



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**

Legislative Assembly
Parliament of Western Australia

Committee Members

Chairman	Dr G.G. Jacobs, MLA Member for Eyre
Deputy Chairman	Ms R. Saffioti, MLA Member for West Swan
Members	Hon. R.F. Johnson, MLA Member for Hillarys Mr N.W. Morton, MLA Member for Forrestfield Ms J.M. Freeman, MLA Member for Mirrabooka

Committee Staff

Principal Research Officer	Mr Mathew Bates
Research Officers	Ms Alice Jones Ms Catherine Parsons

Legislative Assembly	Tel: (08) 9222 7494
Parliament House	Fax: (08) 9222 7804
Harvest Terrace	Email: laehsc@parliament.wa.gov.au
PERTH WA 6000	Website: www.parliament.wa.gov.au/ehsc

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Presented by

Dr G.G. Jacobs, MLA

Laid on the Table of the Legislative Assembly on 10 April 2014

Chairman's Foreword

Building a state-of-the art facility like the Fiona Stanley Hospital (**FSH**) was always going to be a challenging task, but not one that was unprecedented internationally. The hospital build was delivered up to expectation in standard and timing, but there is much more to commissioning a hospital than the bricks and mortar. The handling of the commissioning of the hospital stands in stark contrast to the management of the build, especially in relation to the Information and Communications Technology (**ICT**) elements and clinical readiness of the system.

The facilities management services contract (**FMSC**) signed with Serco locked the State into delivering complex solutions to interface with Serco on an already complex and massive project. Additionally, the State committed itself to transitioning to a full tertiary hospital within one month of opening the doors in April 2014. It seems that this aspect of the FMSC was never reviewed for achievability before the contract was signed, despite wide recognition that it would be impossible for the state to deliver complex solutions and to open a hospital in April 2014. This also applies to transitioning such a large hospital to full operations within a month of opening its doors.

A litany of evidence made it increasingly clear that the commissioning project was not going to be delivered on time, but the warnings went unnoticed for far too long. Poor governance and reporting in the earlier stages of the project meant that it was difficult for anyone to gain visibility of the problems and the potential for delay. Yet, even later on, when the advice about the extent of the problems became clear, it was stifled. Poor communication meant that important advice effectively never saw the light of day. Those with ultimate responsibility for the project were kept in the dark.

The Director General of the Department of Health (**DoH**) seemed to be wedded to the scheduled opening date despite receiving various pieces of advice that this was not possible. In his mind, the commissioning project could be rescued by "ditching" ICT components until they arrived at an ICT solution that could be delivered on time. But it was too little, too late. Those advising him about delay had already taken into account that ICT for the hospital could be significantly scaled down and yet they still concluded that a delay would occur.

A Taskforce was created by Cabinet to give oversight and rigorous governance to the commissioning process, as recommended by the University Hospital

Birmingham Report in July 2012. However, the structure of this Taskforce was flawed. It was prevented from achieving its oversight role by the then Director General of DoH who filtered the information in and out of the Taskforce in his role as chair. It took some time and effort for the Taskforce to gain an understanding of the true status of the commissioning project and conclude that a delay would be necessary. By then, more precious time had been lost on a project that had already slipped well behind schedule.

The legislative structure of DoH is out-dated and no longer reflects the way hospital and health services are delivered in this State. It is imperative that this legislation is replaced so that lines of decision-making authority are clarified.

This protracted failure to recognise the problems with FSH commissioning project has serious implications. It has not only delayed the project delivery but will also ultimately cost the taxpayers of Western Australia a significant sum. It is also important to note that if the contractor had been informed of changes to the scope and timeframe of the project earlier, these costs would have been able to be mitigated. The final accurate figure as to the extra cost to taxpayers will become evident in the fullness of time.

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

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Executive Summary

Delivering a new 783-bed hospital requires the coordination of many elements, including the physical infrastructure, clinical readiness, staff recruitment and training and Information and Communications Technology (ICT) readiness. In the case of the Fiona Stanley Hospital (FSH), this process was made even more complex by the requirement to coordinate with Serco, a private facilities manager. Because of various shortcomings associated with the Department of Health's (DoH) management of its obligations, the decision to delay the opening of FSH has resulted in the payment of an additional \$52.7 million to Serco prior to the hospital's opening. This is in addition to the \$66.1 million that Serco was already entitled to receive. Given the nature of the contract, the earlier Serco was informed of any delay, the earlier it could have begun to mitigate its costs. This means that the amount payable to Serco by the Government would have decreased.

Furthermore, DoH has required significant additional funding for the commissioning of the hospital because, according to DoH, "the scope and number of activities required for the safe and successful commissioning of FSH and reconfiguration of SMHS is significantly more than previously envisaged."

In total, it was confirmed by Treasury that a total of \$330 million in additional funding has been required for the commissioning of the hospital to date.

In conducting this inquiry, we wanted to identify why Serco was not informed earlier, given that advice was received by the Director General in December 2012 that a delay was likely to occur. We also wanted to establish why the problems with commissioning the hospital were only fully realised so late in the project's life.

Unrealistic expectations

The FSH project was a bold vision requiring leadership and good governance to succeed. The most obvious challenge was the digital ICT vision for the hospital, which was intended to create a paperless hospital relying extensively on electronic patient and medical records. With the benefit of hindsight, most of the people associated with the project have acknowledged that this ambition was a step too far. Whilst we do not dismiss those views, it is also clear that the ability to deliver the digital vision was hampered by poor governance and project management, both within the Health Information Network (HIN) and the FSH project team.

The decision to open the hospital in April 2014 and to allow only one month for a transition to full capacity was unrealistic to ensure patient safety. We could find no evidence of other, similarly sized, hospitals reaching full operation in such a short

period of time. Indeed, Mr Kim Snowball, the then Director General of the Department of Health (**DoH**), belatedly acknowledged in January 2013 that “no one in their right mind would believe” that the hospital could have been at full capacity in April 2014.

Despite those managing the project belatedly acknowledging that the ambitious ICT vision and opening schedule were unrealistic, we never received particularly satisfying explanations for how they were included in the \$4.3 billion contract with Serco.

Poor governance

It was only after November 2012 that rigorous governance procedures were implemented to deliver the commissioning project. Prior to this, the approach to governance – especially project reporting – was disjointed and unstructured. The University Hospitals Birmingham (**UHB**) review in July 2012 found that formal reporting arrangements were unclear, and that there was no evidence of monthly programme reports being presented to the Director General.

It is clear that the consequence of this failure to provide integrated reporting across the entire commissioning project was the inability to appreciate the true status of the project. This was exacerbated by a management structure that split responsibilities and ensured that no single person was responsible for managing the various work streams. This is not to say, however, that warning signs about the problems did not exist. The project status reporting that did exist was not uniformly positive. Senior management in the South Metropolitan Health Service (**SMHS**) were raising concerns about the ability of HIN to deliver the ICT elements on schedule. Indeed, Ms Nicole Feely, the former Chief Executive of the SMHS, was so concerned about ICT that she asked Mr Snowball to terminate her contract if he was unwilling to transfer responsibility for FSH ICT.

Ultimately, the existing inadequate governance and management arrangements continued until a few months after the UHB team had completed its review of the commissioning project.

Belated realisation

The UHB Report was the first of a series of reports presented to the Director General in the second half of 2012 identifying significant risks of delay to the hospital opening. The main consequence of the UHB Report was the creation of the Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce (**the Taskforce**), established by Cabinet to improve the governance of the project and oversee its progress.

The UHB Report was followed by a series of reports submitted in December 2012 which quantified the extent of the likely delay – namely, nine to 12 months. These reports

identified the most problematic work streams and provided detailed analysis of the causes for the delay. Importantly, with respect to the problems with ICT, the reports made clear that even radically simplifying the ICT approach would not recover the schedule.

The Taskforce was kept in the dark

Given the oversight role of the Taskforce, we would have expected that all reports relating to the status of the project would have been shared with the Taskforce. This did not happen. Taskforce members reported to us that they were only made aware of reports advising of the likelihood of delay after Mr Snowball departed from the role of Director General. Failure to provide this information to the Taskforce effectively prevented it from achieving its oversight function.

Mr Snowball was of the view that the delays could be mitigated by reducing the scope of the ICT solution for the hospital. In early January 2013, he authorised a plan, known as “Option 2”, which effectively marked the abandonment of the original digital vision. He was satisfied that, having selected Option 2, a report to government on the potential for delay was not necessary.

The Minister’s role

We have been told by the Department of Health that the only documentary advice provided to the Minister for Health about “significant ICT readiness issues” was contained in a short briefing note in December 2012. Furthermore, there is no documentary evidence that Mr Snowball informed the Minister that he had authorised the abandonment of the digital vision.

The Minister has told us that he met fortnightly with the Director General and that, as a result of these meetings, “the challenges around the delivery of services were well known and well understood.” Notwithstanding this, we would have expected the Minister to seek significantly more information about the commissioning project, especially given that the December 2012 briefing note raised the possibility of delay on account of “significant ICT readiness issues.”

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 Premier and 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 12

The University Hospitals Birmingham Report was not given the requisite level of attention by Ministers and key agencies given the seriousness of the issues that it identified.

Finding 2

Page 13

The integrated programs, intended to draw together the various elements of the commissioning project in order to allow for the tracking of critical milestones and paths, were totally inadequate to allow for program management and assurance that timelines were being met.

Finding 3

Page 13

The failure to develop an adequate integrated program at an earlier stage of the commissioning project made it extremely difficult to identify risks and accurately monitor the project's status.

Finding 4

Page 13

According to PricewaterhouseCoopers, even as late as June 2013, the interdependencies in the commissioning project were not fully understood, identified and mapped.

Finding 5

Page 22

In June 2012, the then Chief Executive Officer of the South Metropolitan Health Service (SMHS) recommended the transfer of responsibility for Fiona Stanley Hospital's Information and Communications Technology work stream from the Health Information Network to SMHS. The recommendation was not acted upon.

Finding 6

Page 24

Prior to September 2012, there was a lack of visibility across the various streams of the commissioning project at senior levels in both the Department of Health and the Fiona Stanley Hospital project team. This, in conjunction with the interdependencies, made it almost impossible to gain an accurate understanding of the true status of the project.

Finding 7

Page 25

The Health Information Network's software development was hindered by the delay in completing clinical services plans and the failure to create a clinical reference group at an earlier stage of the commissioning project.

Finding 8**Page 28**

Failure to make timely decisions resulted in avoidable delays to the procurement of important Information and Communications Technology elements, including the Closed Loop Medication Management System.

Finding 9**Page 34**

In March 2013, having received an update on the status of the South Metropolitan Health Service reconfiguration, the Taskforce was so uncertain of the reconfiguration's status that an independent review was commissioned to report back on milestones, capability, workforce requirements, emerging risks and issues.

Finding 10**Page 35**

Serco's reporting on the status of its Pre-operational and Transitional Services obligations was consistent and integrated, and easily interpretable. This demonstrates that such reporting is standard for projects of this type and illustrates the deficiencies in the Department of Health's project management.

Finding 11**Page 37**

By September 2012, Serco's Pre-operational and Transitional Services reports were providing evidence of the problems being encountered across the various streams of the commissioning project, particularly those relating to Information and Communications Technology.

Finding 12**Page 38**

The failure to establish the Fiona Stanley Hospital Project Management Office at the time the contract was signed with Serco in July 2011 resulted in failures to accurately track the status of important work streams under the commissioning project, including workforce and clinical commissioning.

Finding 13**Page 44**

The digital vision was adopted in 2007 and reaffirmed in 2008 by the current government. A \$4.3 billion contract was signed based on the digital vision in 2011. DoH only finalised the elements of digital vision in September 2012, simply to abandon it two months later in November 2012.

Finding 14**Page 47**

The Information and Communications Technology elements of the facilities management contract were initially released in March 2010 as part of the tendering process without the endorsement of the Health Information Network's Chief Information Officer.

Finding 15**Page 49**

The Department of Health did not assess its capacity to meet the April 2014 opening date before including it as the operational service commencement date in the contract signed with Serco.

Finding 16**Page 50**

The four week transition period for Fiona Stanley Hospital was identified in the 2007 Business Case and included in project schedules going forward from that time. It does not seem that DoH revisited the achievability of this timeframe before including it in the contract with Serco.

Finding 17**Page 54**

By December 2012, DoH had been aware for 18 months that a commissioning plan was required. It was a significant failure of DoH that it did not produce the document earlier given its importance.

Finding 18**Page 55**

The January 2013 decision to select a six-month phased opening commencing in April 2014 was not the safest option considered, with the clinical commissioning team noting that the safest option was to phase over six months commencing in October 2014.

Finding 19**Page 56**

The Minister for Health signed a \$4.3 billion contract with Serco where the government was obligated to deliver an operational digital hospital on 1 April 2014. The Committee is not satisfied that the government had assured itself that it could achieve this before signing the contract.

Finding 20**Page 58**

Commencing in July 2012, a series of reports were completed that concluded a delay to the opening of the hospital was likely to occur.

Finding 21**Page 61**

The University Hospitals Birmingham Report provided to the Cabinet and the Department of Health in July 2012 found that a significant number of work streams associated with the commissioning of the Fiona Stanley Hospital were 12 – 18 months behind when compared to equivalent work streams at the University Hospitals Birmingham.

Finding 22**Page 61**

The findings of the University Hospitals Birmingham Report made clear that there were significant and wide-ranging deficiencies associated with the commissioning of the Fiona Stanley Hospital.

Finding 23**Page 64**

In December 2011, the Solomon Report, an independent review of Information and Communications Technology projects across the Department of Health, concluded that the vision for a paperless hospital at Fiona Stanley Hospital was not feasible.

Finding 24**Page 71**

An independent review conducted by Fujitsu consulting in December 2012 concluded that there was an unacceptable risk around the ability of the Health Information Network to deliver the work necessary to enable the provision of a functional and clinically safe Information and Communications Technology solution for Fiona Stanley Hospital by April 2014.

Finding 25**Page 73**

A review undertaken by the Health Information Network in December 2012 concluded, with respect to the Information and Communications Technology (ICT) elements of the commissioning project, that even with a more pragmatic and less ambitious approach, a delay of between nine and 12 months was required in order to have all core ICT systems functioning and to reduce risk to patients.

Finding 26**Page 75**

The review undertaken by Dr David Russell-Weisz in his capacity as Chief Executive, Fiona Stanley Hospital Commissioning in December 2012, concluded that deficiencies in the workforce and clinical commissioning work streams were likely to delay the opening of the Fiona Stanley Hospital. In relation to the Information and Communications Technology (ICT) work stream, Dr Russell-Weisz concluded that a delay of between nine and 12 months was almost unavoidable, even if a scaled-back ICT solution was deployed.

Finding 27**Page 76**

When viewed against the background of the earlier reports, it is difficult to see how the final advice about the risk of delay could have come as a surprise to the then Director General of the Department of Health, Mr Kim Snowball.

Finding 28**Page 77**

The Health Information Network advised Mr Snowball in an earlier version of the ICT Options Paper that a delay of nine to 12 months was still anticipated to successfully open the hospital, even with the de-scoped Information and Communications Technology solution proposed in Option 2. This advice was later removed from the ICT Options Paper following a meeting with the Director General.

Finding 29 **Page 80**

The Taskforce was created with the intention of improving the governance arrangements, and providing inter-departmental oversight, of the commissioning project.

