Document 21

Attachment B

FIONA STANLEY HOSPITAL

INDEPENDENT REVIEW OF COMMISSIONING OF THE HOSPITAL

Review carried out by University Hospitals Birmingham NHS Foundation Trust

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Report status	Final
Dates of review	14/05/2012 - 21/05/2012
Final report issued	11/07/ 2012

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Purpose of the Review

- The Western Australia Director General of Health invited University Hospital Birmingham NHS Foundation Trust (UHB) to undertake an independent review of the status of the commissioning of the new Fiona Stanley Hospital. (FSH)
- The FSH project includes the planning, building and commissioning of a new 780 bed greenfield tertiary hospital in Murdoch. Construction is planned for completion December 2013. The hospital is scheduled to open April 2014 and will be Western Australia's flagship health care facility.
- The FSH will be the largest building infrastructure ever undertaken by the state. Western Australia has limited experience of commissioning large tertiary hospitals and it was considered prudent to undertake a review of the commissioning process.

This report is a snapshot of the programme status at the time of the review.

Terms of reference

Birmingham Model

- Provide an outline of the management model, phases, streams, time, and resources that were required to achieve the commissioning of recent key projects at UHB.
- Draw on the knowledge and experience of other major hospital projects to establish a baseline approach for use as a comparator.

FSH approach

Provide an outline of the approach currently being used for FSH projects including:

- Overall management model, including governance and accountability.
- Co ordination with broader South Metropolitan Area Health Service (SMAHS) reform and transition.
- Commissioning streams, including clinical model design and recruitment, facilities management, information systems and medical technology.
- Integration and management of streams.
- Timeline for commissioning.
- Resources being applied including capacity and capability.

The review team were then asked to compare and contrast the approach being used at FSH, identify the risks and recommend any action that may be required.

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Conduct of the Review

The Review was carried out between 14/05/12 and 21/05/12 at various sites across the Perth Metropolitan Health Economy.

The reviewers adopted a standard interviewing technique asking a series of question to a range of stakeholders. In addition the review team had access to a number of documents before and during the review. The findings and recommendations are therefore based on the evidence provided in the documents and the key themes that emerged from the interviews

The Review Team would like to thank all interviewees for their time and openness, which contributed to the Team's understanding of the programme. The Review Team would also like to thank the facilitation services provided by the Department of Health to support the process.

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The Birmingham Model

UHB has an international reputation for quality of care, informatics/IT, clinical training and research.

UHB provides direct clinical services to nearly 800,000 patients every year, serving a regional national and international population. It is a regional centre for cancer, trauma, renal dialysis, burns and plastics and has the largest solid organ transplantation programme in Europe. It has recently become a Level 1 trauma centre and host of the UK's first and only £20m National Institute for Health Research Centre for Surgical Reconstruction and Microbiology.

UHB employs over 7,200 staff and has successfully transferred its services from two Hospitals into the UK's newest and largest single site hospital via the Private Finance Initiative scheme. The £545m Queen Elizabeth Hospital Birmingham opened its doors to patients on June16, 2010 and the building offers accommodation which has been favourably compared to a high-profile, award-winning private hospital. It has 1,213 inpatient beds, 32 operating theatres and a 100-bed critical care unit, the largest co-located critical care unit in the world.

The co-location of the Queen Elizabeth Hospital Birmingham, the Royal Centre for Defence Medicine, University of Birmingham Medical School and Birmingham Women's Hospital on one site makes UHB one of the largest healthcare campuses in Europe.

Management Model

The Programme Control/Management Office had a dedicated management team who were responsible to the Chief Executive Officer.

It was led by the New Hospital Project Director who ensured the delivery of all of the physical assets and coordinated the whole Programme via the Programme Control office. There was an Executive Director responsible for the delivery of the new models of care and workforce planning. In addition there was significant involvement of the clinical and operational, financial and corporate teams.

The Programme Management approach was adopted to enable UHB to react to changing circumstances without jeopardising critical milestones, UHB could therefore co-ordinate a range of activities needed to achieve the outcomes and benefits throughout the lifetime of the programme.

