursing at Fiona Stanley Hospital.

Cleaning Services

Many of the initial submissions received by the Committee highlighted cleaning services at FSH as a particular area of concern. Media reports have suggested that there are concerns about infection controls and standards of cleanliness at the hospital and there have been reports that standards of cleanliness are not being met.⁹⁶

Under the FMSC, cleaning is the responsibility of Serco. The standard of cleanliness to which Serco must carry out its cleaning functions is outlined in the Cleaning Service Specification, which is an appendix to the FMSC. This document has not been made publicly available by either Serco or the Department and it has not been reviewed by the Committee as part of this inquiry. The cleaning standards contained in the Cleaning Service Specification are complemented by the Victorian Government's *Cleaning standards for Victorian health facilities 2011*.⁹⁷

According to the Department, the hospital's cleaning team cleans 40,000 rooms and areas each month through the use of modern cleaning methods that deliver the highest standards of cleaning. These cleaning methods have been approved by the FSH Infection Prevention and Management Committee.⁹⁸

Serco undertakes routine cleans at scheduled times. Discharge cleans may be required at any time of the day in order to make the room available for the next patient.

In addition to general and scheduled cleans FSH implements a system of Red, Amber and Green cleaning protocols to allow for a risk assessment approach to cleaning. Clinical staff request these cleans where they feel it is appropriate. All types of cleans are available in all areas of the hospital, and cleans are not dependent on a patient's length of time in the room. Three categories of clean are available:

- GREEN – indicating a patient is not known to be infected with any transmissible pathogens.

96 K. Vickery, 'Dirty Secrets Exposed at FSH', *Sunday Times*, 16 August 2015, p. 13.

97 Submission No. 17 from the Department of Health, 14 October 2015, p. 4 (Attachment A).

98 Submission No. 16 from the Department of Health, 23 September 2015, p. 9.

- AMBER – indicating a patient is or may be infected with a low-level transmissible pathogen of concern. The room will be cleaned with the addition of hypochlorite to the cleaning solution.
- RED – indicating that the patient is or may be infected with a more contagious pathogen. The room will undergo the most thorough clean and hypochlorite solution is also used. Upon patient discharge the room is fully cleaned twice (2-step clean).⁹⁹

With respect to cleaning within the Emergency Department (ED) at FSH, the Department advised that Serco rostered cleaning staff to meet expected demand. Given the unpredictable nature of the ED, often experiencing spikes of activity, a Rapid Response Team is available to mitigate against periods of high demand. This team is available to respond to cleaning needs throughout the FSH site.¹⁰⁰

The nature of the concerns raised

The major concern raised by those seeking to highlight Serco's performance of the cleaning service related to the suggestion that Serco was not carrying out cleans to the required standard. Submitters suggested that this was due to inadequate levels of staffing unable to respond to the demand for the service at the hospital. United Voice reported that for one shift, the number of cleaning staff in a department had been reduced by half. Serco confirmed that the number of cleaning staff had been reduced from the peaks experienced immediately following the ED opening in February 2015.

In addition, the Committee is aware of failures in Waste Services as having an impact on the performance of cleaning services. Delays in removal of waste from wards resulted in waste bags and soiled linen bags and carts piling up in utility rooms, as well as waste bins remaining full. This resulted in cleaning staff performing waste service duties themselves prior to commencing their own cleaning duties, which had the potential to impact on the performance of their own duties.

Clinical staff and performance monitoring

Clinicians at FSH are made aware of Serco's obligations for each service under the FMSC. This is done initially as part of the induction process, as well as through interaction with FM team leaders. The Department reports that continual improvements are being made to induction content by working collaboratively with Serco and seeking feedback. Clinical staff may raise a concern regarding Serco's performance through several channels. Staff may:

⁹⁹ Submission No. 17 from Department of Health, 14 October 2015, pp. 6–7 (Attachment A).

¹⁰⁰ Submission No. 17 from Department of Health, 14 October 2015, p. 7 (Attachment A).

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- Discuss an issue with their manager who can then raise it with the FM integration lead;
- Lodge a complaint directly with the Helpdesk;
- Discuss the issue directly with their area FM Service Lead;
- Raise the issue with the Department Contract Management Team. The issue will then be tabled for discussion at Service Group meetings with the FM.¹⁰¹

Performance monitoring and reporting

Under the FMSC 'the FM has a responsibility to report on all identified failures, as is the case with all self-reporting contracts.'¹⁰² The Contract Management Team at FSH monitors Serco's performance and undertakes spot checks and audits of service lines. Its findings are contained in monthly Executive Briefings for each service performed by the FM under the FMSC. Serco also undertakes its own audit process as part of its monthly reporting obligations. These reports include detail of the area audited; the individual elements assessed; and the outcomes of the audit.¹⁰³ In July 2015, a total 16,724 items that had been cleaned were audited with a resulting pass rate of 95 per cent.¹⁰⁴ Whilst acknowledging this achievement, the Committee notes that the Department's own reporting from March 2015 and, in places, April 2015, doubts the 'extremely high pass rate'.¹⁰⁵ Furthermore, the Department's reporting goes into some detail about the disconnect between audit reporting and reality:

*Audit for Hydrotherapy area details 100% pass, however this area has been subject to repeated inspections by the Principal in response to an escalation from staff in the area, and there are still outstanding faults that have not been rectified. This calls in to question the reliability of the auditing process.*¹⁰⁶

Finding 11

The Committee is not convinced the reporting processes are robust and that the guidelines are consistent between both Serco and the Department of Health. The self-reporting concept is essentially flawed and the Department of Health has neither the expertise nor the energy to implement a comprehensive audit system of its own.

101 Submission No. 17 from Department of Health, 14 October 2015, p. 4 (Attachment A).

102 Dr David Russell-Weisz, Director General, Department of Health, Letter, 14 October 2015, p. 5.

103 Submission No. 17 from Department of Health, 14 October 2015, p. 5 (Attachment A).

104 Submission No. 16 from the Department of Health, 23 September 2015, p. 9.

105 Monthly Compliance Review Nov 14 – May 15 in Submission No. 14 from the Department of Health, 21 August 2015.

106 Monthly Compliance Review Nov 14 – May 15 in Submission No. 14 from the Department of Health, 21 August 2015.

The Department's internal reporting

As previously outlined, the Committee requested access to the Department's internal reporting of Serco's performance in order to fully consider the issues being raised in the media and by submitters to the inquiry. In response, the Department provided a range of documents, including 'Executive Briefings', which summarise the many hundreds of pages of total reporting generated each month, for the period March to May 2015. These Executive Briefings reveal that the Department held continuing concerns with in relation to Serco's delivery of cleaning services:

*the performance of the Cleaning Service, particularly in relation to attendance and rectification times, has remained a continuing challenge for the FM in some areas.*¹⁰⁷

These Executive Briefings show that problems persisted with several areas of cleaning services, including:

- A high level of availability failures;
- An inability to substantiate number of isolation cleans performed;
- Confusion from clinical staff surrounding the RAG (Red, Amber, Green) isolation clean model;
- Insufficient detail in a number of areas of self-reporting; and
- The FM staffing model.