Finding 30 **Page 82**

The ability of the Taskforce to fulfil its oversight role was hindered due to the limited information Mr Snowball provided to the Taskforce.

Finding 31 **Page 84**

The briefing Mr Snowball provided at the 6 February 2013 Taskforce meeting omitted any reference to the advice he had received in December 2012 about the need to delay the hospital's opening.

Finding 32 **Page 84**

Mr Snowball's decision to tell the Taskforce at the 6 February 2013 meeting that the Workforce and Information and Communications Technology work streams were "on target" is inconsistent with the information made available to him in various reports, including Dr Russell-Weisz's Baseline Report, but also the Project Management Office reporting.

Finding 33 **Page 86**

Mr Snowball told the Taskforce at the 6 February 2013 meeting that risks to the ICT delivery schedule were being managed. This claim was difficult to reconcile with the advice that had been provided to him since December 2012, and advice in January 2013 that a nine to 12 month delay was envisaged.

Finding 34 **Page 88**

Each of the non-Department of Health members of the Taskforce recollect that no disclosure was made at the 6 February 2013 meeting about the possibility of a delayed opening to the Fiona Stanley Hospital.

Finding 35 **Page 89**

Arising from the Cabinet decision to create the Taskforce, the Department of Health, and by extension Mr Snowball in his capacity as Director General, had an obligation to disclose to the Taskforce information on matters concerning the commissioning of the hospital.

Finding 36 **Page 89**

Mr Snowball ought to have provided the Taskforce with copies of Dr Russell-Weisz's Baseline Schedule Report, the HIN Status & Readiness Working Paper and the ICT

Options Paper. Without these documents, the ability of the Taskforce to carry out its oversight function was undermined.

Finding 37

Page 90

To truly achieve independent oversight, the Taskforce should not have been structured with the Director General as chair.

Recommendation 1

Page 92

For projects of significant cost and importance, where deficiencies have been identified, the Department of the Premier and Cabinet must ensure that any cross-government Taskforce being established has:

- a finite lifespan with strict reporting and meeting obligations;
- an independent or co-chairing arrangement; and
- a requirement that reports be submitted to the Economic and Expenditure Reform Committee, not solely to the individual responsible Minister.

Finding 38

Page 94

Particularly given the content of the 5 December 2012 briefing note, we would have expected the Minister to seek significantly more information about the status of the commissioning project.

Finding 39

Page 101

It was a failure of accountability in government that the decision to de-scope the Fiona Stanley Hospital Information Communications Technology vision was not communicated in a formal briefing note to the Minister for Health. This decision was of such material significance that it demanded disclosure.

Finding 40

Page 102

The Minister for Health had signed a \$4.3 billion contract on behalf of the State, which contained obligations for the State to deliver a digital hospital in April 2014. We are not convinced that the Minister adequately satisfied himself that the obligations of the contract were being met.

Finding 41

Page 104

Regardless of Mr Snowball's view that the risk of delay to the opening of the hospital had been mitigated, he nonetheless had a duty to advise the Minister for Health that he had received advice from the Chief Executive appointed to oversee the commissioning of the hospital that a delay was to be expected.

Finding 42 **Page 108**

Dr Russell-Weisz’s Incoming Government Brief was an accurate and frank appraisal of the status of the Fiona Stanley Hospital commissioning project providing detailed information about the commissioning project as at March 2013.

Finding 43 **Page 113**

Dr Russell-Weisz’s Incoming Government Brief was not provided to the Minister. Mr Snowball’s preferred briefing paper was rejected by Taskforce members on account of its failure to report accurately about the status of the Fiona Stanley Hospital commissioning project.

Finding 44 **Page 122**

The decision to endorse a significantly de-scoped ICT vision via Option 2 for Fiona Stanley Hospital ought to have been submitted to the Minister for Health, and appropriately elevated to the Economic and Expenditure Reform Committee and Cabinet process.

Recommendation 2 **Page 123**

The Minister for Health should repeal and replace the *Hospitals and Health Services Act 1927* (WA), with legislation that accurately reflects the Department of Health’s current operations.

Recommendation 3 **Page 125**

The Department of Health must ensure that a permanent appointment be made to the position of Chief Information Officer, Health Information Network, as soon as possible.

Chapter 1

Introduction

The Fiona Stanley Hospital

1.1 The construction of the 783-bed Fiona Stanley Hospital (**FSH**) was completed in December 2013. Originally intended to be fully operational and at 100 per cent of its capacity sometime in April or May 2014, the opening of the hospital has been delayed by six months until October 2014 and fully capacity is now expected to be reached in March 2015.

1.2 In July 2011, the State Government signed a contract – the Facilities Management Services Contract (**FMSC**) – with Serco to provide all non-clinical services at the new hospital for a period of 20 years. The FMSC was developed on the basis that the hospital would open in April 2014 and reach full capacity soon thereafter. These dates therefore became contractual obligations that the Department of Health (**DoH**) was required to meet.

1.3 These dates were not, however, the only obligations that it was agreeing to when signing the contract. The original business case for the hospital in 2007 included an ambitious goal to create a paperless hospital with the intention of using FSH as pathfinder for future reform of the entire Western Australian health system. This was known as the “digital vision” for the hospital and it influenced a range of aspects across the project, including the hospital’s physical design. The FMSC signed with Serco was also influenced by the digital vision, meaning that Serco’s ability to provide the Information and Communications Technology (**ICT**) elements it was contractually obliged to deliver was critically dependent on DoH delivering an ICT platform in compliance with the digital vision.

The commissioning project

1.4 Ensuring that DoH has the various procedures, policies and other resources (including ICT) in place to allow the successful opening of the hospital in April 2014 falls under what we have described throughout this report as the “commissioning project”. The commissioning project is comprised of several different work streams, each of which (with the exception of the Corporate work stream) has been outlined below. At this early stage, it is also worth highlighting that three of the work streams outlined below – ICT, Workforce and Clinical Commissioning – were the elements of the commissioning project causing the most significant risks of delay.

1.5 Figure 1.1 provides a simplified representation of the commissioning project and its various work streams. Sitting under the work stream were hundreds of individual activities; under those were the many thousands of inputs.

South Metropolitan Health Service reconfiguration

1.6 In order to accommodate the addition of FSH into the wider South Metropolitan Health Service (**SMHS**) health economy, clinical services delivery within SMHS is being reconfigured. The reconfiguration is taking place across all hospitals in SMHS and includes significant changes to the number of staff at each hospital location in addition to changes to the nature of clinical services being delivered at each site. The SMHS reconfiguration represents a significant body of work in its own right, with numerous activities taking place at a range of locations, sharing multiple dependencies with the FSH commissioning project.

Information and Communications Technology

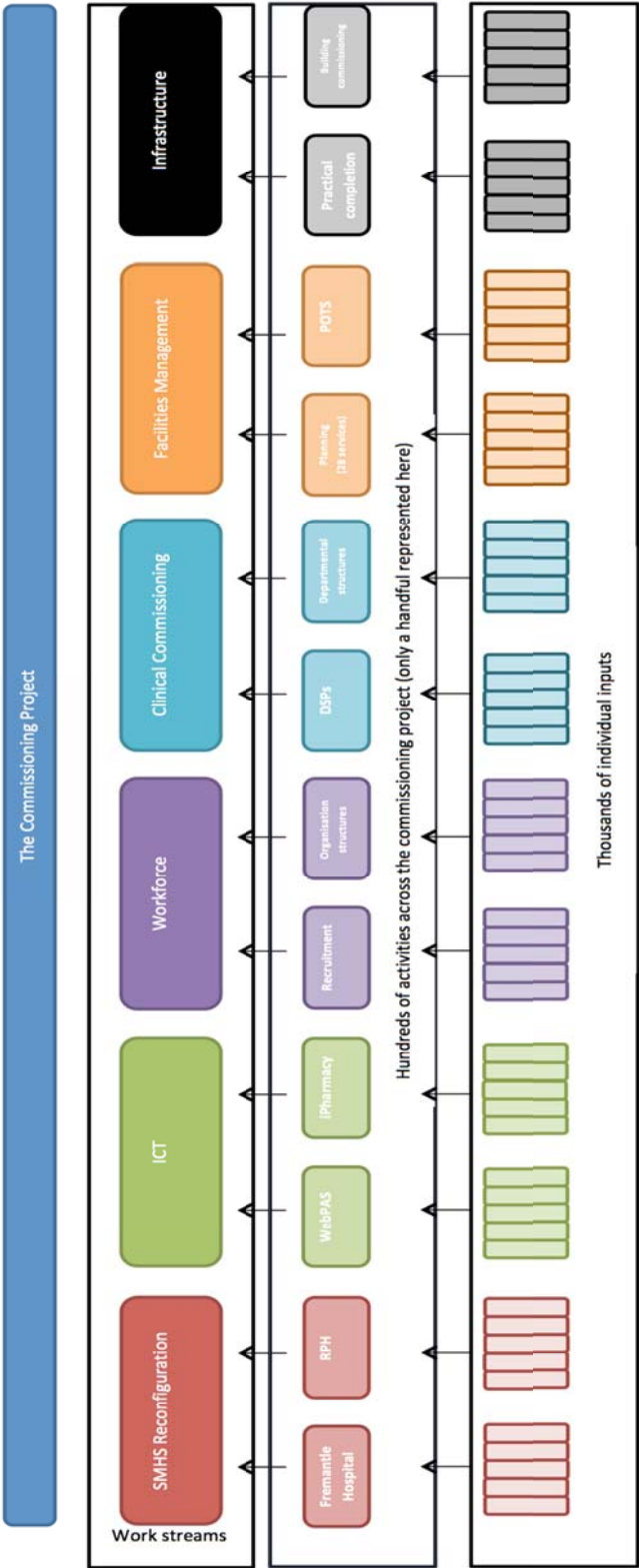
1.7 The ICT work stream encompasses all ICT-centric business and technology services required to operate FSH. These services will be delivered by the Health Information Network (**HIN**), the Health Corporate Network (**HCN**) and Serco. The original intention of the ICT work stream was to:

- Enable the FSH vision of a digital hospital – “a leading tertiary hospital in Australia providing unparalleled levels of accessible, integrated and evidence-based patient-centric care through the utilisation of innovative and modern information and communications technology to enable optimal safety, assessment and treatment, efficiency and stakeholder satisfaction”.¹
- Facilitate the FSH corporate business model that includes a contracted set of Facilities Management (**FM**) services.
- Allow for the seamless sharing of information with other WA Health hospitals.
- Provide efficiency and effectiveness gains in hospital operations.
- Allow FSH to adopt the national agenda for information exchange and shared health records with additional community and external providers across the continuum of care.
- Support improved patient satisfaction through patient centred journeys.²

¹ Department of Health, *Fiona Stanley Hospital: ICT Solution*, September 2012, p. 9 in Submission No. 14 from the Department of Health, 2 January 2014.

² Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

Figure 1.1: A simplified schematic of the commissioning project, outlining work streams, activities and inputs



Workforce

^{1.8} The workforce work stream encompasses all activities that are required to ensure an adequate number of appropriately competent staff are available to deliver patient care and to support those delivering that care. This includes:

- Configuration (organisational structures, position creation and classification).
- Deployment and relocation.
- Recruitment.
- Medical accreditation.
- Training and induction.³

Clinical commissioning

^{1.9} Clinical commissioning involves all activities required to ensure FSH is able to operate as an effective organisation, supporting the delivery of safe and effective clinical services. It includes:

- Activities required to establish and deliver services at FSH.
- Development of clinical services, support services and major patient flows.
- Provision of clinical ICT interface for the development of clinical ICT systems and solutions.
- Development of clinical transition planning including scenario development and user acceptance testing.
- Development of departmental workforce structures to support service delivery models.
- Provision of clinical interface in ongoing clinical design and equipment expertise and decision making.
- Development of hospital and departmental policies, guidelines and clinical pathways.
- Development of a delivery model for clinical education and training.
- Coordinating the transition of services (including patients, equipment and staff) from other SMHS sites to FSH.⁴

³ Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

Facilities Management

1.10 The FM work stream involves all activities that must be completed to ensure the building is ready for occupancy outside of construction and the ongoing delivery of non-clinical services by Serco. The contract with Serco requires it to deliver 28 services, including the day-to-day non-clinical operations for the hospital as well as pre-operational and transition services, equipment procurement and ongoing human resources service, including recruitment support during and after the commissioning process has ended.⁵

Infrastructure

1.11 The infrastructure work stream encompasses the practical completion of the building for handover to Serco and WA Health. Prior to opening for use, the building must be fully commissioned including all engineering services and architecturally significant equipment.⁶

The Inquiry

The decision to launch the inquiry

1.12 Following the state election in 2013, the Education and Health Standing Committee for the 39th Parliament met for the first time in May 2013. At its first meeting, we resolved to hold a preliminary hearing with the Department of Health on 19 June 2013 to discuss, amongst other things, progress with implementing the government-wide efficiency dividend and the agency's budget settings for the 2013–14 financial year.

1.13 Prior to the hearing with DoH, media reporting emerged indicating that there would be a delay to the opening of FSH. Given the significance of these reports, many of our questions at this initial hearing dealt with the delay, how it had come about, and the potential implications of the delay for the contract signed with Serco.

1.14 A second hearing was held on 16 July 2013 during which additional detail about the nature of the ICT problems was explored in greater depth.

1.15 During the budget estimates process in August 2013, the then Treasurer also revealed that the University Hospitals Birmingham (**UHB**) had been tasked by DoH to review the status of the commissioning of FSH. We note that despite holding two

4 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, pp. 6–7 in Submission No. 4 from the Department of Health, 9 October 2013.

5 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

6 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

hearings with the Committee during which delays to the FSH were discussed in some detail, DoH elected not to disclose to us the existence of the UHB Report. We only became aware of it when the then Treasurer told the Parliament about its existence in August 2013.

1.16 We held one final hearing in September 2013 before resolving to go ahead with the Inquiry. During this hearing, it emerged the then Director General of DoH, Mr Kim Snowball, had been provided with a report from Dr David Russell-Weisz in December 2012 indicating that a delay to the hospital would be likely.

1.17 Over the course of the three months during which the information was provided to us, we became increasingly concerned that during 2012 DoH had been in possession of information indicating that a delay to the opening of FSH would be required, but that seemingly little or nothing had been done. We were also concerned that Dr Russell-Weisz's report, which was quite specific about the causes of and need for the delay, had not been shared with either the Minister for Health or the Taskforce established by Cabinet to provide improved governance and oversight to the project.

1.18 Due to these concerns, we resolved to commence an inquiry that examined how DoH had been planned and prepared for the commencement of services at FSH. Importantly, we also resolved to examine the extent to which important information about the status of the project – including, in particular, Dr Russell-Weisz's report about the need for delay – was communicated to those inside the Department and to the Minister for Health and Taskforce.

1.19 At all times, we have been guided by the view that meaningful accountability required full disclosure of information to those individuals or bodies tasked with the important role or overseeing projects such as the commissioning of FSH.

Why the Inquiry is important

1.20 There is also the question about the cost to the government, and therefore the people of Western Australia, that arises from the delayed opening of the hospital. A delayed opening of any hospital would always incur some kind of cost. Under-utilised assets still incur expenses even when they are not in use.

1.21 The situation with FSH is more complex than if it had simply been left empty or under-utilised. Serco has been contracted to provide all non-clinical services at the hospital. A condition of the contract was that the government would deliver a digital hospital ready for full operations in April 2014. Because the government was unable to meet this condition, Serco has received payments totalling \$52.7 million to cover its costs incurred during the period. This payment is in addition to the \$66.1 million payable to Serco during the period January 2014 to March 2015. In total, Serco will be

paid \$118.8 million to provide services at a hospital that is empty for the first six months and then substantially under-utilised for the following six months.