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There was clarity around roles and levels of responsibility. Whilst delivery of the Programme ultimately sat with the Board of Directors of UHB (A Unitary Board comprising of both Executive and Non-Executive Directors) .The CEO's responsibilities for the New Hospital Programme were delegated to the Executive team.

- New Hospital Programme Director responsible for the delivery of the physical asset, contract management and the Programme Management Office.
- Executive Director of Delivery was responsible for Clinical service redesign, workforce planning training and Education.
- Chief Operating Officer was responsible for the move into the new facility.
- Medical Director (MD) and Chief Nurse were responsible for assessing clinical risk in addition the MD was also responsible for the Clinical Information systems.
- Finance Director was responsible for the ten year financial plan. He provided quarterly assurance to the audit committee and monthly assurance to the Board.
- Director of Communications was responsible for Stakeholder mapping, Stakeholder management and internal and external communications

Whilst there were a number of Executives with specific areas of responsibilities to be completed, the overall programme was managed by the PMO led by the NHPD. The overall master programme has up to 70 000 monitored activities. This was updated monthly by an independent programmer reporting across all workstreams to the NHPD. There was therefore assurance independently that all areas of the programme were on time. Monthly exceptions reports were produced and risks and issues updated as required.

The integrated master programme had been compiled on financial close of the project and business case approval. Each activity was logic linked and also included all of the contractual obligations by their timelines.

The New Hospital Programme sat with the already existing Governance and Board Assurance Framework

- The organisation took the decision that all of this planning work had to be completed 6 months prior to practical completion to allow the organisation to focus on the detailed move plans at departmental and individual patient level (½ hour slot planning) This also allowed time for 7 200 directly employed staff and those of stakeholder organisations to undergo the necessary training and orientation to move to the new facilities.
- This also included testing and piloting the models of care work, the workforce changes in the old environment to ensure that it would be embedded by the time the hospital shut and moved into the new facility. The New Hospital Commissioning Move Group structure (led from the top via Executive level NH Commissioning & Move Group) was put in place comprising commissioning work streams which mirrored the new hospital models of care
- Each commissioning work stream headed up by a Divisional Director of Operations who was responsible for co-ordinating the work undertaken by Commissioning Leads.