Availability Failures

In the context of the cleaning service, an availability failure arises when a functional unit (a contractually defined term corresponding to each room in the hospital) is not available for use following a failure to deliver the appropriate level of service.

During the period March to May 2015, the Department was fairly consistent in its description of the number of availability failures attributable to cleaning as being an area for Serco's attention and improvement. Furthermore, the Department was of the view that there was insufficient detail relating to the causes of these failures and rectification action taken. This made it difficult to determine the appropriateness of the action taken by Serco to rectify the highlighted issues.

¹⁰⁷ Department of Health, *Cleaning Service: Service Report – Executive Briefing*, March 2015, p. 2, in Submission 14 from the Department of Health, 21 August 2015.

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Isolation Clean Performance

An Isolation Clean is another contractually defined term contained in the Cleaning Service Specification; however, it is not subject to the fixed cost element of the contract. The cleaning service is, for the most part, a fixed price service which means that the payment to Serco is not affected by increases in demand for cleaning services at the hospital, noting that Serco is currently seeking a variation to the contract for cleaning.

With respect to isolation cleans, Serco is paid an additional amount for each isolation clean performed and these can only occur at the request of a Department employee and the Serco cleaner must record the employee number of the requesting staff member in order to ensure that the isolation clean is an authorised request.¹⁰⁸

The Isolation Cleaning Protocol and Infection Prevention Guidelines currently require that all requests for Red Cleans (Service or Discharge) and Amber Cleans (Discharge only) require an Isolation Clean. These cleans are generally required to address higher resistant organisms.¹⁰⁹

It is clear from the Department's internal reporting that there were concerns regarding the number of isolation cleans taking place at the hospital. Of particular concern was the level of evidence substantiating the number of cleans Serco was reporting it had completed. It is not clear what accounted for the lack of substantiating evidence, but the Committee notes that the internal reporting indicates that an education program was launched in order to communicate to clinical staff that their endorsement of the isolation clean was not an endorsement of the standard to which it had been completed but was instead a mere confirmation that the isolation clean had been authorised.¹¹⁰ The possible confusion experienced by clinical staff was corroborated by evidence from United Voice, which suggested that it was the clinical staff's role to sign off on the performance of an isolation clean, rather than an endorsement of the request that it be provided.¹¹¹

The main problem with the lack of information was that the Department was unable to determine whether the isolation clean had actually been carried out, or whether it was a clean logged through the system as an isolation clean but was subsequently

108 Submission No. 17 from the Department of Health, 14 October 2015, p. 5 (Attachment A).

109 Submission No. 21 from the Department of Health, 13 November 2015.

110 Department of Health, *Cleaning Service: Service Report – Executive Briefing*, April 2015, in Submission 14 from the Department of Health, 21 August 2015.

111 Ms Carolyn Smith, Secretary, United Voice, *Closed Hearing*.

performed as a standard clean. As a result, the Department had not paid any invoice claims relating to the performance of isolation cleans prior to May 2015.¹¹²

By May the Department appears to have satisfied itself with the FM's self-reporting in this area, and invoices appear to have been paid. The Department confirmed to the Committee that the issue of a lack of supporting information 'has largely been addressed through improved reporting [...] the Department Contract Management Team is working with the FM to continue to refine its data collection and reporting methodology to ensure it is robust and complete.'¹¹³

As Table 3.1 demonstrates, the number, and therefore the cost, of isolation cleans has been significantly above the initial forecasts. Given the disparity, it is clear why the Department was keen to satisfy itself that the isolation cleans were taking place at the request of clinicians. There remains, however, an important question that the Department should be investigating: why is the number of isolation cleans so high, and does it point to a deficiency with the service being provided by Serco that is prompting clinical staff to request these cleans? It was confirmed to the Committee from evidence given at a hearing by the Department that isolation cleans are now being tracked by the Department and have been the subject of discussion at clinical meetings.¹¹⁴

Table 3.1: Actual payments for isolation cleans versus forecast amounts¹¹⁵

Financial Year	Month	Actual Volume	Actual Payment	Forecast payment (based on Annual Service Plan)
2014-15	Oct-14	444	\$41,585	\$8,400
	Nov-14	389	\$36,434	\$8,400
	Dec-14	86	\$8,055	\$13,999
	Jan-15	79	\$7,559	\$22,870
	Feb-15	977	\$93,487	\$37,163
	Mar-15	1,819	\$174,057	\$48,598
	Apr-15	1,748	\$167,263	\$48,598
	May-15	1,777	\$170,038	\$48,598
	Jun-15	1,898	\$181,616	\$48,598
	Subtotal	9,217	\$880,094	\$285,224
2015-16	Jul-15	1,806	\$172,813	\$81,335
	Aug-15	1,244	\$119,036	\$81,335
	Subtotal	3,050	\$291,849	\$162,670
Total (Oct 2014 – Aug 2015)		12,267	\$1,171,943	\$447,894

Finding 12

The number of isolation cleans being requested by clinical staff is significantly above the forecast amount, and has been occurring since the hospital commenced operations

¹¹² Department of Health, *Cleaning Service: Service Report – Executive Briefing*, April and May 2015, in Submission 14 from the Department of Health, 21 August 2015.

¹¹³ Submission No. 17 from the Department of Health, 14 October 2015, p. 5 (Attachment A).

¹¹⁴ Mr Leon McIvor, Executive Director Contract Management, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 19.

¹¹⁵ Submission No. 20 from the Department of Health, 6 November 2015, p. 3.

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in October 2014. The Committee's view is that this disparity likely reflects a lack of confidence amongst clinical staff in the adequacy of the general cleans being performed.

Recommendation 8

That the Minister for Health determines the reasons for the excessive number of isolation cleans being performed and report to the Parliament on the outcome of the investigation.

Serco's Staffing Model

Claims made in submissions of inadequate staffing for cleaning services would appear to be substantiated by internal reporting for March and April.

These internal reports identified issues with the performance of cleaning services, particularly for attendance and rectification times. The March 2015 Service Report states '[t]he FM is reviewing its staffing model where required to ensure patient flow is not adversely impacted.'¹¹⁶ This statement is repeated in the April 2015 Service Report, but appears to have been rectified by May 2015, with the report noting 'utilisation of agency staff has ceased with continued recruitment of Serco employees.'¹¹⁷

The FM informed the Committee that the issue of inadequate staffing was a result of higher than expected demand for services:

For each of the service lines, we designed our staffing model in response to the demands that were predicted for the opening of the hospital. That is a balance between historical information and the forecasts that were delivered to us by the state and us ensuring, to the extent that there was a degree of variance, we could deal with that. ...the attendance at the hospital...was significantly higher than anybody anticipated, so what we then had to do was respond immediately by putting additional staff on in all of the areas where that demand required it.¹¹⁸

116 Department of Health, *Cleaning Service: Service Report – Executive Briefing*, March 2015, p. 2, in Submission 14 from the Department of Health, 21 August 2015.