1.22 In total, it was confirmed by Treasury that a total of \$330 million in additional funding has been required for the commissioning of the hospital to date.⁷

1.23 There is no doubt that the earlier that Serco was informed of the delay, the earlier it could have commenced mitigating its costs. This means that the amount payable to Serco by the government would have also decreased in proportion to the costs that Serco could mitigate.

1.24 It is therefore very clear that the earlier that Serco was informed of the need for the delay, the less the cost to the government would have been.

1.25 The fact that unambiguous advice indicating the need for the delay was presented to the Director General in December 2012, and that this advice was then not provided to the Minister, is a cause of deep concern.

Conduct of the Inquiry

1.26 Much of the evidence received during the course of the Inquiry was received in closed session. This was to avoid any potential financial impact on the government during the negotiations with Serco up to December 2013. It also allowed witnesses to provide evidence to the Inquiry without the added complication of media and/or political factors weighing in on their appearance. The transcripts created during these hearings will not be disclosed, although on a number of occasions we have quoted or otherwise attributed certain information to the evidence given by individual witnesses.

1.27 In total, we received over 30 submissions from a number of agencies associated with the FSH project. Much of this evidence was also taken in closed session and will not be published in full; however, we have resolved to table in conjunction with this report a number of documents that have been mentioned extensively in the public debate surrounding both this Inquiry and the delayed opening of the hospital.

1.28 The Committee was also provided with a significant number of emails relating to the commissioning of the project either received by or sent from the Director General. Furthermore, DoH provide an array of internal reporting regarding the commissioning project's status from July 2011 through to September 2012 in addition to meeting papers prepared for the Taskforce. The information contained in the documents was of great assistance as we sought to corroborate the evidence provided by witnesses and to otherwise gain a better understanding of the commissioning project as it progressed following the signing of the contract with Serco in July 2011.

7 Ms Rachael Turnseck, Chief of Staff to the Treasurer, letter, 28 February 2014.

Chapter 2

Governance and program management

Inadequate governance and program management arrangements in place until late 2012 made it extremely difficult to gain an accurate picture of the commissioning project's status. This meant that important decisions about what could and could not be delivered at the hospital by the April 2014 opening date were made far too late in the project's life, thus causing a delayed opening of the hospital and increasing the costs to the State.

Governance was hindered by the lack of a single Senior Responsible Officer running all aspects of the project. In addition, significant deficiencies with project reporting stemmed from the failure to develop a comprehensive integrated program outlining critical pathways and milestones and identifying the many hundreds of interdependencies that existed across the project.

A complex project

2.1 There is little doubt that the process of transforming a completed piece of infrastructure into an operating hospital is a particularly challenging task. In the case of the Fiona Stanley Hospital (**FSH**) it was a task consisting of multiple independent – though interdependent – work streams each consisting of a large volume of activities with innumerable inputs. For ease of reference, throughout this report we refer to the series of undertakings required to bring FSH to an operational level as the **commissioning project**.

2.2 A simplified representation of the commissioning project can be found in Chapter 1 in figure 1.1. Sitting within the ambit of the commissioning project are six separate work streams. Underneath those are the many hundreds of activities that comprise the work streams. The representation in figure 1.1 is constrained by space, and therefore does not demonstrate the full extent of the activities (and has also omitted one of the work streams (Corporate) as it was never in danger of delaying the project). However, in the ICT work stream alone, the Health Information Network (**HIN**) identified the need to deliver over 200 separate applications in order to provide for the Information and Communications Technology (**ICT**) needs of FSH.⁸ Amongst many other activities under the clinical commissioning work stream, there are over 100 departmental service plans outlining how clinical services will be delivered at the

8 Department of Health, *Fiona Stanley Hospital ICT Solution*, September 2012, p. 20 in Submission No. 14 from the Department of Health, 2 January 2014.

hospital.⁹ It is not simply the number of activities that must be completed that has made the commissioning project so challenging. Interdependencies abound across activities and across work streams, meaning that a successfully completed activity in one work stream becomes an input necessary for the completion of an activity in another.

2.3 Managing the interdependencies across the commissioning project was obviously going to be central to successfully delivering the project.

Is complexity a sufficient explanation for the delay?

2.4 Even from the very brief overview of the commissioning project provided above and in Chapter 1, the complexity of the task should be obvious. One witness told us that there was “an almost bewildering range of interdependencies” where “one person’s work product would flow to another person’s area to inform them, to enable them to do something”.¹⁰ This is a useful encapsulation of the challenge, but it does not adequately explain why DoH so obviously failed at meeting it.

2.5 One of the questions that has pre-occupied the Committee since launching the inquiry is how it could be that a contract would be signed creating a series of obligations that the Department was so unprepared to meet. It is made even more difficult to understand when consideration is given to the fact that DoH more or less set the terms of the contract that was eventually signed. DoH nominated the ICT ambitions, the scope of the FM services to be provided by Serco, the one-month clinical transition period to full operations and the April 2014 opening date. It is also worth noting that DoH went ahead with this unique contracting model without first testing it in a smaller facility. Having therefore voluntarily set these terms, it would be reasonable to expect that the Department had established the type of governance and program management arrangements that could have provided the level of assurance needed to deliver a program as complex as the commissioning project. Unfortunately, that was not the case.

The Integrated Program

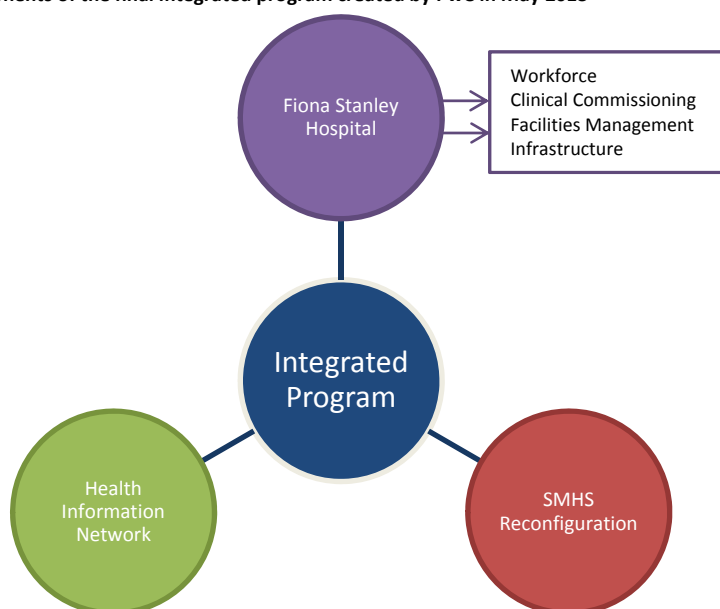
2.6 In simple terms, an integrated program is a collection of processes that ensure that various elements of a project are properly coordinated. Figure 2.1 provides an overview of the separate work streams that should be integrated into, planned for and reported against in the integrated program. Given that the commissioning project involved a wide array of separate but interdependent activities taking place simultaneously, there is an expectation that the Department would have developed a

9 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2.

10 Mr Paul Evans, State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 3.

robust integrated program against which important milestones and dependencies were being planned, tracked and reported. Despite a series of attempts throughout the life of the project, it seems that a sufficiently robust and detailed integrated program was only fully developed after May 2013.

Figure 2.1: Components of the final integrated program created by PwC in May 2013



Prior to May 2013, the integrated program was not robust

2.7 When the University Hospitals Birmingham (UHB) carried out its review (**the UHB Report**) of the status of the commissioning of FSH in May 2012, it found that the lack of a master integrated program did not allow SMHS to monitor and measure progress against significant milestones and critical interdependencies. Furthermore, the UHB Report found that there was insufficient integration of work streams and a lack of awareness of the interdependencies between them.¹¹ Perhaps most damning was the last of the nine “key risks” identified by the UHB Report:

A project of this scale requires a detailed and comprehensive linked master programme. From the evidence provide [sic] to the team there does not appear to be a master programme to provide programme management structure and assurance. Whilst there are programmes

11 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 12 in Submission No. 4 from the Department of Health, 9 October 2013.

*available the lack of a master programme presents a risk to the successful delivery of the SMAHS reconfiguration and the FSH.*¹²

2.8 The UHB Report went to Cabinet at some point between July and September 2012. Given the content of the report, we would have expected it to trigger immediate remedial action from relevant Ministers and their agencies. Given that six months had elapsed between the UHB Report and the comments made by Dr Russell-Weisz in his December *Baseline Report*, and that a new integrated program was developed by PricewaterhouseCoopers (**PwC**) in May 2013, the response to this “key risk” identified in the UHB Report appears to have been languid at best. This is, unfortunately, consistent with the manner in which other report recommendations were responded to across the commissioning project, and is an issue examined in further detail in later sections of this report.

Finding 1

The University Hospitals Birmingham Report was not given the requisite level of attention by Ministers and key agencies given the seriousness of the issues that it identified.

2.9 There was general agreement amongst those who gave evidence to the Committee that the integrated program was a source of trouble for the commissioning project. Ms Nicole Feely, the Chief Executive of SMHS at the time, acknowledged that it had not been possible to develop a “fully integrated program” because “ICT was not able to give us a plan as to their work program.”¹³ One witness even went so far as to tell us that the integrated programs either did not exist or were “high-level bullshit”.¹⁴ The language might be strong, but the conclusion is difficult to refute. Mrs Rebecca Brown, a Deputy Director General of the Department of the Premier and Cabinet, observed that it had been, amongst other things, the “investment in a significant integrated program” (presumably the PwC integrated program) that had allowed the Taskforce to demonstrate in mid-2013 that the April 2014 opening date was not achievable.¹⁵ The implication is that it was not possible to fully understand the correct status of the project without the rigour contributed by a “significant” integrated program that tracks critical milestones, paths and interdependencies. In other words, a true understanding of the project could only be gained if it was considered as a “whole”, across its numerous work streams and activities. This understanding had been

12 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 16 in Submission No. 4 from the Department of Health, 9 October 2013.

13 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 5.

14 Mr Tim Marney, Under Treasurer, *Transcript of Evidence*, 4 November 2013, p. 6.

15 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, pp. 12–13.

missing for much of the project's life and can be directly attributed to the commissioning project's poor governance arrangements.

Finding 2

The integrated programs, intended to draw together the various elements of the commissioning project in order to allow for the tracking of critical milestones and paths, were totally inadequate to allow for program management and assurance that timelines were being met.

Finding 3

The failure to develop an adequate integrated program at an earlier stage of the commissioning project made it extremely difficult to identify risks and accurately monitor the project's status.

2.10 It was only in May 2013 when PwC was engaged to build a new integrated program that the necessary rigour was brought to the integrated program. After PwC had completed its ramp-up activities it reported to the Taskforce the following findings:

- The integrated program consists of three constituent programs with varying degrees of maturity, granularity and robustness.
- That it was operating in a “highly complex environment” with 20 work streams, thousands of milestones, nine different project management tools and a large volume of meetings.
- That the interdependencies were not fully understood, identified or mapped.¹⁶

2.11 It is disconcerting, to say the least, that as late as June 2013 PwC could report to the Taskforce that the full complexity of the project had not yet been determined nor the interdependencies mapped.

Finding 4

According to PricewaterhouseCoopers, even as late as June 2013, the interdependencies in the commissioning project were not fully understood, identified and mapped.

Why does the Integrated Program matter?

2.12 During the course of the inquiry, it became clear from the evidence contained in the many documents provided to us by DoH, and also from the evidence gathered from those directly involved with the project, that the absence of a fully developed

16 PricewaterhouseCoopers, *TASKFORCE Integrated Program: PMO – Summary of assess phase, program reporting and management software recommendations*, 6 June 2013, p. 3 in Submission No. 4 from the Department of Health, 9 October 2013.

integrated program made it difficult to ascertain an accurate picture of the “true” status of the project. At individual levels, many activities were proceeding in a manner that might ordinarily be considered “well”. It was only when measured against their place in the overall program that the significance of schedule slippage and missed targets became apparent. In his *Baseline Report* to Mr Snowball in December 2012, Dr Russell-Weisz observed that there had been a “lack of alignment between work streams” and that it was “essential that all parties (FSH, SMHS, HIN and [Serco]) work closely together as there are significant interdependencies between their individual key tasks”.¹⁷

Numerous attempts were made to develop an integrated program

2.13 Dr Russell-Weisz’s criticism with respect to alignment between the work streams was not based on new information. There had been awareness from at least March 2012 that an integrated program was required. A presentation given by SMHS that month reported that the SMHS reconfiguration plan included six elements: service delivery; workforce; corporate policy and performance; ICT; facilities management; and capital infrastructure. The integrated program would align the SMHS reconfiguration milestones with activities and dependencies for the FSH project, including the construction and facilities management (Serco) elements. It was noted that aligning with HIN’s ICT activities and dependencies remained a “work in progress”.¹⁸ The integrated program was facilitated by the SMHS Project Management Office (**PMO**), which at that time was a function being filled by SMHS employees, and was monitored by regular reporting to the SMHS executive group.

17 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 21 in Submission No. 4 from the Department of Health, 9 October 2013.

18 South Metropolitan Area Health Service, *Integrated Program Management (Presentation)*, March 2012, p. 5 in Submission No. 23 from the Department of Health, 24 February 2014.

Table 2.1: Overview of the various iterations of the integrated program

Dates	Provider	Notes
March/April 2012 – October 2012	PwC on behalf of SMHS	PwC developed an integrated program for which included the four components of the SMHS reconfiguration extant at the time: FSH; FSH Managing Contractor Interface Program; HIN ICT program.
May 2012	PwC	As a component of the work it was carrying out in relation to the alignment of clinical services and ICT, PwC developed a “preliminary integrated milestone plan” in May 2012.
October 2012 – May 2013	Internal, with support from DCWC	
May 2013 onwards	PwC	This version of the integrated program developed in response to resolution of the Taskforce. Described by one Taskforce member as involving “investment in a significant integrated program”. In establishing this version, PwC found that, even at that late stage, interdependencies were not yet fully identified and understood.

2.14 In April 2012, a contract valued at over \$600,000 was signed with PwC for the provision of “integrated project management reporting and governance” services. At the same time, PwC was also completing a review of clinical services and ICT alignment for FSH. This review was to assess the “FSH ICT Services Plan and the interfacing Facilities Management ICT Solutions with a view to identify a common roadmap for implementation and provide practical recommendations for the clinical services and ICT solutions to strengthen solution alignment”.¹⁹ The PwC Report created what it called a “preliminary integrated milestone plan” encompassing the key ICT focus areas that had been the subject of the review.²⁰ The fact that PwC had to create this document in May 2012 suggests either that it was the first time an attempt had been made to create an integrated plan, or that whatever had existed previously was not sufficiently robust.

2.15 The PwC Report is the subject of further discussion in Chapter 5, but it is necessary to highlight here that one of the most important tasks it turned its attention to was the completion of detailed clinical plans that would have enabled the completion of a number of ICT activities. It recommended that detailed plans for clinical processes be completed in three waves by the end of August 2012.²¹ Clinical plans and clinical detail were important inputs for the ICT activities and the misalignment and lack of coordination of this work was creating difficulties in the ICT work stream.

19 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 2 in Submission No. 4 from the Department of Health, 9 October 2013.