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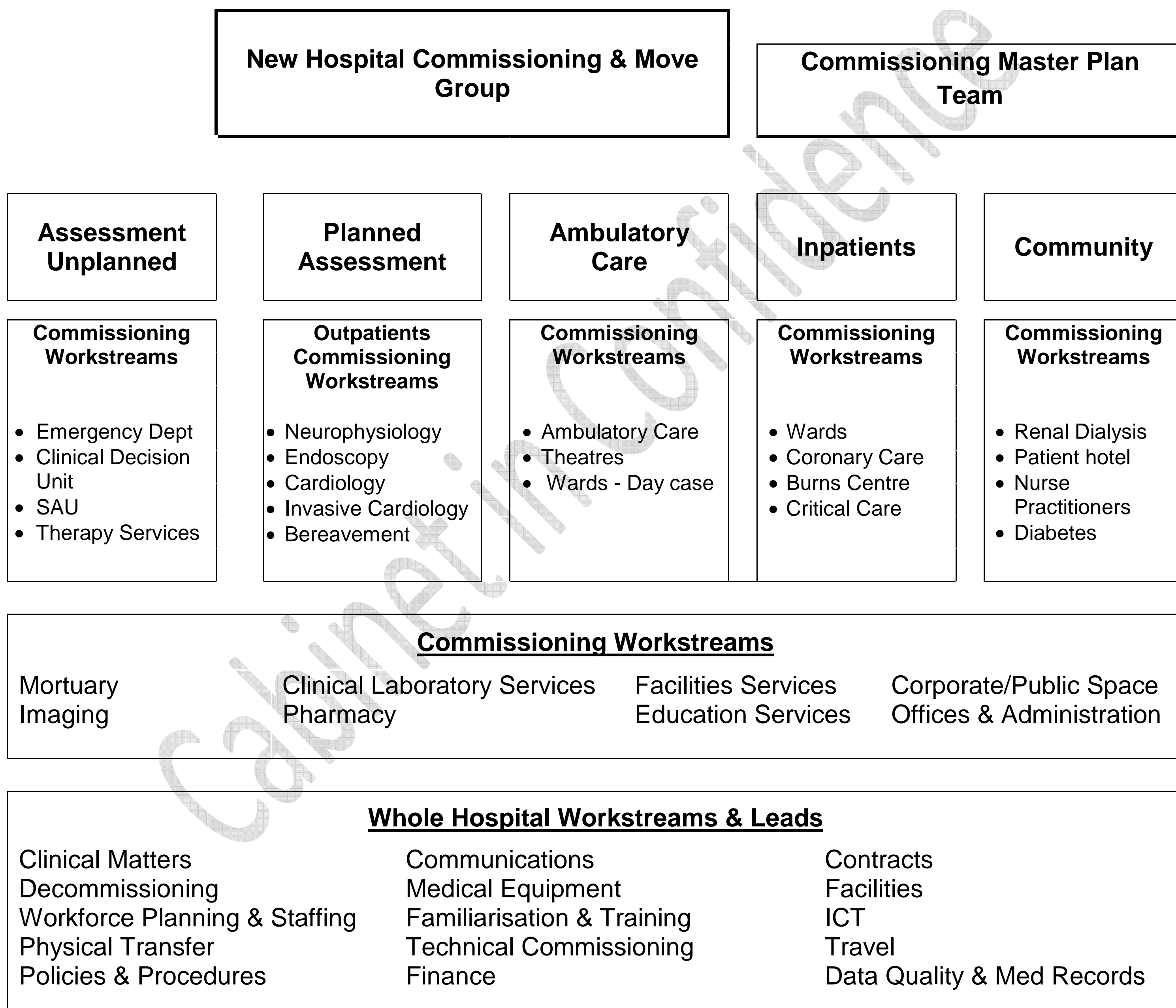
- Commissioning Lead for each main clinical/non clinical function within the model of care (DDOp decision)?
- Key to successful commissioning was through empowered and informed staff. Achieved by the delivery of the commissioning processes via ward/departmental based Team Leaders representing new hospital aggregations.
- See diagram below



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Wider Health Approach and State Government Influence

The State government as early as 2003 appointed a Health reform committee to review the delivery of health in WA. The report recommended reconfiguration of the health service. The Clinical Service Framework developed in 2005 was predicated on the recommendations of the Reid report.

The Reid report as well as recommending improved access to services recognised the influence of changing demographics on provision of services. North and South corridors are the main areas of population growth. The original report proposed the closure of the Royal Perth hospital .This decision has since been superseded.

WA clinical service framework 2010-2020 identified the need to undertake extensive reconfiguration of services, in order to facilitate the commissioning of the FSH.This reconfiguration was due to commence in 2011-2012 and run until 2014-2015.The strategy Post 2015/15 is still being ratified.

SMAHS Approach

FSH will be the major tertiary hospital in the SMAHS and will offer health care to communities south of Perth and across the State. Serco Australia will be responsible for the provision of non clinical services. WA Health will employ clinical and allied health care professionals.

The Reconfiguration strategy identified the need to:

- Improve access to hospital care
- Ease the burden and reduce dependency on tertiary hospitals
- In addition the DOH Strategic Intent 2010-2015 identified the need to improve and protect the health of WA by:
- Caring for individuals in the community
- Caring for those who need it most
- Making best use of funds and resources
- Supporting team

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FSH will become SMAHS major tertiary hospital and Royal Perth will downsize. A State rehab facility will be established at FSH and Shenton park campus will close. The reconfiguration would facilitate improved utilisation of tertiary services, reconfigure general hospital services and improve State rehabilitation facilities.

The CSF predicates the level of services currently delivered at each site. Clinical service plans for SMAHS and site specific Clinical Service plans are being reviewed by Clinical Cluster Leads to advise on risks and operational concerns.