117 Department of Health, *Cleaning Service: Service Report – Executive Briefing*, May 2015, p. 2, in Submission 14 from the Department of Health, 21 August 2015.

118 Mr Mark Irwin, Chief Executive Officer, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 18.

Contract Variation Proposal

Internal reporting for March and April 2015 reveal that:

*the FM has informally advised that it believes it is providing a cleaning service above Specification requirements in some areas, and is reviewing the potential to submit a Variation claim against the increased staffing it has provided. Further clarification will be sought on this issue prior to a formal submission being made by the FM.*¹¹⁹

Serco confirmed to the Committee that it had submitted a variation proposal arising from its view that it is being required to perform cleaning services to a level greater than is required of it in the contract.

The Committee sought clarification on this proposed variation from the Department. When asked if a proposal for variation had been lodged due to Serco exceeding specification requirements, the Department advised:

*Based on exceeding service standards, not necessarily, and there are variations that have come and gone, some of which are still under review.*¹²⁰

The Committee asked additional questions about the nature of the variation request at a subsequent hearing; the Department provided additional clarification and indicated that the proposal from Serco was not 'just based on things like increased level of services; it's based on changes to square metreage and those sorts of things.'¹²¹

Serco was more forthcoming with detail on this proposal when they gave evidence before the Committee:

*...within a number of parts of the hospital, such as the cancer centre, the imaging area et cetera, the request has now been that we do in-between cleans. Effectively, we have accepted what we have been asked and we are delivering those services today [...] but that is not what we were originally contracted to deliver.*¹²²

119 Department of Health, *Cleaning Service: Service Report – Executive Briefing*, March 2015, p. 1, in Submission 14 from the Department of Health, 21 August 2015.

120 Mr Leon McIvor, Executive Director Contract Management, South Metropolitan Health Service, *Transcript of Evidence*, 14 October 2015, p. 24.

121 Mr Leon McIvor, Executive Director – Contract Management, South Metropolitan Health Service, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 20.

122 Mr Bill Cotter, Contract Director – Fiona Stanley Hospital, Serco Pacific, *Transcript of Evidence*, 21 October 2015, p. 8.

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Finding 13

Serco has lodged a variation to the contract for cleaning services. The variation is on the basis that Serco is currently performing cleaning services that it was not originally contracted to deliver. The Committee notes that Serco was significantly more willing to outline the basis for its variation proposal than the Department of Health had been.

Recommendation 9

The Minister for Health reports to the Parliament the outcome of Serco's contract variation proposal, including – should the variation proposal be successful – full details of Serco's altered cleaning responsibilities and the estimated annual cost to the Department of Health.

Linens Services

The nature of the concerns reported to the Committee

Linens Services were also reported to have encountered problems in the early days of FSH's operation. The Committee received complaints about the regularity with which patients' bed linen was being changed which, it was claimed, left patients lying in soiled bed linen. The Committee also heard that soiled linen was piling up in utility rooms on wards as it was not being cleared regularly enough.

These claims were reflected in the Operational Review, which reported that:

*there were issues of soiled linen not being automatically changed and not being changed when requested.*¹²³

The review also highlighted the risk of infection from patients lying in soiled linen, as well as the potential for tension between patients and clinical carers as a result of clinical staff not responding to requests for changes of bed linen. It also reported complaints made by patients and their families and carers about linen not being changed and beds not being made.

The Australian Nursing Federation (ANF) attributed delays in the changing of bed linen to shortages of nursing staff.¹²⁴

The Committee heard that changes of linen occurred less frequently at FSH than at other public hospitals, with the FMSC stating that linen changes occur only on request from clinical staff. Similarly, it was reported to the Committee that soiled linen cages were piling up as they not regularly collected from utility rooms. Instead, soiled linen would only be collected after a job had been logged.

123 Australian Commission on Safety and Quality in Health Care and MMK Consulting, *Review of operational clinical and patient care at Fiona Stanley Hospital*, June 2015, p. 27.

124 Submission No. 1 from Australian Nursing Federation, 5 June 2015, p. 2.

Unions also reported persistent problems with Linen Services, in particular in the removal of soiled linen:

*We have quite a few linen bags piling up often...but it just sits there in the cage waiting to be collected. Which we have to log a job for...even though they know we go through a lot of linen every day...it doesn't get collected automatically.*¹²⁵

In addition the ANF highlighted concerns from nurses that linen which had been laundered had been returned dirty.¹²⁶

As outlined in Appendix 6, Serco disputed the content of these claims.

At the outset it was unclear to the Committee whether these reports reflected a series of isolated incidents or a continuing systemic issue. It was also unclear whether the problems arose due to an aspect of the design of the contract, or due to Serco's performance under that contract.

Finding 14

The Department of Health has responded to patient concerns and improved Linen Services at Fiona Stanley Hospital. As the linen service is not a service with a fixed-price component, the improvements to the linen service will result in extra payments to Serco arising from the increased volume of linen.

Response from the Department of Health

The Committee wrote to the Department seeking further information on the operation of Linen Services. In particular the Committee was interested in procedures and policies in place for the changing of bed linen. The Department responded:

FSH policy is that patient bed linen is to be changed according to the patient's condition and requirements. The following practices have been in-place since commissioning:

- *The changing of linen immediately once soiled.*
- *Daily changing of linen for patients colonised with Antimicrobial Resistant Organisms...done immediately after showering, before the patient returns to their bed.*
- *Daily for patients with wounds producing exudate.*

¹²⁵ Closed submission.

¹²⁶ Submission No. 1 from Australian Nursing Federation, 5 June 2015, p. 3.

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- *After the patient has showered for surgery and daily following the surgical procedure.*
- *Every one to two days in the acute care setting, based on patient preference if none of the above reasons apply.*
- *Every one or two days in non-acute care settings such as the State Rehabilitation Service...based on patient preference when none of the other reasons apply.*
- *At discharge of the patient.*¹²⁷

It is important to note that, in most cases, the actual changing of bed linen and the decision as to whether a change is required rests with clinical staff and not Serco:

*Since opening, nursing staff have been responsible for changing linen, with the exception of the discharge clean and the associated linen change when a patient is discharged (which is the responsibility of the FM).*¹²⁸

The Operational Review recommended that systems be put in place to allow routine changes of bed linen to occur which was not solely reliant on nursing staff requests. The Department informed the Committee that in response to this recommendation:

*...ward/area cleaning teams were instructed to be more proactive in communication with clinical teams about cleaning needs. Cleaners were instructed to attend morning meetings (huddles/scrums), to identify patients about to be discharged, and to identify any other patient that may require a linen change.*¹²⁹