20 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 13 in Submission No. 4 from the Department of Health, 9 October 2013.

21 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

2.16 PwC's contract for the provision of integrated project management was not renewed following its expiry in October 2012. There appears to have only been two integrated program PMO reports generated during this period, plus a series of milestone plans. Donald Cant Watts Corke (**DCWC**) assumed responsibility for management of the PMO on behalf of SMHS until the integrated program was transferred to DoH in December 2012.²² Because of the out-dated legal structure of the Department (an issue examined in further detail in Chapter 8), SMHS is a separate legal and reporting entity to the central office that is DoH. Therefore, moving responsibility of the integrated program to DoH was more than a mere internal shuffle, although the purpose and significance of the relocation is not immediately apparent. DCWC continued to assist with the management of the program until May 2013, when a new contract was signed with PwC to provide an integrated program for HIN, FSH and the SMHS reconfiguration project.²³ This iteration of the integrated program was tasked with six key roles:

- Critical milestones: the identification and tracking of milestones within each program (i.e. FSH, HIN and SMHS reconfiguration) that will materially impact successful delivery.
- Critical paths: the identification and tracking of the material, cumulative actions required to deliver each critical milestone.
- Interdependencies: the identification and mapping of the material links between critical milestones across the three programs.
- Risk management: the identification, assessment and escalation of risks to relevant forums at appropriate times.
- Change control: the assurance of rigour, consistency and transparency around any material changes.
- Cost: forecasting the budget and tracking expenditure against it.²⁴

Project governance

2.17 Complex projects are not delivered on time or on budget by accident. Success is almost always the result of hard work and meticulous planning overseen by a rigorous governance mechanism. Sadly, for much of the commissioning project's life, the governance structures in place proved incapable of providing the level of assurance required to successfully deliver a project consisting of multiple, interdependent

22 Submission No. 23 from the Department of Health, 24 February 2014, p. 10

23 Submission No. 23 from the Department of Health, 24 February 2014, p. 10.

24 PricewaterhouseCoopers, *TASKFORCE Integrated Program: PMO – Discussion Document*, May 2013, p. 3 in Submission No. 4 from the Department of Health, 9 October 2013.

streams necessitating sustained effort over several years. Despite repeated warnings from an ever increasing number of reports about shortcomings with the governance of the project, little was done to address the problem until late 2012 when Dr Russell-Weisz was appointed to lead the project and a steering committee in the form of the Taskforce was created.

What is governance?

2.18 Governance is the process by which organisations are led and are held to account. It is a catch-all phrase that encompasses how decisions are made, communicated, implemented, monitored and assessed. Ideally, good governance will provide strategic direction, ensure objectives are achieved, risks are managed and resources are used effectively.²⁵ Elements of good governance include clear decision-making frameworks, effective communications mechanisms and appropriate skills and capacities, such as financial management. The nature and complexity of governance arrangements must reflect the scope and size of the project being undertaken.²⁶

2.19 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. Applying the principles of good governance, this would have required the appointment of a single Senior Responsible Officer (SRO) sitting at the top of the structure with responsibility for all aspects of the project. A SRO is considered to be essential for achieving the implementation of an initiative or project.²⁷ This is the person to whom the relevant minister and agency executive should rely upon for progress reports and details of emerging risks. The Australian National Audit Office suggests that a project's SRO should "consider whether they have the right skills to oversee the implementation of the initiative" and that "this is not a matter to be left to chance, or to learning on the job."²⁸ The SRO should be an individual with the necessary expertise and experience to deliver a highly complex undertaking and he or she should be provided with the resources – financial and human – needed to successfully achieve project outcomes. The SRO should be supported by a Project Steering Committee supplying assurance and probity. The Steering Committee should provide scrutiny and useful pushback against assumptions being made by the project team and the SRO, and it should be comprised of senior people delivering the project and independent experts or representatives from other government agencies. The SRO should chair the Steering Committee.

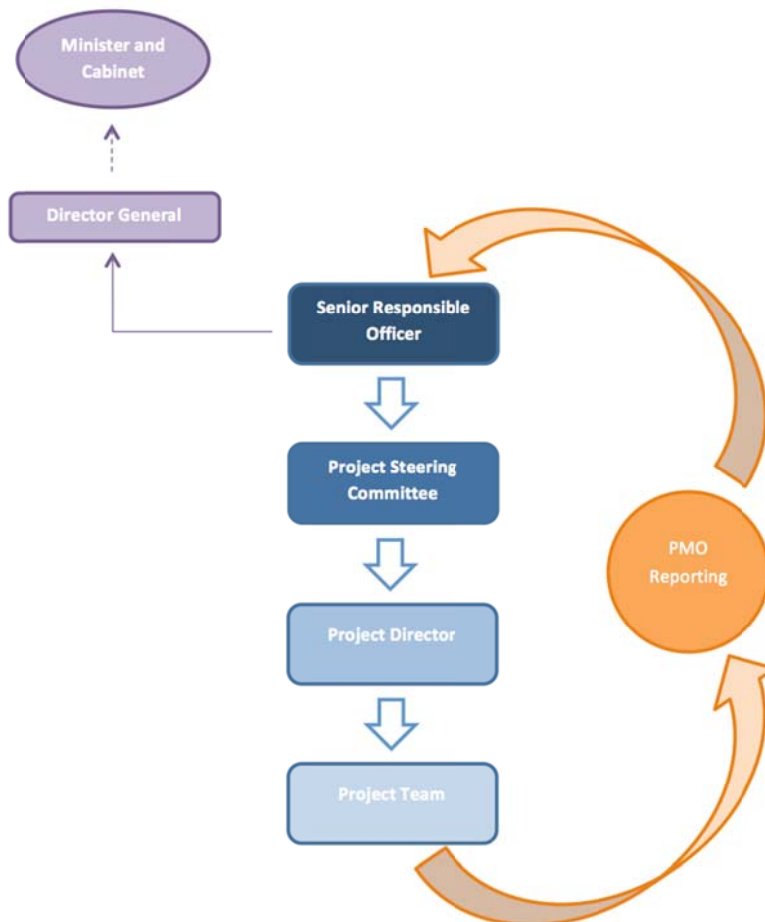
25 Australian National Audit Office, *Implementation of Programme and Policy Initiatives*, October 2006, p. 13.

26 Australian National Audit Office, *Implementation of Programme and Policy Initiatives*, October 2006, p. 13.

27 Australian National Audit Office, *Implementation of Programme and Policy Initiatives*, October 2006, p. 1.

28 Australian National Audit Office, *Implementation of Programme and Policy Initiatives*, October 2006, p. 13.

Figure 2.2: A simplified model of an ideal governance structure, including independent PMO reporting



2.20 Both the SRO and the Steering Committee rely upon accurate reporting about the status of the project in order to understand emerging risks and make the right decisions in response to those risks. To that end, they require visibility to all aspects of the project and should be provided with regular, standardised reporting outlining progress and identifying risks and associated mitigation strategies. Often, this reporting responsibility is filled by a PMO.

2.21 Finally, there must be clear lines of authority and decision making. This can be devolved within the project team where appropriate, but visibility of decisions made must be maintained by the SRO and Steering Committee.

2.22 Unfortunately, a structure similar to the one outlined above was only introduced late in the project's life. In combination with the shortcomings described earlier in relation to the integrated program, the lack of rigorous oversight and discipline introduced via detailed governance arrangements allowed the commissioning project to drift along in an informational vacuum with no awareness of its true status or

an assessment of the likelihood that it could be delivered in time to allow the April 2014 opening.

Interdependencies require a robust governance model

2.23 As noted in paragraph 2.3, managing the various interdependencies is the single most significant issue making the commissioning project such a challenging undertaking. Without a sound governance structure with clear lines of authority, and managers with visibility of all aspects of the work streams and subordinate activities, it is difficult to envisage how the commissioning project could be delivered. We asked DoH to provide us with an explanation of the governance arrangements in place for the project prior to changes brought about in September 2012 when the Taskforce was created. In response, the diagram in figure 2.3 was provided. This contrasts with the governance structure adopted after that period, outlined in figure 2.4.

2.24 It is immediately apparent that ICT and HIN do not feature in the earlier governance model. Equally apparent is the emphasis given to facilities management issues in this structure, with two separate bodies responsible for this issue reporting to the CEO of SMHS. Issues relating to commissioning were to be handled by the Major Health Infrastructure Projects Steering Committee (**MHIPSC**) sitting almost at the top of the governance structure outlined in figure 2.3. Operational responsibility for the commissioning activities sat within the FSH Project Team and was overseen by the FSH Executive Director.

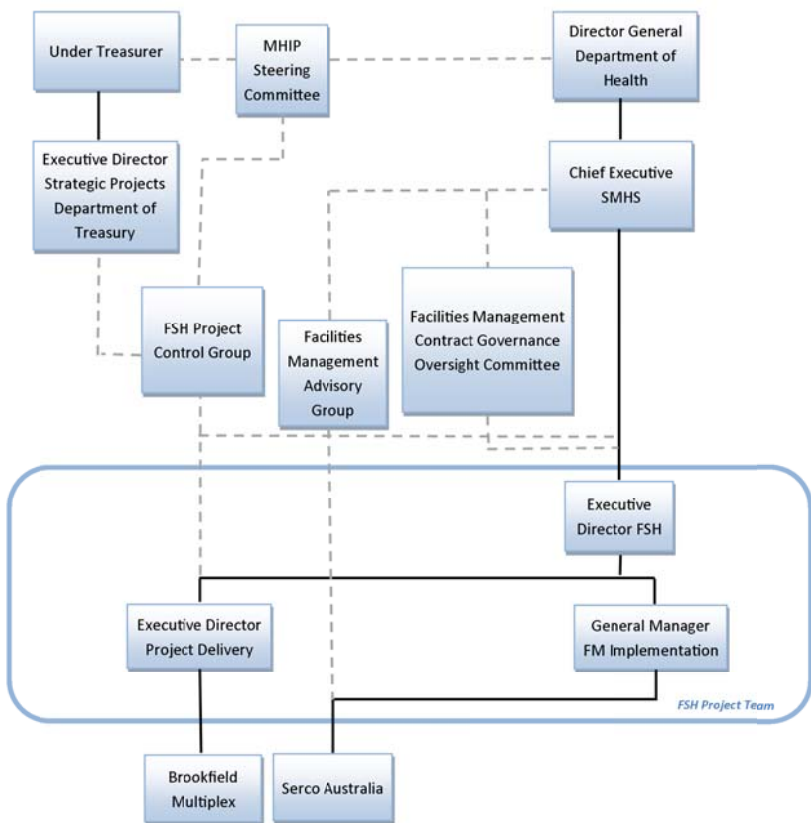
2.25 The absence of HIN and ICT from the governance model is significant. From the commencement of the commissioning project through to September 2013, the ICT aspects of the program were not under the control of either Ms Feely in her capacity as CEO of SMHS or Dr Russell-Weisz once changes to governance were made in September 2012. Although the post-September 2012 changes were an obvious improvement they were clearly deemed to be insufficient, given the decision in September 2013 to bring the responsibility for FSH ICT under the direct control of Dr Russell-Weisz and the FSH project team.

2.26 Many of those giving evidence to the inquiry have indicated that this lack of control over ICT was a source of considerable difficulty, especially given that HIN reported directly to the Director General, Mr Snowball. According to Ms Feely, she was reporting to Mr Snowball that she held concerns about HIN's ability to deliver the ICT required.²⁹ It does not appear, however, that her view was given precedence to that of HIN which continued to report the deadlines could be achieved. This was such a problem that in June 2012, Ms Feely suggested to Mr Snowball that SMHS take over

29 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 6.

responsibility for delivering ICT for FSH.³⁰ She felt so strongly about the issue that she asked Mr Snowball to terminate her contract if he chose not to endorse her request.³¹ In the end, he chose to do neither.

Figure 2.3: Governance arrangements for FSH project prior to September 2012³²

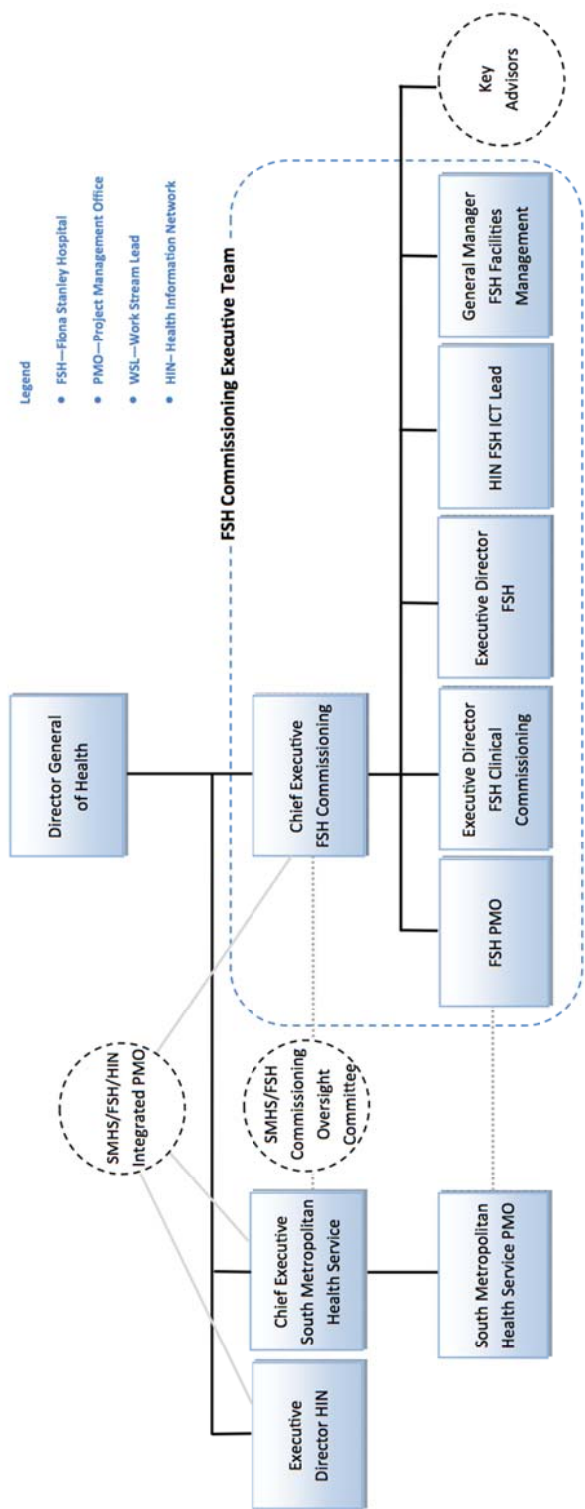


30 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, email to Mr Kim Snowball, 12 June 2012 in Submission No. 23 from the Department of Health, 24 February 2014.

31 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 12.

32 Submission No. 14 from the Department of Health, 2 January 2014, p. 4.

Figure 2.4: Governance arrangement for commissioning project post-September 2012³³



33 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013 in Submission No. 15 from the Department of Health, 9 January 2014.

Finding 5

In June 2012, the then Chief Executive Officer of the South Metropolitan Health Service (SMHS) recommended the transfer of responsibility for Fiona Stanley Hospital's Information and Communications Technology work stream from the Health Information Network to SMHS. The recommendation was not acted upon.

A Senior Responsible Officer with visibility of all commissioning activities was not appointed

2.27 Prior to September 2012, when significant changes were made to the governance arrangements following the completion of the UHB Report, there was a lack of visibility at senior levels across the various streams of the commissioning project. Because of extensive interdependencies across these streams, the absence of visibility at SRO level made it almost impossible to gain an accurate understanding of the true status of the project.