Reconfiguration Strategy

SMAHS are committed to:

Activity based management and activity based funding (ABF) modelled on expected activity rather than block funding. ABF was recommended in 2008 with a commitment to establish federal efficient price by 2012/13. New ways of working generate improved efficiencies and service delivery will be based on clusters of services delivered across all sites.

Four phase approach to Reconfiguration Strategy

- Phase 1 Service delivery model development July-Oct 2011
- Phase 2 Detailed implementation planning Nov 2011-June 2012
- Phase 3 Implementation July 2012-Dec 2013
- Phase 4 Physical Move

Reconfiguration strategy splits all related projects into three main arms:

- Projects required to prepare and plan for service reconfiguration
- Physical relocation
- Dual provision of services across sites

Documentation sent to the review team prior to their arrival in Perth identified that the SMAHS reconfiguration strategy group identified the following risks:

- Operational Funding resource during reconfiguration
- Communications adverse publicity poor stakeholder community engagement
- Workforce potential deficit –of skilled workforce to deliver model
- Patient flows the Service delivery models do not match the patient flows.
- Programme risk reputation, budget, planning and under performance

They had further split the risks into three main funding streams:

- Project and change management of reconfiguration
- Service transition and readiness
- Workforce

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Findings of the UHB Review Team:

Areas of good practice

- The review team found teams with commitment to making the Fiona Stanley and SMAHS programme a success. Although significant progress has been made in compiling documentation, the formation of a dedicated stand alone team to concentrate on the delivery of the FSH, will enable the wider SMAHS team to concentrate on site wide operational issues and day to day management.
- There was good clinical engagement at Cluster Lead level and the area wide approach taken to the programme should be commended compared to the silo'd reconfiguration approach found in most Health economies.
- All interviewees demonstrated a commitment to embrace the challenges associated with a change of this magnitude and recognised the urgency of finalising the clinical models of care, in order to facilitate the commissioning of the FSH.
- The time constraints associated with changes of this magnitude was recognised by the wider group.
- A Programme Management Office has been established.

Due to restrictions in time the review team have not undertaken an independent review of the delivery of the Physical Asset. However, through the interview process no concerns have been raised indeed the team have been assured that the build may be ahead of time.
The team have however, been told further variations may be required.

Immediate Action required:

The review team have identified through the interview and preparatory process a number of concerns that without immediate action could severely impact on the delivery of the programme and the timely opening of the Fiona Stanley Hospital. Without action the review team cannot provide full assurance at this point around the successful completion of the reconfiguration strategy or the successful opening of the Fiona Stanley Hospital.

Concerns:

- A structure is in place that has been designed to ensure that the Accountable Officer has all of the information available to them in order to determine if the programme is on track. However, on the evidence provided to the review team there appears to be a skills deficit to deliver a programme of this nature and complexity. The structure and tools being used are not sufficiently robust to provide this assurance.
- From the information provided there is insufficient integration of the work streams and a lack of awareness of the importance of the interdependencies.

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- The review team considers from the evidence provided when compared to the UHB Programme that a significant number of the workstreams are 12-18 months behind. The lack of a Master Integrated Programme does not allow SMAHS to monitor and measure progress against significant milestones or critical interdependencies.

- The Clinical Cluster leads have carried out considerable work on clinical strategies however, there was no evidence presented to the team of the detailed work being completed and transitioned to a detailed service plan within the timescale.

- Whilst work has been carried out on workforce, there is no detailed workforce plan drafted at staff group level at this stage. SMAHS acknowledge that there are shortages in some specialties but it is unclear to the team how or when the recruitment will begin. In the absence of a costed work force plan the review team can give no assurance on affordability.

- At the level of SMAHS Financial planning: From the information provided to the reviewers it is unclear how the financial models will link to the clinical service models, particularly with the introduction of ABF and a Nationally Efficient Price. - it should be noted however the team were unable to interview the GGM Finance but a number of team members were asked this questions around financial planning.