The Department also advised that it had implemented a number of additional strategies in response to the recommendations. The aim of these was to improve and clarify existing processes and to increase staff responsiveness. This included a revision of the FSH linen policy, an audit of all wards and units to confirm the frequency with which linen was changed which resulted in confirmation that practices were being adhered to, and a review of linen stock which resulted in top-up deliveries being necessary for a number of units in order for there to be adequate availability.¹³⁰

The Department's internal reporting

The Department's internal reporting for March and May 2015 indicates that:

127 Submission No. 17 from the Department of Health, 14 October 2015, p. 8 (Attachment A).

128 Submission No. 17 from the Department of Health, 14 October 2015, p. 8 (Attachment A).

129 Submission No. 17 from the Department of Health, 14 October 2015, p. 8 (Attachment A).

130 Submission No. 17 from the Department of Health, 14 October 2015, p. 8 (Attachment A).

*the Linen Service is continuing to mature and improve, however there are still ongoing issues with effective stock control and imprest management.*¹³¹

These documents also highlighted several ongoing issues with the FMSC Linen Service in the early part of the year. Critical issues reported included:

- High numbers of top-up requests being made indicating linen imprest levels were not optimised.
- Inaccurate self-reporting of KPIs by the FM.
- Low stock levels of scrubs and blankets.¹³²

It is noteworthy that, once again, there are concerns about the accuracy of Serco's self-reporting and monitoring. In March 2015 the Department held a degree of concern about the KPI self-reporting of the FM. The Executive Briefing reported that:

*Accuracy of KPI self-reporting is being affected by the Service not undertaking adequate monitoring and quality assurance activities.*¹³³

Specifically, the inaccurate self-reporting of KPI performance by the FM related to; no evidence of audit details being provided, a lack of audit detail, a lack of analysis of audits, or audits not being carried out. In addition, for some KPIs the FM was reporting 100 per cent compliance despite data showing that there were failures for the KPI.¹³⁴

When questioned about this in a hearing with the Committee the Department elaborated that:

it is not that the data was not there, it is the way the data is presented. Sometimes our feedback is as simple as, 'Can we have that information presented in a different way?' or 'Can we have it in a raw Microsoft Excel format so that we can do something with it ourselves?' and those sorts of things. Those sorts of feedback continue and there has

131 Department of Health, *Linen Service: Service Report – Executive Briefing*, Fiona Stanley Hospital, March 2015, p. 1; in Submission No. 14 from Department of Health, 21 August 2015.

132 Department of Health, *Linen Service: Service Report – Executive Briefing*, Fiona Stanley Hospital, March-May 2015, p. 1; in Submission No. 14 from Department of Health, 21 August 2015.

133 Department of Health, *Linen Service: Service Report – Executive Briefing*, Fiona Stanley Hospital, March 2015, p. 1; in Submission No. 14 from Department of Health, 21 August 2015.

134 Department of Health, *Linen Service: Service Report – Executive Briefing*, Fiona Stanley Hospital, March 2015, p. 2; in Submission No. 14 from Department of Health, 21 August 2015.

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*certainly been a substantial improvement in the way it comes through.*¹³⁵

It is the Committee's view that the information contained in the internal reporting indicates that the problems relating to Serco's self-reporting are more substantial than the Department was willing to acknowledge during hearings. This applies not simply to the Linen Service but more broadly across service delivered by Serco. Having said that, the Committee accepts that Serco performance reporting is improving, as the Department indicated:

*there has been a steady and sustained improvement in the way reporting is done.*¹³⁶

Finding 15

Although the Committee accepts that the quality of Serco's self-reporting has improved, the Committee is of the view that the problems were common to most services provided by Serco and were not, in many cases, of the standard required for the Department of Health to effectively manage the contract and monitor Serco's performance.

Helpdesk

The role of the Helpdesk at Fiona Stanley Hospital

The Helpdesk at FSH was envisaged to be a 'one stop shop' for information and interconnectivity for patients, staff and the general public. The Helpdesk was designed to log both internal and external calls for FSH. This meant that it would perform a vast range of functions, from taking a call from connecting concerned relatives and friends to patients, to logging ICT and building faults, to operating as a switchboard connecting clinical staff with one another. This multifaceted approach had a broad scope and high degree of complexity in its implementation.

Potential problems were accurately identified

Both Serco and the Department have acknowledged problems with the operation of the Helpdesk. The problems primarily stem from higher than expected call volumes following the commencement of Phase 3 operations at the hospital in February 2015. This was a risk identified in the lead-up to the Phase 3 commencement. The December 2014 Integrated Program report included a new 'extreme' risk covering Helpdesk operations. The manner in which the risk is captured in the reporting accurately reflects the situation that eventuated and is worth reproducing in full:

135 Mr Leon McIvor, Executive Director Contract Management, South Metropolitan Health Service, *Transcript of Evidence*, 19 October 2015, p 11–12.

136 Mr Leon McIvor, Executive Director Contract Management, South Metropolitan Health Service, *Transcript of Evidence*, 19 October 2015, p. 11.

Risk Of: Helpdesk unable to cope with the volume and complexity of calls to support hospital operations.

Caused By: Helpdesk being single point of contact for resolution of multiple functions including ICT queries, external and internal switchboard and internal service requests enquiries.

Resulting In: Callers needs not met in a timely or satisfactory way.¹³⁷

Those problems were then confirmed by the internal reporting

The internal reporting revealed that while staff had been trained in the technical aspects of the Helpdesk, there was a lack of corporate knowledge and familiarisation with hospital environments. This led to problems in interpreting information provided by the Department to assist Helpdesk staff, for example in interpreting rosters for clinicians, which led to calls being misdirected or to simply ring out.

Most importantly, the reporting acknowledged that the initial goal of having one number for all internal and external calls was ‘unrealistic and overambitious’. However it noted that ‘wholesale change at this late stage must not be too great and there needs to be a measured response considering that corporate knowledge will take time...[t]his issue will need considerable post commissioning work’.¹³⁸

Serco has sought, and on occasion received, KPI relief

Serco has acknowledged the challenges it has faced in providing the Helpdesk service. In giving evidence to the Committee, it gave emphasis to some of the staffing difficulties associated with delivering the service:

*...we had some challenges...[o]ne is the helpdesk, which was really primarily a lot of new staff coming together in a very rapid space of time and sheer demand, mainly of internal calls going through the helpdesk rather than external call, and we ramped up additional staff immediately to respond to that.*¹³⁹

On 14 May 2015 agreement was given by the FSH Taskforce for partial KPI relief to be granted to Serco for the period 1 October 2014 to 31 March 2015.¹⁴⁰ Under this arrangement, failure points were still incurred by Serco, but abatement dollar amounts were rescinded. Serco’s performance in relation to the helpdesk is measured by four KPIs. Under these KPIs, ninety-five per cent of calls to the Helpdesk must be answered

¹³⁷ December 2014 IPMO Report, p. 22.