2.28 As has already been noted, HIN did not, for example, report either to Ms Feely, in her capacity as Chief Executive Officer of SMHS, or to Mr Brad Sebbes, in his capacity as Executive Director of FSH; reports were instead made directly to the Director General, Mr Kim Snowball. In late 2011, a review of WA Health's ICT strategy (**the Solomon Report**) found that the Director General filled the role of SRO for ICT programs within HIN. Although this was acknowledged as carrying some benefits, including ensuring executive support for strategy, the reviewers also noted that the role was undertaken in a "significant and busy portfolio".³⁴ This conclusion is almost certainly correct, but there are other problems with having an agency CEO fill this role, particularly when the agency is as large as DoH and the demands on the Director General's time are as extensive and diverse as those experienced leading the Department of Health. This is also to say nothing about whether a non-ICT specialist had the skills to oversee delivery of the project.

2.29 Despite the fact that Ms Feely was reporting serious concerns about the ability of HIN to deliver the ICT aspects of the commissioning project, she did not have control over those aspects. HIN, which did have the control, was apparently telling the Director General that the paperless vision for the hospital could be delivered.³⁵ The difficulty here is that neither party – HIN nor Ms Feely – were in a position to provide advice on the status of the hospital that took full consideration of all the issues impacting upon the project. The problem was exacerbated by the complex interdependencies that existed between the ICT and clinical commissioning elements of the project. Ms Feely

34 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 31 in Submission No. 4 from the Department of Health, 9 October 2013.

35 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 6.

was not in possession of a full understanding of HIN's positions. Similarly, HIN itself was not in a position to know how the status of the elements of the project under Ms Feely's control might impact upon its own work. There is also a question about the accuracy of the reporting coming from HIN, which was an issue that several witnesses raised with us during the course of the inquiry.

2.30 We have come to characterise this period of the commissioning project as being one dominated by ignorance, arguably brought about by a certain amount of incompetence. Because of the lack of visibility across the project it was almost impossible for those in a position of authority to accurately report on the status of the project. This conclusion is supported by a range of evidence provided to the Committee during the course of the inquiry. For example, Dr Russell-Weisz told us that he spent his first five weeks in his new position as CEO FSH Commissioning "burying into the ICT" trying "to get to the bottom" of it.³⁶ In terms of the situation with the workforce work stream, in the four weeks following Dr Russell-Weisz's *Baseline Report* the status slipped from "amber" to "red", an indication that problems with workforce would now delay the opening of the hospital. This was not because something had gone wrong in those four weeks. Instead, it was simply a situation whereby more information was available and, therefore, Dr Russell-Weisz was in a position to more accurately report the true status of the workforce commissioning stream.³⁷

2.31 Mr Sebbes pointed out that he was "not even sure what [his] role was" in terms of ICT and that it was a "little bit on the side".³⁸ His comments match those of other people involved in the project from the FSH and SMHS teams that their visibility of ICT was limited and also the cause of problems. He reported that "we were being advised that the ICT program within Health was being delivered" and that "until we actually checked that in some detail, we believed that."³⁹ Mr Sebbes offered similar comments in relation to the clinical commissioning work stream, indicating that the problems with respect to visibility were not simply limited to ICT. According to Mr Sebbes, it was only after reviewing in detail the status of clinical commissioning that it became apparent that "some of the things that should have been there were not there in the detail".⁴⁰

36 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 2.

37 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 16.

38 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 29 January 2014, p. 3.

39 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 29 January 2014, p. 3.

40 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 29 January 2014, pp. 7–8.

2.32 In November 2012, around the same time that Dr Russell-Weisz was appointed the SRO for the commissioning project, Mr Snowball directed Mr Jon Harrison “to take immediate and full control of all ICT related projects and operational areas at HIN, required to deliver FSH”.⁴¹ In effect, Mr Harrison became the SRO for the ICT aspects of the commissioning project, although he had held a senior project management position since July 2012. By August, he had concluded that the reporting he was receiving about the status of the ICT projects lacked detail and he began losing confidence in the information that he was receiving:

*It was not comprehensive enough to look at, in a master plan sense, the complexities of all the moving parts of Fiona Stanley, including [Serco], ourselves, many of the suppliers and the clinical commissioning team.*⁴²

2.33 This was the same information that was being provided to Mr Snowball about the status of the ICT elements of the commissioning project. Mr Harrison’s dissatisfaction with the quality of this information prompted him to commission an independent review of HIN’s FSH ICT efforts. This report made a number of important findings and recommendations regarding project governance and is explored in more detail in paragraph 5.31.

Finding 6

Prior to September 2012, there was a lack of visibility across the various streams of the commissioning project at senior levels in both the Department of Health and the Fiona Stanley Hospital project team. This, in conjunction with the interdependencies, made it almost impossible to gain an accurate understanding of the true status of the project.

There was insufficient coordination across the commissioning work streams

2.34 It is important to highlight that the problems with respect to governance were not simply limited to the elements of the project for which HIN held responsibility, although often the problems manifested themselves in ways that hindered HIN’s ability to carry out its responsibilities. In many respects, much of what HIN was being asked to do was dependent on receiving detailed specifications and technical inputs from the FSH project team working within SMHS. It is clear that the level of interaction between HIN and the FSH project team was insufficient. Indeed, engagement between the two areas was described in one report as “sporadic, unstructured and disjointed”.⁴³ More specifically, the delay in developing clinical services plan, and the absence of a clinical reference group had resulted in ICT developers attempting to lead changes to the way

41 Submission No. 5 from the Department of Health, 14 October 2013, p. 3.

42 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 29 January 2014, p. 8.

43 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 12 in Submission No. 4 from the Department of Health, 9 October 2013.

that clinicians delivered services, rather than the other way around. In other words, HIN's software developers had limited clinical expertise to draw upon when designing software. A logical consequence of this lack of access to clinician expertise was a lack of clarity regarding the scope and extent of software to be deployed into the hospital.⁴⁴

2.35 It is our view that the lack of coordination across the commissioning work streams was a direct consequence of the failure to create a usable integrated program and the failure to appoint a SRO with visibility across the entire commissioning project.

Finding 7

The Health Information Network's software development was hindered by the delay in completing clinical services plans and the failure to create a clinical reference group at an earlier stage of the commissioning project.

Decision-making authority was unclear

2.36 The Solomon Report found that a number of the governance bodies were in place at HIN in late 2011 and that almost none of them were equipped with the requisite decision making powers.⁴⁵ Instead, they existed to make recommendations presumably to the Director General in his capacity as the SRO for ICT projects. Similarly, there was lack of clarity with respect to the escalation procedures to be employed should a project encounter difficulty. Similar findings were made 12 months later during the course of a review – the Project Delivery Review Report – conducted for HIN by Fujitsu. It seems that the outcome of the lack of clarity surrounding decision-making authority was a failure to make key decisions in a timely fashion.

2.37 With respect to the needs of FSH, the Solomon Report recommended that a governance structure be established that provided accountability and authority, and that this structure:

[...] should be chaired by the South Metropolitan Area Health Service Area Chief Executive, and include senior Health Information Network participation. The Health Information Network should take responsibility for developing the detailed plan and leading the change management process (in conjunction with the Fiona Stanley Hospital

44 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

45 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 31 in Submission No. 4 from the Department of Health, 9 October 2013.

*executive and clinical team), and resources should be allocated to the Health Information Network accordingly.*⁴⁶

2.38 The Solomon reviewers provided additional detail about this recommendation in the text of the report, stating that the role of this improved governance structure would be to develop, approve, cost, plan, monitor and amend FSH's ICT needs.⁴⁷ It is clear from the text of the Solomon Report that the reviewers had identified the need to re-allocate authority for FSH ICT downwards within the Department, to a level where operational control and expertise could more quickly respond to the significant demands and challenges posed by the scale and importance of the ICT project. Although the recommendation was accepted by the Department, it was only fully implemented in November and December 2012 when the ICT Commissioning Governance Group (**CGG**)⁴⁸ was established. It is noteworthy that the CGG was the first body within DoH to acknowledge that the original ICT plans for the hospital would not be achieved and that a significantly de-scoped solution would need to be endorsed.⁴⁹

The Closed Loop Medication Management System

2.39 The delay associated with making a decision about the Closed Loop Medication Management System (**CLMMS**) is perhaps a useful example of the problems with decision-making outlined above. CLMMS describes a series of technologies and associated clinical practices intended to minimise the incidence of harm arising from the mishandling of medications. One of the most important means for achieving this outcome is the introduction of a degree of pharmacy automation involving the use of automated medication units (**AMUs**). These AMUs were always assumed to be in scope for FSH,⁵⁰ but on the question of whether the hospital could operate without these systems, we received mixed answers. DoH told us that space had been included in the hospital's design for pharmacy shelves and safes, and that CLMMS was not on the "critical path" for the opening of the hospital.⁵¹ Others associated with the ICT aspects of the project told us that they had been told the hospital could not open without some degree of pharmacy automation. We also note that during an earlier hearing prior to

46 WA Health ICT Review *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

47 WA Health ICT Review *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 32 in Submission No. 4 from the Department of Health, 9 October 2013.

48 In some documents, the ICT Commissioning Governance Group is also referred to as the ICT Clinical Commissioning Group. According to DoH, the two bodies are the same: Ms Fiona Hope, Acting Principal Project Officer, Department of Health, Electronic Mail, 6 January 2014.

49 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, pp. 7–8 in Submission No. 4 from the Department of Health, 9 October 2013.

50 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 15 in Submission No. 4 from the Department of Health, 9 October 2013.

51 Submission No. 25 from the Department of Health, 8 March 2014, p. 2.

the commencement of the inquiry, Mr Giles Nunis, a senior manager brought in to provide leadership to the ICT program, agreed that CLMMS was one of the ICT systems contributing to the delay.⁵² We are obviously not in a position to resolve this disparity in evidence, although we find it a credible possibility that the delays in deciding to go ahead with CLMMS did contribute to the delayed opening of the hospital. We also did not clearly establish what impact the changed timeframe for implementation would have on the delivery of the FM services by Serco.

2.40 In late 2011, the Solomon Report recommended that “advanced medications management”, including ePrescribing, medication decision support and preferably closed loop delivery, become a priority for DoH. The report went on to recommend that medications management should be brought forward in ICT planning and ultimately recommended the advancement of the medications management component of the Clinical Information System by January 2012.⁵³ The PwC Report conducted in May 2012 recommended that a final decision as to the implementation of CLMMS on “day one” at FSH should be made by 30 June 2012.⁵⁴

2.41 The outgoing Acting Chief Information Officer (CIO) for HIN, Mr Alan Piper, prepared a handover document for the incoming Acting CIO, Dr Andy Robertson, in December 2012. He reported the following with respect to CLMMS:

*Significant benefits have been identified for the implementation of closed loop medication management. This was identified as a priority by the independent review in December 2011. The current systems framework does not have the functional capacity to support for closed loop medication management. If this implementation is a priority it will require a carefully planned, affordable, strategy.*⁵⁵

2.42 Clearly, a decision about the CLMMS had not been made in the 12 months since the completion of the Solomon Report. According to Dr Russell-Weisz, when he commenced as Commissioning Chief Executive in November 2012, he immediately authorised the decision that enabled the work leading up to procurement of the CLMMS to go ahead.⁵⁶ A public tender was released on 7 January 2013 and a preferred supplier was contracted in July of that year. According to Mr Nunis, the process of

52 Mr Giles Nunis, Deputy Director General, Department of State Development, *Transcript of Evidence*, 16 July 2013, p. 3.

53 WA Health ICT Review *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 36 in Submission No. 4 from the Department of Health, 9 October 2013.

54 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

55 Alan Piper Consulting, *Transition and Handover Report, WA Health ICT and HIN*, 17 December 2012, p. 7 in Submission No. 10 from the Department of Health, 29 November 2013.

56 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 16 July 2013, p. 4.

implementing CLMMS at the hospital would take 12 months.⁵⁷ This timeline obviously places the implementation of the CLMMS beyond the original April 2014 opening date, and means that it should be operational by July 2014.

2.43 It is unclear why there was such obvious difficulty with finalising the decision regarding CLMMS, especially given that many people seemed to think that the hospital could not open without it, and that numerous reports had recommended that a decision be made about it much earlier. Perhaps what is most surprising is the ease with which the decision was made once Dr Russell-Weisz commenced as Commissioning CEO. In November 2012, as he was putting together his Baseline Report, he identified CLMMS as a system that had always been “flagged” for FSH, but for which a decision had not been made. Once the benefit of the system had been established, work was commenced “straight away” in order to ensure that the tender could be released.⁵⁸ It is difficult not to conclude that the reason why Dr Russell-Weisz was able to make the decision so quickly, and others had not, is because there was finally a governance structure with a suitably empowered senior officer sitting at the head of the commissioning project able to make decisions with the benefit of sufficient visibility across all work streams.

Finding 8

Failure to make timely decisions resulted in avoidable delays to the procurement of important Information and Communications Technology elements, including the Closed Loop Medication Management System.

A contract signed and a department unprepared

2.44 If the content of this chapter could be summarised in a single sentence it would be the following: governance and program management arrangements made it almost impossible to gain an accurate picture of the commissioning project’s status. This meant that important decisions about what could and could not be delivered at the hospital by April 2014 were made far too late in the project’s life, thus rendering a delayed opening almost inevitable and increasing the costs to the State.

2.45 A \$4.3 billion contract was signed creating obligations for the State without the State satisfying itself that it could fulfil its obligations.

57 Mr Giles Nunis, Deputy Director General, Department of State Development, *Transcript of Evidence*, 16 July 2013, p. 3.

58 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 16 July 2013, p. 4.

Chapter 3

Project reporting

Until December 2012, there was no single specific report tracking the status of the Fiona Stanley Hospital commissioning project. Such a report would have identified risks and important commissioning work streams unique to FSH, including clinical commissioning and workforce. The lack of attention given to clinical commissioning seems to have resulted in time delays and inadequate resourcing.

Poor project reporting did not allow an overall picture to be presented to decision makers at crucial points throughout 2012. This also increased the difficulty associated with generating a Cabinet submission recommending a delay to the commissioning of Fiona Stanley Hospital. Indeed, the submission took some three months to draft, and many Taskforce members grappled with the lack of detailed information available to them when drafting the submission.

Reporting was fragmented and inconsistent

3.1 Effective project governance relies upon timely and accurate monitoring of the performance and progress of a project. In the previous chapter, the shortcomings with project governance and program management were examined in some detail. Project reporting is an important component of project governance, as it allows for the communication of risks impacting upon the project as well as providing updates as to project status. It is also an important mechanism for providing accountability as the project progresses from concept to reality. In accordance with the other elements of governance outlined in the previous chapter, there were also significant problems associated with the quality and consistency of reporting generated for the project.

Formal reporting arrangements were inadequate

3.2 The absence of detailed, useable and consistent reporting was a common theme across the various independent reports and reviews commissioned to provide advice to the Department about various aspects of the commissioning project. There can be no accountability without reporting, and even the most robust governance model is only as good as the project status reporting that it receives. It is for this reason that the following conclusion, contained in the University Hospitals Birmingham Review (**the UHB Report**), should have been particularly alarming to those responsible for delivering the commissioning project:

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 program of this size it should be expected that this report mechanism provides an update on all workstreams [sic] against critical milestones.*⁵⁹

3.3 This conclusion prompted the Committee to seek significant further detail about the nature and extent of reporting provided to the Director General for the commissioning project in the period commencing with the signing of the contract and ending in September 2012. The result was the production of several archive boxes containing numerous lever-arch folders. We have provided an overview of the reports in the sections below. None of these reports provided a single specific update tracking the status of the Fiona Stanley Hospital commissioning project.