- From the information provided via the interview process the team were made aware of a general lack of confidence in the ICT systems delivery and a lack of understanding of what is to be delivered in terms of the Electronic Medical Record. There is little evidence of integration of ICT service elements across the various agencies. The risk management and mitigation around failure to deliver a full range of IT solutions is lacking.

- From the evidence provided the risk management processes appear to be in development, are not sufficiently mature to adequately identify, mitigate and manage risks inherent in a Programme of this complexity.

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Comparison of the Birmingham and FSH Approach

The Birmingham programme was 12 to 18 months ahead of the current Fiona Stanley programme and had a team in post with both operational and programme management capabilities and skills. The team where completely focused on the delivery of the New hospital programme, this team was lead by an experienced Project Director.

The Birmingham programme had a much greater level of detailed planning completed at this stage including all of the clinical modelling and many of the new models of care were being tested in the old site to ensure that the model produced high quality outcomes for patients. It was important to ensure efficiencies were realised.

The workforce modelling was complete and updated as changes were required due to changing circumstances. The Trust had for each area, department including skill mix and grades a dynamic financial and activity model that was updated following any changes to either the organisations funding or the programmes objectives. The model could be updated as changes where required for instance the reconfiguration of services or change of policy from the centre. Consultant job planning was underway and agreement had been reached with the various universities around training of all staff including junior doctor's nurses and professions allied to health. The move sequence had been agreed for each of the 4 phases. Discussions were well underway around training placements during the patient move period, this allowed students to benefit from the experience of clinically assessing and moving large volumes of patients from one institution to another, invaluable experience that they may never gain again in their career If they do experience a large move on this scale again at least they would have a small base of knowledge to draw from, thus enhancing the skills available to the NHS in the future. The overall master programme was completed to a level of detail which showed which services would move into the new building at each of the four phases. This programme was updated on a weekly basis as changes were required. This included a review of Cancer services which resulted in this service being transferred to a completely different part of the Trust Estate.

The tender for removals had been let and the activity had been agreed with the Ambulance Service. As the moves had been agreed the removal firm could be engaged to allow for the very detailed planning around the non patient moves. The Ambulance service and police were involved in the detailed planning around the patient move. Therefore the costs of moving into the new hospital could be established at a very early stage in order to feed directly into the financial model.

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.

Experience from other programmes both in the UK and across the world demonstrate that the criteria outlined above are among the most important success factors in terms of successful delivery.

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From the evidence provided to the reviewers there are a number of elements which require significant development in the FSH/ SMAHS programme.

To ensure successful delivery of the FSH, refer to the conclusion, risks and recommendations.

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Review Conclusion

- Based on the evidence available the review team is unable to give the Director General adequate assurance that the FSH operational implementation programme in its entirety will be delivered on time or within allocated budgets, although with decisive and timely action, this may be retrieved.

- This is a highly complex programme within a health system that is facing the opening of a new hospital, service reconfiguration affecting a number of other hospitals and stakeholders at a time when the financial regime for the funding of healthcare is undergoing significant change. The review team did not receive sufficient assurance that the teams delivering the implementation programme have the necessary skills and capabilities to deliver a programme of this complexity (it should be remembered that the review team are not making this comment in relation to the build project as we have not reviewed progress).

- There are very clear state wide, indeed global recruitment issues to be addressed. The lack of planning around recruitment poses an even bigger risk in WA with expansion both in the public and private sector. It is intended that a proportion of the workforce will relocate from other reconfigured hospitals, the reviewer's could find little evidence that detailed cross system planning had been carried out on workforce.. No detailed workforce plans, including aspects of education, training, or orientation plans to address the specific requirements of the FSH programme were presented to the review team

- The review team were informed that there was a bed model, a financial model and a workforce model. However little confidence was expressed during interview in these models. The team were unable to find concrete examples evidence of updating of individual models or integration across the various models.