¹³⁸ December 2014 IPMO Report, p. 91.

¹³⁹ Mr Joseph Boyle, Transition Project Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 18.

¹⁴⁰ Submission No. 17 from the Department of Health, 14 October 2015, p. 10 (Attachment A).

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within fifteen seconds, and ninety-nine per cent of calls need to be answered within thirty seconds. Serco described this requirement as ‘rigorous’, and requiring a period of adjustment in order to reach this standard.¹⁴¹

By April, Serco was achieving three out of four of its KPIs, and all four KPIs in the following months. By August and September, Serco had slipped behind again, although this was described by Serco as being marginally behind.¹⁴²

Serco issued an Excusing Cause Notice (ECN) in July 2015 in relation to its Helpdesk KPIs. The Department informed us that this ECN was issued in relation to some of the complexities in delivering the Helpdesk service, in particular in relation to the Department’s failure to provide an Identity Access Management System.¹⁴³

This was confirmed by Serco, which informed the Committee that:

*...in terms of the actual excusing cause notification...in the delivery of the solution we are at a point whereby we are quite dependent on the state to deliver certain systems, and one of those systems is an identity access management system. That solution is effectively to identify all joiners and leavers, who come through the hospital. That solution has not been put in place by the state, so we wrote to the state and effectively said that because of that, we have to have more employees in the actual help desk area to achieve the KPIs.*¹⁴⁴

These improvements notwithstanding, the successful functioning of the Helpdesk system is reliant on the provision of an Identity Access Management System by the State. As Serco explained to the Committee:

One of the key dependencies from the outset was a very complicated ICT tool called the identity access management system. The state...decided not to go down that route. Inevitably that means that the process of...the management of the identification of staff, leavers and joiners, is a more complicated process and sometimes the calls take more time to locate people, to locate their number, to identify

141 Mr Mark Irwin, Chief Executive Officer, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 4.

142 Mr Bill Cotter, Contract Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 4.

143 Mr Leon McIvor, Executive Director Contract Management, South Metropolitan Health Service, *Transcript of Evidence*, 19 October 2015, p. 27.

144 Mr Bill Cotter, Contract Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 4.

*them, and that extra time, when you are dealing with 99 and 97 per cent performance levels, is a factor in the achievement of that KPI.*¹⁴⁵

The Department provided the following information regarding the status of the Identity Access Management System:

*WA Health will continue to pursue the development of the Identity Access Management (IAM) system. This work will be considered within WA Health's overall ICT reforms, as outlined in the WA Health ICT Strategy 2015-2018 and within affordability parameters. It will be assessed against other ICT priorities across WA Health.*¹⁴⁶

The following additional information about what had been communicated to Serco in relation to the system was also provided:

Important to note, WA Health formally advised the FM on 7 November 2013 that it would not be delivering its own enterprise IAM system and agreed on 5 August 2014 the associated impacts with the FM in lieu of not providing an IAM system.

In the absence of an IAM System the WA Health Facilities Reference Guide 1.6 states that:

- *Microsoft Active Directory is the primary authoritative network directory for authentication with supporting role based authorisation capabilities; and*
- *All future applications and services developed for a Facility must utilise Active Directory for Authentication and provide role based authorisations.*

*The Microsoft Active Directory is currently being utilised by the FM.*¹⁴⁷

Dispute resolution process

Although it is not clear to the Committee that the situation regarding Helpdesk and the ECN has yet reached the stage of a dispute between Serco and the Department, it is probably worthwhile to outline the dispute resolution processes built into the contract.

145 Mr Joseph Boyle, Transition Project Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 4.

146 Submission No. 20 from the Department of Health, 5 November 2015, pp. 4–5.

147 Submission No. 20 from the Department of Health, 5 November 2015, p. 5.

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In the first instance, either party may refer an item to the Facilities Management Advisory Group (FMAG) for resolution. The FMAG has six members; three each from the Department and Serco. Its primary functions are to:

*provide leadership, to facilitate the effective management of this Contract, and to assist in the resolution of Disputes, as set out in clause 35. The role of the Facilities Management Advisory Group is advisory only and its decisions are not binding on the parties.*¹⁴⁸

If the FMAG is unable to resolve the dispute, either party may refer the dispute for advisor appraisal or expert determination. Each party must pay their own costs and an equal share of the costs of the Advisor or Expert.

Supplies Management

Early on in the inquiry, submitters claimed that there were large scale problems with the ordering of medical and other supplies at FSH. Some submitters claimed that there was widespread over ordering of supplies, which resulted in wastage. This was attributed to the FM's unfamiliarity with providing supplies management in a clinical environment.

The Department's internal reporting revealed that supplies management was, by March 2015, being temporarily provided as a joint service with the Health Corporate Network (HCN). This was done under an 'Interim Supply Model' arrangement.

The Department advised the Committee that problems with Serco's provision of supplies management were identified in the lead up to the Phase 3 opening of FSH. The Department informed the Committee that:

*the interim service model was implemented to increase product and system standardisation across all DoH sites and improve economies of scale.*¹⁴⁹

In addition to this, the Department confirmed that there had been instances, in and around the time of the hospital's opening, where certain items had been unavailable to clinical staff due to insufficient stock. In response to this the Department established a process whereby staff could obtain supplies urgently if required to minimise disruption to the delivery of clinical services. This issue has now been rectified with the introduction of the Interim Supply Model with HCN.¹⁵⁰

Serco further explained to the Committee that:

148 Facilities Management Services Contract, Clause 6.5(b).

149 Submission No. 17 from Department of Health, 14 October 2015, p. 9 (Attachment A).

150 Submission No. 17 from Department of Health, 14 October 2015, p. 10 (Attachment A).

*The biggest challenge we had in developing the service was in the finalisation of all requirements within the supply service...as the supplies service came close to finishing, we were still experiencing difficulties in finalising detailed requirements of all the consumables and supplies required. As we got through phase 1 and phase 2 successfully...we sat back and reviewed a readiness for phase 3 and felt collectively that with all the changes and finalisation of the requirements, that we were best served involving HCN in that process and we ultimately settled on a model where Serco manages internal management of supplies, with HCN delivering the supplies into the hospital.*¹⁵¹

The FM advised the Committee that the problems arose from not being able to accurately finalise the requirements for consumable sets and supplies. Delays occurred in the process of working through these, and the backlog of work for the FM necessitated that HCN provide some support.

The level of involvement and support from HCN to the FM increased from 24 December 2014. The supplies management model is currently undergoing revision in order to bring it into broad alignment with the health support services supplies model at other metropolitan hospitals.

The Department advised that, due to the ongoing nature of the review of the model, no decisions have been finalised, and therefore there have been no alterations to the monthly payments to the FM for this service.¹⁵²

However, there remains a significant amount of stock held by the FM which must be audited and handed over to the Department. This stock results from over-ordering of supplies, with an element of this to be written off as wastage. This wastage will ultimately have a cost attached to it. However, at this stage negotiations between the Department and the FM are continuing and no finalised dollar amount has been calculated.¹⁵³

Finding 16

The Supplies Management Service is currently being jointly managed by the Department of Health and Serco as a result of deficiencies associated with Serco's management of the service.