3.4 A summary of the internal reporting mechanisms made available to the Committee by the Department of Health (DoH) has been included in table 3.1. Additional detail is provided over the following pages.

Table 3.1: Summary of project reporting

Date Commenced	Report	Audience	Notes
Oct 2010	HIN PMO	Senior HIN and DoH executives, plus members of the WA eHealth Project Council.	PMO reporting for all HIN projects. FSH just one of a number being reported.
Aug 2011	Serco POTS Reporting	FSH and SMHS executives. Copies were also forwarded to the Director General.	These reports were a contractual requirement.
Feb 2012	SMHS Reconfiguration PMO	SMHS Area Executive Group.	The reconfiguration allowed coordination of health services across SMHS in response to the capacity relocation to FSH.
May 2012	Integrated PMO	Initially, SMHS Area Executive Group. After Dec 2012, copies provided to Taskforce members and senior officers attending Taskforce meetings.	After May 2013, PwC provided Integrated PMO services. Prior to this date, Integrated PMO was described as lacking in key areas.
July 2012	HIN FSH Executive Summary Status Report	DoH senior executives, including CEO SMHS and the Director General.	Created in response to view that existing reporting on HIN's FSH activities was not comprehensive enough.
Dec 2012	FSH PMO	FSH Hospital Executive Committee members.	Appears to have commenced in conjunction with the establishment of the Taskforce.

59 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 15 in Submission No. 4 from the Department of Health, 9 October 2013.

Integrated PMO

3.5 The lack of an integrated program is relevant in a discussion about the quality of the reporting associated with the commissioning project, as it appears to have substantially increased the complexity of the reporting that was available for two primary reasons. Firstly, it fragmented the presentation of important information, making it difficult to grasp what was critical and what was not. Secondly, it did not adequately display the interdependencies that existed across the commissioning project, meaning that the significance of a missed milestone in one activity was not clearly linked to its impact upon another, separate activity.

3.6 Anyone wanting an overall picture would have had to trawl through the many different documents, including a range of different Project Management Office (**PMO**) reports, Pre-Operational and Transitional Services (**POTS**) Reports from Serco, and other “ad-hoc” reports generated from the South Metropolitan Health Service (**SMHS**), to establish connections.⁶⁰ We found no evidence that this happened.

HIN PMO

3.7 At the time the contract with Serco was signed, the Health Information Network (**HIN**) had in place an already established PMO providing monthly reporting on all Information and Communications Technology (**ICT**) projects being undertaken across the WA Health portfolio.⁶¹ HIN’s Fiona Stanley Hospital (**FSH**) responsibilities were included in this lengthy monthly report, which typically devoted only two pages out of over 100 to the FSH project.

3.8 The Solomon Report noted that, as of December 2011, there was no dedicated PMO for FSH in the HIN organisational structure, a situation that “does not support effective project management for such a high priority project.”⁶² It recommended that this be established as a priority, with a suggested timeframe of January 2012, and that the PMO “should be accountable for the integrated project/portfolio plan, dependencies, risks, and change management and communication implications.”⁶³ The Solomon Report also noted that there was presently no documented and detailed plan outlining the suite of systems and applications to be implemented at FSH.⁶⁴ Given the

60 Submission No. 23 from the Department of Health, 24 February 2014, p. 12.

61 Submission No. 23 from the Department of Health, 24 February 2014, p. 9.

62 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 33 in Submission No. 4 from the Department of Health, 9 October 2013.

63 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, Recommendation 11, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

64 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 16 in Submission No. 4 from the Department of Health, 9 October 2013.

contractual requirements under the FM contract and Serco's reliance on WA Health providing specific systems and applications, it was "strongly recommended" that a detailed, integrated ICT plan for FSH be developed, incorporating Serco's and HIN's activities and timelines, to ensure that ICT developments were linked to the construction schedule.⁶⁵ Development of the integrated ICT plan was noted to be "a matter of urgency", with a suggested timeframe of February 2012.

3.9 The status report on the Solomon Report recommendations, prepared in March 2013, indicated that a PMO had not yet been established as recommended – the response in relation to this recommendation merely notes that a HIN FSH ICT Lead was identified in November 2012, with a "small monitoring and reporting team" appointed and "clear roles for each team members defined."⁶⁶ The earliest substantive draft of the FSH ICT plan was completed in March 2012 and revised in June 2012; ultimately, the FSH ICT Solution, which outlined the ICT vision and high-level solution design for FSH, was not developed until September 2012, some seven months later than recommended.⁶⁷

3.10 The independent FSH HIN Project Delivery Review Report completed in December 2012 found that the level of governance applied to projects largely depended on the individual project managers rather than a standard enforceable process and that the HIN PMO was "viewed as a reporting office rather than a Quality and Delivery Governance body."⁶⁸ The review recommended that the HIN PMO had to be "empowered and supported with resources, tools, templates and standards to enable it to perform" its role.⁶⁹ Several months later, Mr Giles Nunis reported to the Taskforce on 4 April 2013 that the HIN PMO program was "at a reasonable level although not using [an established project management methodology] as well as they should."⁷⁰

HIN FSH Executive Summary Status Reports

3.11 Commencing in July 2012, HIN began producing "executive summary reports" for the FSH ICT components. These reports were forwarded by Ms Nicole Feely, the then Chief Executive Officer of SMHS, to the Director General in conjunction with other

65 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, Recommendation 6, pp. 7, 17 in Submission No. 4 from the Department of Health, 9 October 2013.

66 Department of Health, *Status of FSH ICT Recommendations*, March 2013, p. 5 in Submission No. 4 from the Department of Health, 9 October 2013.

67 Submission No. 14 from Department of Health, 2 January 2014, pp. 1-2.

68 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, pp. 5, 13 in Submission No. 4 from the Department of Health, 9 October 2013.

69 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, Document 24, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

70 Minutes of the FSH Taskforce Meeting, 4 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

commissioning project reporting. According to Mr Jon Harrison, HIN's FSH ICT lead, these reports were initiated because he felt that the reporting that had existed prior to this was not comprehensive enough. He was also determined to ensure that the recommendations contained in the May 2012 PricewaterhouseCoopers (**PwC**) report were being picked up and implemented.⁷¹ Given the impetus for the creation of the executive summary reports, it is perhaps not surprising that most of the milestones being tracked relate to the recommendations made in the PwC Report. The reports made clear that most of the target dates for responding to and implementing the PwC recommendations are missed, often by several months.

3.12 Prior to the creation of the executive summary reports, simple two or three page reports were being provided by the former Acting Chief Information Officer, Mr Alan Piper, to Ms Feely and the Director General.⁷²

SMHS Reconfiguration PMO

3.13 In February 2012, the Strategy and Development PMO within SMHS began providing monthly reports to the SMHS Area Executive Group updating the status of the SMHS reconfiguration across six streams: Service Delivery; Workforce; Corporate Policy and Performance; ICT; Capital Programs; and Facilities Management. Prior to the commencement of these reports, verbal updates were provided by senior managers and stakeholders.⁷³ By mid-2012, it had become apparent that the connections existing between the various work streams would require a "truly integrated PMO" across all of the programs, and the SMHS reporting was to be altered accordingly.⁷⁴ In addition to the PMO reporting, the SMHS Area Executive Group was also provided with an ad hoc "hot issues" report in April and May 2012.

3.14 The reports adopted the standard Red/Amber/Green (**RAG**) ratings scale when reporting on the status of the various reconfiguration streams. Table 3.2 below summarises the ratings given to the streams for the period May 2012 – November 2012. Clearly, the ratings revealed a program experiencing significant difficulty across almost all of its streams. It is important to note that these ratings do not relate specifically to the status of the FSH commissioning project, although there is little doubt that FSH was reflected in these ratings. For example, commentary about the status of FSH clinical commissioning activities is provided in most of the SMHS reconfiguration PMO reporting, and notes are made about the impact of delays in one stream crossing over to affect others.

71 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 29 January 2014, p. 8.

72 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 29 January 2014, p. 8.

73 Submission No. 23 from the Department of Health, 24 February 2014, p. 12.

74 South Metropolitan Health Service, *July 2012 Briefing Note for Area Executive Group*, in Submission No. 23 from the Department of Health, 24 February 2014.

Table 3.2: Collation by the Committee of SMHS reconfiguration work streams reported in PMO reports May – Oct 2012⁷⁵

	May 2012	June 2012	July 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012
Service Delivery				NOT PROVIDED TO THE COMMITTEE			
Workforce							
Corporate Policy and Performance							
ICT							
Capital Program							
Facilities Management							

3.15 Ms Jodie South, Group General Manager, Strategy and Development, SMHS, presented a project status report on the SMHS reconfiguration to the Taskforce at its meeting on 28 March 2013; this included a live SMHS reconfiguration PMO report from 22 March 2013, which the Taskforce noted “provided detail but unclear what the dependencies and risks are and how they are being reviewed in line with the FSH program.”⁷⁶ The Taskforce recommended that an independent review of the SMHS reconfiguration program be commissioned to report to the Taskforce on milestones, capability, workforce requirements, emerging risks and issues. Mr Alan Bansemer, a former WA Health Commissioner, was engaged in May 2013 to conduct this review.⁷⁷

Finding 9

In March 2013, having received an update on the status of the South Metropolitan Health Service reconfiguration, the Taskforce was so uncertain of the reconfiguration’s status that an independent review was commissioned to report back on milestones, capability, workforce requirements, emerging risks and issues.

Serco’s Pre-Operational and Transitional Services reports

3.16 Under the terms of the Facilities Management Services Contract, Serco has been required to submit a POTS Report before the tenth day of each month during the

75 Adapted from information in Submission No. 23 from the Department of Health, 24 February 2014.

76 Minutes of the FSH Taskforce Meeting, 28 March 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

77 Minutes of the FSH Taskforce Meeting, 9 May 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

pre-operational and transitional services period. The contract places obligations upon Serco that DoH would have done well to itself observe, namely that the “Facilities Manager must ensure that all of the information contained in the Pre Operational and Transitional Services Report or the Service Report (as the case may be) is consistent and integrated, does not contain any contradictory information and is clear, legible and easily interpretable by the Principal.”⁷⁸ Of all of the differing types of project reporting generated prior to September 2012, the POTS reporting from Serco was the closest to what we would have expected for an undertaking of the scale and cost of the commissioning project. These reports included clear detail about actions either undertaken that month or to be carried out in the following month, issues impacting on Serco’s program, including identifying the length and cause of delay, and a rigorous and detailed risk register.⁷⁹

3.17 The POTS reports were regularly provided to the Director General in conjunction with a SMHS response providing either a summary of and/or comments on the content of the POTS report. Whilst Serco’s reporting reflected its contractual obligation to report in a consistent and easily understood fashion, the same could not be said of the SMHS reports. Sometimes the SMHS reports were brief three or four page documents, at other times they were more comprehensive and amounted to 10 pages in a tabulated format. At other times they consisted of the entire POTS reports with numerous “track changes” comments strewn through the pages. On one occasion, the SMHS report had ballooned to 107 pages in length. Very few people, least of all the Director General, would have had enough time in their schedules to read through and absorb the information contained in those 107 pages.

Finding 10

Serco’s reporting on the status of its Pre-operational and Transitional Services obligations was consistent and integrated, and easily interpretable. This demonstrates that such reporting is standard for projects of this type and illustrates the deficiencies in the Department of Health’s project management.

3.18 But for those who were paying attention, the POTS reporting in the months immediately before September 2012 reveals troubling detail about the status of the commissioning project. Commencing in July, Serco begins acknowledging that the POTS program was progressing “through a challenging period”.⁸⁰ This same acknowledgement remains in the reports through to September (the Committee did not request access to the reports after this date). Serco had been reporting a range of delays arising from failures by the Principal (i.e. DoH) to respond in a timely fashion to a

78 Facilities Management Services Contract, Schedule 16, Clause 1(b).

79 Eight POTS Reports were provided to the Committee in Submission No. 23 from the Department of Health, 24 February 2014.

80 Serco, *Pre Operational and Transitional Services Report*, July 2012, p. 3 in Submission No. 23 from the Department of Health, 24 February 2014.

number of issues. In August, however, Serco begins to report on the outcome of some of those delays, particularly as they related to ICT:

*Delays in the conclusion of outstanding solutions for Health Technology and ICT non-compliant items have caused pressure on the ICT critical path and contingency plans for less automated delivery alternatives are being reviewed.*⁸¹

3.19 In relation to its obligations under the Health Technology work stream, Serco was reporting that:

*Delivery of Health Technology Service Plans and procedures are dependent upon the provision of information from the Principal relating to clinical business processes, speciality specific volumetric's, policy and applications.*⁸²

3.20 Prior to September 2012, Serco was concluding the executive summaries of its POTS reports with a statement indicating that it remained or was on track to deliver all contracted deliverables. The pattern does not repeat in September 2012. Instead, Serco reports that:

*[...] a number of challenges exist within the program in particular relating to the overall ICT solution and need to be managed carefully to achieve all contractual milestones and deliverables.*⁸³

3.21 It seems that this statement was another of the many warning signs that were appearing in the various reports being created during this period. Taken with other comments contained in the POTS report, including that delays in agreeing the requirements for health records management might lead to a less “digital” solution, and that there was a possibility that not all integration points between Serco’s and HIN’s ICT components had been identified – even at that late stage – and it seems clear that there were significant troubles being reported.⁸⁴

81 Serco, *Pre Operational and Transitional Services Report*, August 2012, p. 3 in Submission No. 23 from the Department of Health, 24 February 2014.

82 Serco, *Pre Operational and Transitional Services Report*, August 2012, p. 44 in Submission No. 23 from the Department of Health, 24 February 2014.

83 Serco, *Pre Operational and Transitional Services Report*, August 2012, p. 44 in Submission No. 23 from the Department of Health, 24 February 2014.

84 Serco, *Pre Operational and Transitional Services Report*, August 2012, p. 5 in Submission No. 23 from the Department of Health, 24 February 2014.

Finding 11

By September 2012, Serco's Pre-operational and Transitional Services reports were providing evidence of the problems being encountered across the various streams of the commissioning project, particularly those relating to Information and Communications Technology.

Fiona Stanley Hospital PMO

3.22 Until the establishment of the FSH PMO in December 2012, there did not appear to be FSH-specific reporting being generated on a monthly basis that provided a consistent measure for the progress of the commissioning project. Although the SMHS reconfiguration reporting took FSH into account, it seems almost as if FSH and its unique needs and challenges were lost in the much larger reconfiguration program.

3.23 The FSH PMO reported against six work streams: Corporate, Infrastructure, Workforce, Facilities Management, Clinical Commissioning and ICT.⁸⁵ Whilst there was some similarity with the work streams contained in the SMHS reconfiguration reporting, the work streams for the FSH reporting were separate from the much larger scope of the SMHS reconfiguration, which was taking into account multiple sites across the entire SMHS health system.

3.24 It almost goes without saying that the establishment of the FSH PMO came far too late in the life of the commissioning project; it should have been established at the same time that the contract with Serco was signed.