- The FSH programme is predicated on comprehensive integrated IT capability both through clinical care and FM services. From the information provided to the review team during the interviews there was a lack of awareness of the capabilities of the system and how ICT could be used to support clinical pathways. and what is to be delivered in the new hospital. The clinicians were unable to articulate the clinical ICT strategy for the FSH and there was conflict between the expectations of what is being delivered centrally versus what is to be delivered locally.

- The FM contract with SERCO was not part of the terms of reference for the review and, in any case, the review team were unable to dedicate a prolonged period of time to the status of the contract, due to the complexity of the programme to be covered in the week, However, it was evident that there needs to be a broader understanding of the contract, plans, obligations, roles and responsibilities across the FSH implementation program and the team.

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The nine key risks identified by the review team for the FSH health service implementation are as follows:

- FSH is the largest Health infrastructure and health service implementation programme undertaken in the state; in order to deliver such a large programme an experienced team is required with competencies to run complex programme management systems. This should be a team that is fully dedicated to the delivery of this programme led by an experienced programme director. They should be unencumbered by day to day operational management issues. A number of the key team members currently leading and managing the implementation programme have other responsibilities, and thus are not solely dedicated to the FSH programme. They have not managed a programme of this magnitude, and there are programme management skills deficits within the team.

- Programme delivery is reliant on clarity of roles and responsibilities. The SMAHS reconfiguration programme involves a number of agencies which adds to complexity. The review team were not assured from the evidence provided that sufficient levels of role definition were present to ensure adequate governance arrangements around the FSH programme. Formal reporting arrangements for the whole programme are unclear and the review team could find no evidence of monthly programme reports being presented at the DG level, For a programme of this size it should be expected that this report mechanism provides an update on all work streams against critical milestones. This highlight should report all risks associated with the programme including management and mitigation strategies. There should be a comprehensive management and mitigation strategies and a comprehensive issues list available to allow for transparency.

- Whilst it was not possible to gauge the maturity of the FSH financial model (as the SMAHS ED Finance was on leave at the time of the review) it will be critical to ensure a comprehensive Area and FSH operational financial framework is complete, based on agreed detailed service plans and an agreed workforce model.

- Alignment of service reconfiguration strategies and operational strategies is paramount in the delivery of large scale programmes. From the evidence presented to the team there does not appear to be the required level of alignment between the reconfiguration strategies and operational plans.

- Western Australia has recognised a challenge with regards to workforce recruitment. The SMAHS reconfiguration requires significant workforce changes and additional recruitment to meet future demand. The state of readiness of the workforce plan from the evidence provided to the team poses significant risk due to the timelines involved in workforce reconfiguration. Particularly with regards to Senior or very Specialist positions that require a long lead in time. Whilst all health systems are constantly evolving the introduction of further service changes that affect the location of services at FSH will significantly increase the risk to the programme substantially.

- The FSH is predicated on state of the art ICT in order to deliver both clinical and non clinical services. The interdependency between the HIN programme, Serco ICT project

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and clinical reconfiguration if not aligned poses significant risk to the delivery of the FSH. Particularly as no evidence of contingency plans were presented to the review team

- Large scale programme require mature risk and assurance processes. The risk management process presented to the team lacked the maturity required.

- There was no evidence of a comprehensive communication plan to manage stakeholders, internal and external, including both the community and the broader Government.

- A project of this scale requires a detailed and comprehensive integrated linked master programme. From the evidence provide to the team there does not appear to be a master programme to provide programme management structure and assurance. Whilst there are programmes available the lack of a master programme presents a risk to the successful delivery of the SMAHS reconfiguration and the FSH.