151 Mr Joseph Boyle, Transition Project Director – Fiona Stanley Hospital, Serco Asia Pacific, *Transcript of Evidence*, 21 October 2015, p. 22.

152 Submission No. 17 from Department of Health, 14 October 2015, p. 9 (Attachment A).

153 Submission No. 17 from Department of Health, 14 October 2015, p. 10 (Attachment A).

Chapter 3

The Sterilisation Service

The evidence provided to the Committee suggests that the Sterilisation Service should never have been included in the contract signed with Serco.

The provision of the Sterilisation Service at FSH attracted a significant amount of media and public interest earlier in 2015 following public revelations of problems in the delivery of the service by Serco. In particular the suggestion that contaminated surgical instruments had been included in surgical packs and sent to the hospital's operating theatres. The Department provided the Committee with a range of documentation relating to the circumstances surrounding the decision of the State to 'take out' sterilisation and assume responsibility for delivery of the service.

Given the outcome, the specific detail of those events is not especially central but it is worth noting that minor problems with the Sterilisation Service first became apparent following the Phase 1 opening of the hospital in October 2014.¹⁵⁴ At that point, the Department began to work with Serco to review processes and ensure that contractual outcomes were being met. The most significant problems began to occur after the Phase 2 opening, when the operating theatres came into use. At that point, a breach notice was issued to Serco, and remedy plans were required. The Department was unsatisfied with the content of those rectification plans and, given the ongoing problems, issued a 'take out' notice removing responsibility for the service from Serco.

The contract contains provisions transferring the costs associated with removing a service from Serco back to Serco. In other words, the cost to the State of terminating the Sterilisation Service component has been borne by Serco. In the longer term the costs associated with the Department operating the Sterilisation Service may be greater than if Serco had retained the service, but that is a separate issue to the immediate costs that arise from the transfer of the service.

In this instance, the Department took the steps necessary to ensure that its interest in obtaining value for money through the contract was defended.

Finding 17

Given the inclusion of the Sterilisation Service in the Facilities Management Services Contract, the Committee questions the level of scrutiny applied to the contract by the Minister when he signed it. It should have been obvious that this service required the expertise of the Department of Health in delivering patient-centric care.

154 Dr David Russell-Weisz, Director General, Department of Health, *Transcript of Evidence*, 19 October 2015, p. 12.

Finding 18

The Acting Director General, Professor Bryant Stokes, and Chief Executive Officer of Fiona Stanley Hospital Commissioning, Dr David Russell-Weisz, made the right and only choice in transferring the Sterilisation Service from Serco back to the Department of Health, given risks to patient safety.

Finding 19

The Committee was not convinced that all measures were adopted to reassure post-surgical patients at Fiona Stanley Hospital that they were at no risk to exposure from poorly sterilised instruments.

Chapter 4

Self-reporting

Accountability

The FMSC requires Serco to self-monitor its own performance and provide monthly reports to the Department on its performance against KPIs. There is nothing unique about this approach to contract management; it is common to most relational contracts and is considered to be appropriate given that these contracts are long-term and characterised by strong cooperative elements and a significant degree of interdependence. Relational contracts are thought to replace the traditionally adversarial approach to contracts with open collaboration between the parties.

Although self-monitoring might be the accepted standard for these types of contracts, this does not mean that this approach is without its difficulties. The interests of the parties to the contract do not always align and, in this case, the Department will be relying upon Serco's reporting to determine whether services are being delivered to the appropriate standard. The reporting will also be used in order to calculate failure points and any associated payment abatements.

Throughout this report, the Committee has identified a number of areas where the Department's own internal reporting was identifying deficiencies with Serco's self-reporting. The deficiencies have included:

- concerns about the credibility of audit results;
- concerns about the accuracy of KPI self-reporting due to inadequate monitoring and quality assurance activities; and
- complaints about the ways in which Serco was presenting data.

Interestingly, in relation to the last point above, hospitals in the United Kingdom have experienced situations where information was being provided in formats that made it difficult for contract managers to actually measure the performance of their service providers.¹⁵⁵

There is a wide body of literature from the United Kingdom's National Audit Office indicating the importance of performance reporting and management in the extraction of value for money from contracts such as the FMSC. The Committee has been

155 Public Accounts Committee, *Building Foundations for Value: An analysis of the processes used to appoint Serco to provide non-clinical services at Fiona Stanley Hospital – Western Australia's largest ever services contract*, Report No. 16, June 2012, p. 117.

Chapter 4

reassured by the evidence provided by the Department regarding its approach to managing the contract; however, given the financial implications of this contract the Committee is of the view that additional external scrutiny should be provided to Serco's self-reporting and the Department's assessment of the accuracy of that reporting.

Finding 20

The significant financial implications of the operation of the Facilities Management Services Contract at Fiona Stanley Hospital by Serco calls for accuracy of reporting by Serco, and rigorous contract management by the Department of Health.

Recommendation 10

That the Minister for Health supports the Committee's request to the Auditor General that his office carries out an audit of the management of the Facilities Management Services Contract.

To that end, the Committee resolved to write to the Auditor General requesting that his office commence a performance audit examining Serco's self-reporting and the Department's assurance processes around the quality of that reporting. A copy of the letter sent to the Auditor General is included in Appendix 5 to this report.

The Auditor General, as the Parliament's auditor, has an important role to play in ensuring that this significant contract is properly scrutinised and held to account in the Parliament.

A handwritten signature in black ink, appearing to read 'G.G. Jacobs', with a large, stylized flourish extending from the end of the signature.

DR G.G. JACOBS, MLA
CHAIRMAN

Appendix One

Inquiry Terms of Reference

That the Committee inquire into and report on the risks to patients and staff, and the financial implications to the State arising from the:

- transition and operation of clinical services to Fiona Stanley Hospital by the Department of Health; and
- management by Serco of the services it is contracted to deliver at Fiona Stanley Hospital.