3.25 The failure to establish an FSH PMO earlier is particularly regrettable in light of the almost total absence of clinical commissioning from the other reports that were being generated at the time. As noted in paragraph 1.9, clinical commissioning involves all activities required to "ensure FSH is able to operate as an effective organisation, supporting the delivery of safe and effective clinical services".⁸⁶ The impact of inadequate clinical commissioning efforts, including upon ICT preparations, had been noted in other reports but there had been a regrettable absence of consistent and standardised reporting tracking the progress of this particular work stream. Whilst the SMHS reconfiguration reports began to note that a "lack of resources to complete commissioning planning and implementation may impact commissioning project,"⁸⁷ without comprehensive reporting it would have been difficult to gain an accurate picture of the impact of resourcing levels upon the project.

85 Department of Health, *Status of Recommendations from UHB Review*, May 2013, Document 55 in Submission No. 4 from the Department of Health, 9 October 2013.

86 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

87 *SMHS Reconfiguration PMO Monthly Report*, July 2012, p. 2 in Submission No. 23 from the Department of Health, 24 February 2014.

3.26 Indeed, Dr Russell-Weisz concluded in his December 2012 *Baseline Report* that the resourcing made available to the clinical commissioning work stream had been “too few, too late and with too much emphasis away from clinical services in the favour of infrastructure.”⁸⁸ The result was a clinical commissioning process significantly behind schedule; however, in the absence of detailed reporting about the issue, senior managers in charge of the commissioning project seem to have been unaware about the extent of the problem.⁸⁹ Similar problems clearly existed in relation to workforce, which in the weeks following Dr Russell-Weisz’s commencement as Commissioning CEO, went from an amber to red rating on the RAG rating scale on the basis that more information had been made available about the project, rather than the project actually getting worse during that period.⁹⁰

Finding 12

The failure to establish the Fiona Stanley Hospital Project Management Office at the time the contract was signed with Serco in July 2011 resulted in failures to accurately track the status of important work streams under the commissioning project, including workforce and clinical commissioning.

Cabinet Submission delay

3.27 The Taskforce resolved to make a Cabinet submission at a meeting on 21 March 2013, the very first meeting chaired by Dr Russell-Weisz following Mr Snowball’s departure.⁹¹ It was only in mid-May 2013, however, that a suitable version of the submission was prepared and finally presented to Cabinet on 10 June 2013.

3.28 One telling detail that emerged from the internal departmental emails provided to the Committee by DoH was the obvious difficulty encountered when the Taskforce attempted to make a formal report to the Cabinet about the need for delay. It is clear from the comments made by the Taskforce members in their emails that there was a certain level of exasperation regarding the adequacy of internal reporting. Dr Russell-Weisz told us that the Taskforce wanted to ensure that they did not present a “half-baked submission” and that “it did take longer that [he] would have wanted”.⁹²

3.29 As the drafting progressed through April and into May, Taskforce members continued to highlight the challenge caused by the lack of an adequate understanding

88 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 14 in Submission No. 4 from the Department of Health, 9 October 2013.

89 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 29 January 2014, pp. 7–8.

90 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, pp. 16–17.

91 Minutes of the FSH Taskforce Meeting, 21 March 2013, p. 3 in Submission No. 4 from the Department of Health

92 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 16.

of the status of the project. It was suggested that one paragraph in the draft be reworded:

*To explain the lack of clarity in all the issues surrounding commissioning, that multiple reviews are being undertaken to determine risks, deficiencies and delays, and (if a timeframe must be included) at best we can hope for a 6 month delay until the reviews are complete and issues are clear to the taskforce.*⁹³

3.30 One of the DoH employees charged with composing the submission acknowledged that there were “significant gaps in regard to the information that is available” and that there would be “more clarity on the status of the UHB [recommendations] later in the week” in addition to further information on the clinical commissioning and workforce work streams.⁹⁴

3.31 In mid-May, Taskforce members were still grappling with the lack of certainty, with one member noting that if he were reading the submission for the first time, he would find it “very odd that the UHB Report was delivered in September, and that the Taskforce has been in place for 6 months, yet no definitive advice is being provided [on] commissioning.”⁹⁵

Conclusion

3.32 It is clear that the governance and project reporting arrangements were insufficient for the complexity of the project. The lack of accurate reporting made it impossible to determine the true status of the commissioning project and the associated risks and costs. This was a difficulty shared by the Taskforce as it prepared its submission to Cabinet advising of the need to delay the opening of the hospital. The Taskforce report was not as timely as it should have been which delayed the authorisation to commence renegotiations with Serco. This delay in reporting to Cabinet would have impacted upon the final cost to the State, because the sooner Serco was informed the sooner it could mitigate its costs arising from failure to open the hospital on 1 April 2014.

93 Email sent by Ms Natasa Spasic, Policy Analyst, Department of Treasury, to Taskforce members, 30 April 2013 in Submission No. 22 from the Department of Health, 21 February 2014.

94 Email sent by Mr Neil Bennet, Health Infrastructure Unit, Department of Health, to Taskforce members, 29 April 2013 in Submission No. 22 from the Department of Health, 21 February 2014.

95 Email sent by Mr Nicholas Egan, Deputy State Solicitor, to Taskforce members, 7 May 2013 in Submission No. 22 from the Department of Health, 21 February 2014.

Chapter 4

Unrealistic expectations

The Department of Health set ambitious aims for Fiona Stanley Hospital project right from the beginning. Unfortunately, the ambitions proved too much for the Department with several key elements proving impossible to deliver as originally planned.

The digital vision for a paperless hospital was significantly scaled-back in early 2013, with many of the originally envisaged features having been abandoned in an attempt to reign in the length of delays. Many of the senior people subsequently associated with the project reported that they never believed it could be achieved, and even the Health Information Network (HIN) was reporting that the digital vision was beyond its technical capacity to deliver. Unresolved questions remain regarding what was done with HIN's advice and why it was seemingly ignored.

The ambition to open the hospital in April 2014 over a period of four weeks was plainly unrealistic. The Department of Health did not adequately assess its ability to be ready for the April 2014 opening date before signing the contract with Serco. Similarly, the four-week phasing period to full hospital operations seems to have also gone un-assessed. Indeed, so unrealistic was this ambition that Mr Snowball remarked that “no one in their right mind would believe” that the hospital would be at full capacity in April 2014.

The Digital Vision

A commitment was made to the idea of a digital hospital early in the project's life

^{4.1} Right from its inception, the Fiona Stanley Hospital (FSH) has been intended to serve as a model for the way in which the delivery of health services could be reformed in Western Australia. The project's Business Case, presented to State Cabinet in 2007, stated that “ICT is critical to the reform of the WA Health system to improve the delivery of patient care”.⁹⁶ The Business Case went on to commit to achieving “a new ICT capability for the health system to deliver business benefits beyond hospitals...”.⁹⁷ This would involve the procurement of “new core systems” including electronic health records and electronic document and records management systems in addition to a

⁹⁶ Department of Health, *Fiona Stanley Hospital Business Case*, December 2007, p. 62 in Submission No. 2 from the Department of Health, 12 August 2013.

⁹⁷ Department of Health, *Fiona Stanley Hospital Business Case*, December 2007, p. 62 in Submission No. 2 from the Department of Health, 12 August 2013.

range of clinical information systems across pharmacy, pathology and allied health.⁹⁸ As early as November 2007, Jim McGinty, the then Minister for Health, was telling the Parliament that the ambition was to move to a “completely paperless hospital, where all patient records, patient movements, medications, treatments and things of that nature are provided by a complex IT system.”⁹⁹ The same vision was reiterated by the present Minister for Health, Dr Kim Hames.

4.2 At some point after 2007, the various Information and Communications Technology (ICT)-based ambitions for the hospital became known as the “digital vision”. This vision appears to have informed numerous aspects of the project across its entire breadth, including the physical design of the hospital buildings. For example, FSH lacked the physical space for storing paper based records, as it had been assumed in the hospital design process that the hospital would indeed be a “paperless” facility.¹⁰⁰

4.3 This digital vision for the hospital was also used to develop the ICT services procured through the Facilities Management Services Contract (FMSC) signed with Serco in July 2011. Indeed, the digital vision had been a component of DoH’s procurement of the FMSC from as early as March 2010 when the initial ICT Services Scope was released to the market as part of the FMSC procurement process.¹⁰¹ No doubt the vision was refined and detail added as negotiations with Serco proceeded through 2010 and into the middle of 2011.

4.4 By June 2011, the ICT components of the FMSC had been finalised and the “digital vision” for the hospital had been used as the basis for the formation of a series of contractual obligations between the Department of Health (DoH) and Serco. Because of the nature of the FMSC and the division of effort between Serco and DoH, there were mutual obligations created by the contract with respect to ICT. Serco was dependent on DoH to deliver on its obligations in the same way that DoH became dependent on Serco. It is not hard to come to the conclusion that this mutual dependence, and the associated interdependence it created, required clarity from both parties as to what would be delivered and when that delivery would occur.

4.5 Although the digital vision had been adopted four years earlier, prior to 2012 insufficient work had been undertaken to realise the vision.

98 Department of Health, *Fiona Stanley Hospital Business Case*, December 2007, p. 62 in Submission No. 2 from the Department of Health, 12 August 2013.

99 Hon J.A. McGinty MLA, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 15 November 2007, p. 7264.

100 Health Information Network, *Fiona Stanley Hospital ICT Options Discussion Paper*, v4.0, 9 January 2013, p. 7 in Submission No. 7 from the Department of Health, 15 November 2013.

101 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2.

The details of the digital vision were only finalised in September 2012

4.6 According to DoH, the digital vision was finalised in the ICT Solution document prepared by HIN in September 2012:

*A leading tertiary hospital in Australia providing unparalleled levels of accessible, integrated and evidence based patient centric care through the utilisation of innovative and modern information and communications technology to enable optimal safety, assessment and treatment, efficiency and stakeholder satisfaction.*¹⁰²

4.7 The ICT Solution document also included the “high-level solution design that would deliver the ICT centric business and technology services required to operate FSH”.¹⁰³ The ICT Solution document was intended to enable stakeholders to:

- *Understand the entire ICT solution for FSH;*
- *Define the appropriate scope of ICT projects that will contribute to the FSH solution; and*
- *Define the initial form of the ‘State-Wide ICT Footprint’ that will undergo regular enhancement.*¹⁰⁴

4.8 The ICT Solution document also identified the key business and technology services required; the major information systems delivering those services; the major ICT infrastructure and other devices and equipment required; in addition to a commissioning model.¹⁰⁵ Unfortunately, work on the ICT Solution document had commenced at a time when the FSH commissioning team was very small, the hospital’s clinical services plan had not been completed, and identifying “business owners” to assist in the development of ICT solution was very difficult.¹⁰⁶ The outcome of these problems was an ICT solution that reflected the original digital vision but that bore no relationship to what could actually be delivered at the hospital in the time that was available.¹⁰⁷

102 Department of Health, *Fiona Stanley Hospital: ICT Solution*, September 2012, p. 9 in Submission No. 14 from the Department of Health, 2 January 2014.

103 Submission No. 14 from the Department of Health, 2 January 2014, p. 2.

104 Department of Health, *Fiona Stanley Hospital: ICT Solution*, September 2012, p. 10 in Submission No. 14 from the Department of Health, 2 January 2014.

105 Department of Health, *Fiona Stanley Hospital: ICT Solution*, September 2012, p. 10 in Submission No. 14 from the Department of Health, 2 January 2014.

106 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

107 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

4.9 Indeed, the digital vision was so delayed in its implementation that it was estimated in 2013 that it would take another five years to implement it.¹⁰⁸

The digital vision was abandoned almost as soon as it had been finalised

4.10 Faced with this unacceptable delay, work began in November 2012 – only two months after the digital vision had been finalised and included in the comprehensive ICT Solution document – to “realign” the ICT ambitions. This work on the realignment continued through December 2012 and into the new year. On 25 January 2013, the Director General, Mr Kim Snowball, formally authorised the abandonment of the digital vision in favour of a more pragmatic solution intended to lay the foundations for achieving a digital hospital over a longer timeframe.¹⁰⁹

Finding 13

The digital vision was adopted in 2007 and reaffirmed in 2008 by the current government. A \$4.3 billion contract was signed based on the digital vision in 2011. DoH only finalised the elements of digital vision in September 2012, simply to abandon it two months later in November 2012.

Many people never had any faith in the digital vision anyway

4.11 Many of the senior officials that gave evidence to the Committee expressed the view that the digital vision for the hospital was not achievable. There was particular scepticism with respect to the ambition to deliver a paperless or even paper-light hospital. In December 2011, the Solomon Report of DoH’s ICT programs had concluded that the delivery of a paperless hospital was not possible. The comments made by the review panel are unusually prescient and are worth reproducing in full:

*The panel does not believe a ‘paperless’ Fiona Stanley is feasible at this stage of the WA eHealth strategy. For example, missing elements include clinical notes, prescriptions, and referral letters. Attempts to scan all paper are likely to lead to its own inefficiencies and should only be selectively implemented.*¹¹⁰

4.12 Mrs Rebecca Brown, the Department of the Premier and Cabinet’s representative on the Taskforce told us that it had become clear throughout 2012 that the vision for a paperless hospital would not be achieved. According to Mrs Brown,

108 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 7 in Submission No. 4 from the Department of Health, 9 October 2013.

109 Submission No. 14 from the Department of Health, 2 January 2014, p. 1.

110 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

people had been aware – at least since the Solomon Report – that the aspiration of the paperless hospital would probably not be achieved.¹¹¹

4.13 Dr Andy Robertson, the Acting Chief Information Officer for DoH, held a similar view to Mrs Brown. He also told us that the digital vision for the hospital “was probably never achievable” and that “it was probably a step too far. It was admirable, but technically it was never going to be achieved”.¹¹²

4.14 Similarly, Mr Jon Harrison, a senior HIN officer placed in charge of the FSH ICT efforts in July 2012 in response to a recommendation contained in the University Hospitals Birmingham Report, was of the view that the digital vision could never have been delivered by April 2014.¹¹³

4.15 Dr David Russell-Weisz, the Commissioning Chief Executive, concluded after having come into the role in November 2012 that the full digital vision was “extraordinarily ambitious”.¹¹⁴

4.16 Ms Nicole Feely, the former Chief Executive Officer of the South Metropolitan Health Service, told us that she agreed with the conclusions of the Solomon Report and that discussions about the achievability of the paperless hospital had been occurring well before December 2012.¹¹⁵

The Health Information Network’s opinion in early 2010

It seems HIN did not think the digital vision could be achieved either

4.17 Towards the end of the Inquiry we were provided with evidence indicating that senior management associated with the FSH project had been advised in early 2010 by HIN that the digital vision for a paperless hospital was not achievable. The evidence was not provided anonymously, and we are satisfied that it is authoritative.

4.18 The evidence indicates that those responsible for the FSH project were told that HIN did not have the technical capability or capacity to deliver the systems that were being asked for. DoH was advised to scale back its requirements for FSH, or the hospital would not be able to function. We have not been able to establish with any degree of certainty the exact nature of the response to these reports, although the

111 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 3.

112 Dr Andy Robertson, Acting Chief Information Officer, Health Information Network, *Transcript of Evidence*, 20 November 2013, p. 4.

113 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 27 November 2013, p. 2.

114 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 2.

115 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, pp. 3, 6.

information provided to us indicates that there was a view amongst the FSH and DoH leadership that the problems mentioned by HIN could be managed. In any event, given that the digital vision was included in the contract signed with Serco, it is clear that the advice about HIN's inability to deliver what was being asked of it was rejected.