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SUMMARY OF RECOMMENDATIONS

Rec. No.	Recommendation	Completed by
1.	There should be a team concentrating on the delivery of the FSH programme, led by an experienced Director. The operational day to day management of SMAHS should be carried out by a different team. Although close integrated working will be required. Transparent processes will need to be in place, and the interdependencies of these teams need to be recognised.	August 2012
2.	To ensure oversight by the DG a transparent governance arrangement needs to be put in place setting out clear roles and responsibilities, clear reporting arrangements, with FSH programme reporting directly to the DG, this should replicate the way the Area leads report to the DG	August 2012
3.	To enhance the FSH programme delivery the dedicated team will require a clear programme management structure with the appropriate skills and competencies. This will ensure an effective management and assurance process. This team should also have an experienced practioner who can compile, manage, monitor and report on progress against the master programme. This programme should bring together all critical milestones across all the work streams and highlight all the obligations in respect of the delivery of information or action that the private sector is dependant upon.	
4	Clinical Strategy-The cluster leads detailed clinical plans need to be finalised in the next month this will allow for the other important work to progress around workforce, training, recruitment and detailed planning for the move and stakeholder management. This work will require close integration with the Exec Directors at each of the institutions, in order for them to develop the budgetary and clinical modelling requirements for all the services.	July 2012
5	Workforce strategy-once the clinical strategy is agreed the workforce plan can be finalised. Work needs to commence immediately on agreeing final placement of all staff, currently working in SMAHS/NMAHS. There needs to be a comprehensive training analysis to assess the skills gap. Recruitment and training programmes will need to be agreed. Recruitment for all identified ”hard to	December 2012

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	recruit" positions should commence immediately A decision is urgently required on when the senior team for FSH will be recruited, they should be in position by December 2012 Ensure the financial model and activity model is updated once the clinical strategy and workforce plans are agreed. This model needs to be in sufficient detail to provide ongoing assurance around affordability of the programme. It must include all "commissioning costs" i.e. double running ,removals etc.	
6.	Obtain high level agreement that the current reconfiguration and location of services is the plan that will be used to open FSH. If agreement cannot be obtained the FSH programme team must ensure that all of the programmes are sufficiently flexible to allow changes to be made and critical links to be identified. Where there are critical inter-dependencies the team must be responsive enough in their planning to accommodate change	August 2012
7.	There must be a high level agreement with clinical input on the deliverables around the ICT programme, including the components being delivered by the HIN team and how they interface with the Serco obligations. Immediate resolution of this issue will allow for the remaining time to be used for the implementation testing and training. There should be a comprehensive, detailed, integrated ICT programme to ensure successful delivery of these components. A comprehensive communications plan needs to be put in place to ensure all staff moving to FSH understands the ICT capability within the new building.	August 2012
8.	Conduct a risk review, preferably with an experienced risk manager who understands both the complexity and interdependencies of this programme. Ensure that the risk management and risk mitigation plans are in place. Robust scenario and contingency planning needs to be in place.	June 2012

The recommendations highlighted above are the most critical to ensure successful delivery of the FSH project.

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The recommendations below are also vital to success but follow on from the key recommendations above

Rec. No.	Recommendation	Rec. No.
	Complete a stakeholder map to ensure that all stakeholders have been identified and their contribution to the programme is understood. Ensure that there is a comprehensive communication strategy to deal with internal and external stakeholders. Agree a media strategy.	
	Agree the monitoring arrangements for the Serco contract, that will be required post December 2014. This should include monitoring of all services provide by Serco, reporting arrangements, clarity regarding how the helpdesk will function and certainty around how the financial model is maintained.	
	Agree the detailed move programme for all services, down to departmental level, ensuring engagement with the Ambulance service and removal contractors.	
	Agree the plans for the decommissioning of the areas of the other hospitals where activity is moving either to the FSH or another institution. A detailed programme of bed closures must be in place and included within the integrated master programme. This should then be monitored via regular updates by the FSH team	
	Finalise the efficiencies derived from the detailed service plans, including both bed and cash efficiencies. Monitor against activity and financial plans and report on a monthly basis to the DG.	

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The review was carried out in accordance with the specified terms of reference by:

Morag Jackson New Hospitals Project Director

Tim Jones Executive Director of Delivery

Jane Roddick Clinical Commissioning Manager

On behalf of University Hospital Birmingham

All interviews were conducted as per attached schedule, on occasions small groups of staff where seen together with their consent.

Also needs a page as an attachment/ appendix of the all the people interviewed (I have attached the final list separately for you to go through).

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