Appendix Two

Committee's functions and powers

The functions of the Committee are to review and report to the Assembly on:

- a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;
- b) annual reports of government departments laid on the Table of the House;
- c) the adequacy of legislation and regulations within its jurisdiction; and
- d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

Appendix Three

Submissions received

Name	Position	Organisation
Mr Mark Olson	State Secretary	Australian Nursing Federation
Mr Tim Evans	Corporate Affairs	Serco Asia Pacific
Mr Phillip Olsen		
Mr Phillip Olsen		
Mr Dan Hill	Secretary	Health Services Union
Mr Colin Penter	Convenor	Serco Watch
Mr Tony Ahern	Chief Executive	St John Ambulance Western Australia
Mr Paul Boyatzis	Executive Officer	Australian Medical Association Western Australia
Closed submission		
Closed submission		
Closed submission		
Dr Ian Jenkins	Director Intensive Care, Fremantle Hospital and Health Service	Australian Medical Association Western Australia
Closed submission		
Closed submission		
Closed submission		
Mr Mark Olson	State Secretary	Australian Nursing Federation
Dr David Russell-Wiesz	Director General	Department of Health
Dr David Russell-Weisz	Director General	Department of Health
Dr David Russell-Weisz	Director General	Department of Health
Closed submission		
Closed submission		
Dr David Russell-Weisz	Director General	Department of Health
Dr David Russell-Weisz	Director General	Department of Health

Appendix Four

Hearings

Date	Name	Position	Organisation
24 June 2015	Mr Philip Olsen		
12 August 2015	Closed Hearing		
19 August 2015	Dr Ian Jenkins	Chair, Inter-hospital Liaison Committee	Australian Medical Association
	Ms Marcia Kuhne	Director, Industrial Relations/Legal	
19 August 2015	Mr Mark Olson	State Secretary	Australian Nursing Federation
23 September 2015	Mr Daniel Hill	Secretary	Health Services Union of Western Australia
	Ms Melissa Wagner	Senior Organiser	
	Mr Richard Barlow	Lead Organiser	
14 October 2015	Hon Dr Kim Hames MLA	Minister for Health	Department of Health
	Dr David Russell-Weisz	Director General	
	Dr Robyn Lawrence	Acting Chief Executive, South Metropolitan Health Service	
	Mr Leon Mclvor	Executive Director, Contract Management, South Metropolitan Health Service	
	Dr Hannah Seymour	Medical Co-Director, Fiona Stanley Hospital	
	Mr Giles Nunis	Government Chief Information Officer	
19 October 2015	Dr David Russell-Weisz	Director General	Department of Health
	Dr Robyn Lawrence	Acting Chief Executive, South Metropolitan Health Service	
	Mr Leon Mclvor	Executive Director, Contract Management, South Metropolitan Health Service	
	Dr Hannah Seymour	Medical Co-Director, Fiona Stanley Hospital	
	Professor Bryant Stokes	Former Acting Director General	
21 October 2015	Mr Mark Irwin	Chief Executive Officer	Serco Asia Pacific
	Mr Joseph Boyle	Transition Project Director at Fiona Stanley Hospital	
	Mr Bill Cotter	Contract Director for Serco at Fiona Stanley Hospital	
	Mr Andrew Wheble	Operations Director at Fiona Stanley Hospital	

Appendix Five

The Committee's letter to the Auditor General



Address all correspondence to the
Principal Research Officer

Enquiries to: Ms Alison Sharpe
Telephone: (08) 9222 7394
Facsimile: (08) 9222 7804
Email: laehsc@parliament.wa.gov.au
Web: www.parliament.wa.gov.au

Ref: A523722

EDUCATION AND HEALTH STANDING COMMITTEE

11 November 2015

Mr Colin Murphy
Auditor General
Perth BC
PO Box 8489
PERTH WA 6849

Dear Mr Murphy

Request for audit: Serco self-reporting at Fiona Stanley Hospital

You may be aware that the Education and Health Standing Committee will next week be tabling a report examining the Department of Health's management of the transition to and operation of services at Fiona Stanley Hospital (FSH).

An important part of the Committee's investigation has been the delivery of non-clinical services by Serco at the hospital under the Facilities Management Services Contract (FMSC). Like most 'relational contracts', the FMSC relies upon self-reporting by Serco of its performance against its contractual obligations. The delivery of 'value for money' in contracts such as these stems from multiple sources, but none is more critical than the requirement that the contractor deliver services to the standards stipulated in the contract.

In the United Kingdom, the National Audit Office (UKNAO) has published a vast array of reports and guidelines outlining some of the challenges associated with managing and attaining value for money from contracts such as the FMSC. Ensuring the accuracy of self-reporting provided by contractors is just one of many of these challenges identified by the UKNAO.

In discussing the role of self-reporting in WA Health's management of the FMSC, the Committee resolved today to write to you and request that your Office commence a performance audit examining, in particular, the accuracy of Serco's self-reporting and the level of scrutiny applied to that self-reporting by WA Health. It is the Committee's view that commencing the audit in the second half of 2016 will allow the self-reporting and other contract management regimes sufficient time to have matured.

In making this request, it is important to emphasise that the Committee is not suggesting that Serco's self-reporting thus far has been deficient or misleading; however, the Committee does note that WA Health's own internal reporting on Serco's reports indicates that there have been some problems. Similarly, the Committee is not suggesting that WA Health's contract management has been inadequate.

Instead, the Committee is influenced by the materiality of risks that might arise from early deficiencies in the management of the contract. FSH is an important State asset and provides tertiary level health care to one half of Perth's population, in addition to providing a range of specialist services for all Western Australians. At a total cost of \$4.3 billion over 20 years, the FMSC is second only in total value to the contract signed by WA Health for the management of the new Midland Health Campus. It is also, by WA Health's own admission, a complex contract cutting across most activities at FSH.

The Committee notes that your office is either currently undertaking, or is planning to commence, a number of audits examining WA Health's performance, and that some of these audits may involve examining limited elements of the FMSC. It is the Committee's view that the elements of the FMSC discussed in this letter require a separate performance audit by your office.

The Committee will be including a copy of this letter requesting that you conduct the audit in its report.

Should you have any questions about this correspondence please contact the Committee's Principal Research Officer, Ms Alison Sharpe, on 9222 7394 or the Clerk Assistant (Committees), Mr Mathew Bates, on 9222 7398.

Please note that correspondence addressed to or received from the Committee becomes the property of the Legislative Assembly and cannot be forwarded to any other party without the authorisation of the Committee.

You are also advised that FOI provisions cannot be applied to Committee documents, including your correspondence to the Committee, by virtue of Schedule 1, s.12 (c) of the *Freedom of Information Act 1992*, which holds that matter is exempt if its disclosure infringes the privileges of Parliament.

Yours sincerely



DR G.G. JACOBS, MLA
CHAIRMAN

Appendix Six

Committee's letter to Serco

Address all correspondence to the
Principal Research Officer

Enquiries to: Ms Alison Sharpe
Telephone: (08) 9222 7394
Facsimile: (08) 9222 7804
Email: laehsc@parliament.wa.gov.au
Web: www.parliament.wa.gov.au

Ref: A525991



EDUCATION AND HEALTH STANDING COMMITTEE

13 November 2015

Mr Mark Irwin
Chief Executive Officer
Serco Asia Pacific
By email

Dear Mr Irwin

Opportunity to provide additional feedback

I refer to an email received on 12 November 2015 from Ms Kat Lothian in which Serco requested to be given an opportunity to respond to evidence that may have been taken in closed session and which Serco has thus far not had access to.

For the most part, I am satisfied that many of the concerns raised have been discussed, in both general and specific terms where appropriate, with Serco or in open sessions with the Department of Health or other submitters. Having said that, there are some items where further input from Serco would be welcomed:

Cleaning

- Staffing levels were raised by a number of submitters and this issue was discussed with Serco during the hearing. The Committee acknowledges that additional staff members were brought on board following February 2015, and that some of these staff members were from employment agencies. Staffing levels have since reduced but remain above initial numbers from February. In one instance, the Committee was told that the number of staff in one particular department for one shift had been halved.
- The number of isolation cleans performed at the hospital was discussed with the Department of Health during public hearings. The Department has since confirmed that the number of isolation cleans performed was significantly above forecast amounts.

Linen

- Concerns were raised about delays associated with removing spoiled linen from linen cages. Spoiled linen was described as 'piling up'.
- Management of imprest and stock levels is discussed, based exclusively on the Department's own reporting of Serco's performance in this area.

Portering

- The question of whether porters can 'touch' patients was an issue raised by many submitters and discussed at some length by the Committee during hearings with both Serco and the Department, in addition to the discussions held during the Committee's visit to the hospital. The outcome of these discussions is reflected in the report.

The Department's internal reporting

- Many of the questions raised by the Committee during hearings with both Serco and the Department were informed by the content of the Department's internal reporting. Serco may or may not be aware of the content of these internal reports, but the Committee will not be releasing them publicly.
- The Committee outlines comments about the accuracy and general quality of Serco's self-reporting and also notes that the Department had informed the Committee that the quality of Serco's self-reporting had been improving.

As the Committee's inquiry is nearing its end, it would be appreciated if a response (if applicable) could be provided by 5:00 p.m. **Tuesday, 17 November 2015**. Should you have any questions about this letter, please contact Mr Mathew Bates, Clerk Assistant (Committees), on 9222 7398.

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You are also advised that FOI provisions cannot be applied to Committee documents, including your correspondence to the Committee, by virtue of Schedule 1, s.12 (c) of the *Freedom of Information Act 1992*, which holds that matter is exempt if its disclosure infringes the privileges of Parliament.

Yours sincerely



DR G.G. JACOBS, MLA
CHAIRMAN

Serco's letter to the Committee

Bringing service to life



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Chairman, Education and Health Standing Committee
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17 November 2015

Dear Dr Jacobs

Opportunity to provide additional feedback

Thank you for your letter of 13 November 2015 inviting us to provide further input to the Committee and particularly areas that were not covered during the hearing on 21 October 2015.

Given the short time frame to respond, we have provided information where possible. There are areas that cannot be investigated because of the lack of genuine information made available to Serco and not tested for accuracy. This is disappointing given that we have been fully open, accountable and available during the inquiry process.

As we have discussed with you previously, we pride ourselves on our proactive and thorough response when unanticipated issues arise. We do not resile from the fact that there were issues associated with the opening of the hospital but, where there have been issues, we have taken active steps to resolve them quickly and effectively.

1. Cleaning - staffing

Serco has been open and accountable regarding all of our staffing numbers for Fiona Stanley Hospital. We have always had sufficient staff for the predicted demands of the hospital. Where we have required more staff because actual demand outweighed predicted demand, we have been quick to respond and provide additional staff at our own cost.

Your letter says the committee was told that one particular department for one shift has been halved. This has not been raised with us by the particular department. Does the person or group that provided this commentary have any real knowledge of our staffing? Which department and which shift? Over what time period? Serco is willing to investigate these claims if put to us with some level of clarity. At this time, it would appear to be without any foundation.

If the committee could provide us with specific details about the claims being made, including the timeframe, we would be happy to respond to those specifics.

2. Cleaning – isolation cleans

We can confirm that isolation cleans are undertaken at the direction of clinical staff.

3. Linen – soiled linen

These claims have no foundation. Serco is willing to investigate if put to us with some level of clarity but cannot respond to general claims that are not based on any specific details, including who raised concerns and under what circumstances. I can confirm that we have not received any complaints, formal or informal, that match these claims since we opened the hospital.

For background information, all soiled linen is stored in sealed bags and kept in appropriate utility rooms. It is collected and removed within linen cages on a regular basis throughout the day. While regular scheduled tasks are undertaken to remove linen from wards and other areas, staff across the hospital can place a call to the Helpdesk to have linen or other items removed at any time.

4. Imprest and stock levels

All imprest and stock in the hospital, including both linen and supplies, has been purchased at the request and direction of WA Health staff, including clinicians.

We run an efficient and effective supplies management service at Fiona Stanley Hospital which receives compliments from clinical staff every week.

Specifically to linen, our team worked closely with senior clinicians in each area prior to hospital opening to agree linen imprest levels for each area and this was reviewed regularly after opening to ensure that the ongoing needs of each area were met. We do also hold a significant amount of clean buffer stock in the lower ground level to enable us to meet the changing needs of areas if their requirements change at short notice.

5. Portering

I am pleased that the inaccuracies around portering have been clarified with you. I would just like to reiterate once again that our porters handle patients each and every day – up to 1000 patients moves are undertaken a day by our portering team.

At WA Health's request and direction, the turning of patients and holding of limbs during theatre sessions is a clinical task and is not undertaken by our porters.

6. The Department's internal reporting

We agree that having a robust performance management regime drives strong and accountable performance. Key performance indicators – of which we have 480 – provide good control and oversight of performance, more so than in any other public hospital in WA.

I am not aware of the content of WA Health's internal reporting but we do work as closely as we can with the WA Health team and where there are issues or areas for improvement, we have consistently resolved them in a timely manner.

For the information of the committee, we have endeavoured to meet the needs of WA Health since operational service reporting commenced in January 2014. From this time we regularly requested information from the WA Health team as to whether the reporting met their requirements and to develop continuous improvement, which we continue to do. While we



believed that our reporting met the needs of the contract, we were keen to ensure that it also met the practical needs of the hospital and the WA Health team.

We first received feedback from WA Health on our operational service report in October 2014 and we have worked closely since then to ensure that all reporting meets the expectations of WA Health.

We note that improvements have been made, and I am pleased that there has been recognition that the extensive reporting undertaken by our team is meeting the needs of the WA Health team.

Once again, this is an example that where issues have arisen, either real or perceived, we have responded positively to ensure the best outcomes for the hospital and WA Health.

Thank you for the opportunity to respond to some of the issues that have been raised.

Finally, I am concerned that in some cases there are not specific details to enable us to respond. This is inconsistent with our evidence which is based on measurable fact-based reporting. On that basis, I trust that unconfirmed commentary without review will be clearly treated as such if included in the Committee's report.

Please do not hesitate to contact either Bill Cotter or myself if you have any questions on the above.

Yours sincerely

A handwritten signature in dark ink, appearing to read "Mark Irwin".

Mark Irwin
Chief Executive Officer
Serco Asia Pacific