4.19 On the basis of the information that was provided to us, we asked DoH a series of questions about the nature of the advice provided by HIN in early 2010. The answers provided did very little to settle our concerns about how the digital vision informed the services to be provided by Serco and thus found its way into the contract.

4.20 We told DoH that we had become aware that HIN informed DoH that the digital vision for FSH could not be achieved. We asked DoH to tell us what advice had been provided by HIN with respect to the vision for the paperless hospital in the months immediately prior to April 2010. In response, DoH told us:

*There is no documentary evidence available about what was being advised by the then CIO or other senior HIN staff with respect to the vision for a paperless hospital.*¹¹⁶

4.21 We then asked DoH to outline the sources of the advice and the nature of the disagreements if the advice coming from HIN had not been consistent. DoH told us:

*There is no documentary evidence found that there was any opposing or contradictory view to the plan for a paperless facility prior to 2010.*¹¹⁷

4.22 We note that the answer does not respond to the question we posed, which was seeking information about the months immediately prior to April 2010, not prior to the calendar year 2010. We also asked DoH about two specific documents which we know to exist – we have physically reviewed one of the documents, although neither of them are in our possession – created by HIN in the period immediately prior to April 2010: a gap analysis document and a demarcation document. We also asked DoH to provide us with any other documents it deemed would give the Committee an insight into HIN's thinking with respect to the digital vision at the time (i.e. in the vicinity of April 2010). DoH did not seem to be aware of the two documents we were referring to, and instead provided us with copies of a range of documents created in 2007 in support of the original business case for the hospital.

4.23 Indeed, in answering our request for any documentation that DoH thought might assist us in understanding HIN's position in relation to the digital vision, DoH

116 Submission No. 28 from the Department of Health, 19 March 2014, p. 1.

117 Submission No. 28 from the Department of Health, 19 March 2014, p. 2.

could only provide us with documentation created some three years earlier. Our evidence suggests that HIN had no input in the intervening three years.

4.24 There is an obvious disparity between the confidential evidence provided to us and DoH's responses to our questions. Nevertheless we remain inclined to accept that advice was provided by HIN to DoH in early 2010 indicating that it could not deliver the digital vision for the hospital.

The CIO did not endorse the ICT Services Scope

4.25 Prompted by the confidential evidence that we had received, we asked DoH whether the ICT Services Scope had been endorsed or otherwise signed-off by the Chief Information Officer (**CIO**). The ICT Services Scope was released to shortlisted bidders in March 2010 and described the scope of ICT services that DoH was seeking to be provided via the facilities management contract. According to DoH, there was no documentary evidence indicating that the CIO had endorsed the ICT services scope before it had been released to the market. The Department could not tell us if releasing documents such as this one without CIO endorsement was typical back in 2010, but stressed that it was currently required that all official documents be subject to CIO review prior to release to areas outside of HIN.¹¹⁸

4.26 The information provided by DoH in response to our questions immediately raises several lines of inquiry. Is there, for example, a connection between the advice from HIN's senior management that the digital vision could not be delivered, and the release of the ICT Services Scope without CIO endorsement? According to DoH, the then CIO resigned his position either in March or April 2010 (two dates are provided by the Department in its correspondence to us).

4.27 We are concerned that the ICT elements of the \$4.3 billion contract signed with Serco could have been released into the tendering process without the endorsement of HIN's Chief Information Officer. This endorsement would have provided the necessary assurance that the agency understood what it was required to deliver and was ready and capable of doing so.

Finding 14

The Information and Communications Technology elements of the facilities management contract were initially released in March 2010 as part of the tendering process without the endorsement of the Health Information Network's Chief Information Officer.

118 Submission No. 28 from the Department of Health, 19 March 2014, p. 2.

A fully operational hospital in April 2014

4.28 There are two elements associated with the opening date nominated for FSH. The first relates to the selection of 1 April 2014 as the date on which operations would commence. The second relates to the belief that the hospital could be fully operational in a single month. Our concern arises from the inclusion of both these conditions in the contract signed with Serco, particularly given that these are conditions that DoH set for itself.

4.29 In relation to the phased opening of the hospital there appears to have been a belated acknowledgment that a one-month transition to full operation was not realistic. Unfortunately, this realisation occurred after the contract was signed and begs the question as to how it could have been included as a condition of the contract.

Nominating April 2014 as the opening date

4.30 After nominating 1 April 2014 as the “planned operations commencement date” in the Facilities Management Services Contract (**FMSC**) signed with Serco, both the Department of Health and Serco accepted the risks associated with ensuring that their respective responsibilities would be ready by that date. Private partners to a contract such as the FMSC will accept almost any risk, but in doing so a price will be extracted in the form of a “risk premium”. It goes almost without saying that the risk to Serco of being ready to deliver the non-clinical services at FSH by April 2014 would have been priced into its bid. It would have assessed those risks and identified any costs to it should those risks have been realised. No doubt it would have also assessed its ability to meet the deadline before signing the contract. In simple terms, DoH has paid Serco to take on a risk that now, for the most part, will not be realised due to shortcomings caused by the Department. This is undoubtedly a failure of contracting and risk management by DoH.

4.31 It is a failure that possibly could have been avoided had DoH fully assessed the risks around the April 2014 opening date before signing the contract. Although the “bricks and mortar” elements of the project were going well, there is a great deal more involved with opening a hospital than simply constructing the walls and the roof. It is clear, however, that DoH did not assess its ability to have these other requirements in place in time for the April 2014 opening date before signing the contract. The date had been selected solely on the basis of the construction schedule and not in conjunction with the other critical dependencies that might delay the opening of the hospital.¹¹⁹ The risk register prepared in May 2011 identified some risks on the clinical

119 Submission No. 2 from the Department of Health, 12 August 2013, p. 2.

commissioning side, but did not assess the Department's readiness against those risks.¹²⁰

4.32 It is clear from the evidence that no formal assessment of the Department's ability to meet the April 2014 deadline was carried out prior to signing the contract with Serco. This was a serious oversight, and the failure to carry out this assessment has cost the people of Western Australia a significant sum of money.

Finding 15

The Department of Health did not assess its capacity to meet the April 2014 opening date before including it as the operational service commencement date in the contract signed with Serco.

A four week transition period?

4.33 There are similar problems associated with the decision to stipulate in the contract that the hospital would be fully operational over a period of four weeks commencing on 1 April 2014. Before we formally commenced the inquiry we sought answers from DoH as to how a month-long "transition period" had been included in the contract. A satisfactory explanation was never forthcoming, other than to note that consultants engaged by DoH had indicated that similar projects had required a "short period of actually opening up the hospital".¹²¹ It seems that this advice from the consultants was included in the Business Case submitted to Cabinet in 2007, as 20 business days are allowed for transition to services in the original plan.¹²² It does not seem that DoH revisited the achievability of this timeframe before including it in the contract with Serco.

4.34 We sought to validate this assumption against international experience and were unable to find evidence of other hospitals of similar size and complexity reaching full operational capacity in as little as four weeks. Indeed, the Forth Valley Hospital in Scotland, which Serco operates and which served as a model for Serco's successful FSH bid, opened in a series of stages over a period of twelve months.¹²³

120 Department of Health, *FSHFM Risk Register worksheet v2 – May 2011*, in Submission No. 2 from the Department of Health, 12 August 2013.

121 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 16 July 2013, p. 2.

122 Department of Health, *Fiona Stanley Hospital Progressive Package Master Programme* (an appendix to the FSH Business Case) in Submission No. 2 from the Department of Health, 12 August 2013.

123 NHS Forth Valley, *Minutes of the NHS Forth Valley Board*, 25 May 2010. Available at: http://www.nhsforthvalley.com/__documents/about-us/board-matters/board-meetings/2010-papers/tuesday-25th-may-2010/finance-and-performance-issue/nhsfv_board_250510_item_4.3_nhs_forth_valley_corporate_plan.pdf. Accessed on 18 February 2014.

Finding 16

The four week transition period for Fiona Stanley Hospital was identified in the 2007 Business Case and included in project schedules going forward from that time. It does not seem that DoH revisited the achievability of this timeframe before including it in the contract with Serco.

4.35 In July 2011, the Director General oversaw the negotiation of a \$4.3 billion contract with Serco, which included a month-long transition period commencing in April 2014. Subsequently, in an email in January 2013 to the newly appointed Executive Director of Clinical Commissioning, Mr Snowball claimed that “no one in their right mind would believe” that the hospital could have been at full capacity in April 2014.¹²⁴ Such a statement obviously begs the question as to why a one-month transition was included in the contract in the first place, particularly given that its inclusion has resulted in the need for an additional \$36 million to be provided to Serco to cover its own expenses during the extended transition period. We have not been particularly satisfied by the answers provided in response to our questions about this issue, but we note that one possible explanation was provided to us by Dr Russell-Weisz, who noted that the detailed work regarding clinical commissioning had not been completed at the time the contract was signed with Serco.¹²⁵

4.36 Although we appreciate that the likelihood of having had these detailed plans completed in July 2011 was quite low, much of the evidence received during the course of the inquiry indicates that the resources and time made available to clinical commissioning efforts did not reflect its level of importance. Most alarming was that many of the senior managers associated with the project seemed to be aware of this shortcoming. Ms Feely told us that much of the cost of the SMHS reconfiguration and FSH commissioning was absorbed into SMHS’s operational budget and that there “was not a lot of money floating around” to cover the cost of the work.¹²⁶ With the assistance of PricewaterhouseCoopers (**PwC**), Ms Feely submitted a proposed budget in January 2011 seeking an additional \$197.7 million to cover the costs associated with the SMHS reconfiguration, including FSH commissioning, but excluding ICT costs.¹²⁷ According to DoH, the “transitioning period and funding requirements outlined were inconsistent with the scheduled opening date for [FSH]”.¹²⁸ On that basis, a review of the PwC budget was conducted and a business case was developed by DoH that was

124 Email sent by Mr Kim Snowball, Director General, to Ms Liz MacLeod, Executive Director, FSH Clinical Commissioning, 28 January 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

125 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 14.

126 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 5.

127 Submission No. 26 from the Department of Health, 10 March 2014, p. 2.

128 Submission No. 26 from the Department of Health, 10 March 2014, p. 2.

consistent with the April 2014 opening date. This business case estimated costs of \$68.297 million over the period 2011–12 to 2014–15. In the 2012–13 state budget, \$50.4 million was made available for FSH commissioning and SMHS reconfiguration.¹²⁹

4.37 The estimates made by DoH in response to the PwC proposal, and the funding made available to DoH in 2012–13, ultimately proved to be woefully inadequate compared to the actual costs associated with commissioning the hospital. In explaining the need for the additional \$75 million provided in the 2013–14 Government Mid-Year Financial Projections Statement for the commissioning and reconfiguration, DoH told us that it had “become apparent that the scope and number of activities required for the safe and successful commissioning of FSH and reconfiguration of SMHS is significantly more than previously envisaged”.¹³⁰ This is, perhaps, something of an understatement and is difficult to reconcile given the existence of the PwC proposal from January 2011. Indeed, DoH knew or ought to have known, that the task that it was undertaking was especially complex; it had even been provided with a proposed budget that proved rather prescient.

4.38 Perhaps the simplest way to demonstrate this is to highlight the fact that PwC recommended that 28 staff members were to work on the clinical models of care to be provided at FSH and the reconfigured SMHS sites, with their work to commence some 38 months prior to the opening of FSH.¹³¹ As the following parts of this chapter make clear, however, these clinical commissioning efforts were significantly under-resourced and have required a substantial injection of funds and staff numbers in order to deliver even by the revised October 2014 opening date.

Inadequate resourcing contributed to schedule pressures

4.39 The basic figures on resourcing for clinical commissioning indicate the degree to which its complexity and importance had been underestimated:

- The initial team of FSH staff working on clinical commissioning numbered six or seven people, although there was an expectation that this effort would ramp up as

129 Submission No. 26 from the Department of Health, 10 March 2014, p. 2.

130 Submission No. 18 from the Department of Health, 31 January 2014, p. 5.

131 PricewaterhouseCoopers, *SMHS Reconfiguration Cost Modelling*, January 2011, p. 30 in Submission No. 26 from the Department of Health, 10 March 2014.

the opening date moved closer.¹³² The current team comprises about 50 to 60 staff.¹³³

- The original timeframe for completion of the Department Service Plans (**DSPs**) was December 2012; however, by November 2012, only eight out of 91 were complete.¹³⁴ The current team has completed over 80 DSPs in the last 12 months.¹³⁵
- The original budget allocation in 2012–13 for “clinical service readiness”, including FSH clinical commissioning staff, was \$12,916,000. In the 2013–14 Government Mid-Year Financial Projections Statement, additional funding of \$24,147,000 was allocated over three years.¹³⁶

4.40 The impact of this deficiency in resourcing extended beyond the Clinical Commissioning work stream itself. In his December 2012 Baseline Schedule Report, Dr Russell-Weisz identified the schedule pressure caused by the lack of complete DSPs given their interdependency with the Workforce and Facilities Management work streams:

... the DSPs are now being described as part of a sequence of much more work that leads to the clinical readiness of the hospital on opening. The majority of DSPs are still being drafted which has the potential to cause delays in the Workforce and Facilities Management Work streams if additional work is required to align planning.

*A Commissioning Scheduling Plan has not been developed to date, and is now underway, however the delays as outlined above are making delivery of this much harder.*¹³⁷

4.41 Dr Russell-Weisz also noted that the need to align the various work streams was critical and would further add to scheduling pressures:

132 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2; Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 4. Mr Sebbes told us that clinical commissioning was originally a joint responsibility of the FSH team and the SMHS clinical planning team, which comprised “20-odd” people.

133 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2.

134 Department of Health, *Fiona Stanley Hospital Incoming Government Brief*, 1 March 2013, p. 10 in Submission No. 15 from the Department of Health, 9 January 2014.

135 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2.

136 Submission No. 18 from the Department of Health, 31 January 2014, pp. 5-7; Submission No. 24 from the Department of Health, 4 March 2014, p. 1.

137 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, pp. 14–15 in Submission No. 4 from the Department of Health, 9 October 2013.

The Clinical Commissioning work is not aligned to the FM and ICT plans. Once departmental service plans are complete, the FM service plans, management plans and ICT plans must all be aligned. This will further increase schedule pressure.

The FM Service and Management Plans are near completion with Serco maintaining progress towards its 21st December 2012 milestone. The ICT Business Process Maps have been developed but these have yet to undergo clinical scrutiny. Without the DSPs to guide these, it is likely that there may be gaps in the planned services across the three work streams that will impact quality and safety of patient care. Aligning the outputs of the three work streams is therefore critical to FSH opening.¹³⁸

Unrealistic commissioning timeframes

4.42 As noted above at paragraph 4.32, a four-week transition period to full operational capacity was specified in the FMSC. In May 2013, Dr Russell-Weisz said that the original timeframe, regardless of the commissioning start date, was “not safe nor achievable, nor took into account [the] need for training, complexities, testing, interface, etc.”¹³⁹ Indeed, the necessity for a longer phasing period appears to have been acknowledged sometime in late 2012.¹⁴⁰ Working to the original timeframe, the proposed staged opening for FSH was as follows:

Table 4.1: Original proposed staged opening¹⁴¹

Stage	Proposed Date	Services	Comments
1	17 Mar 2014	State Rehab Services	Including other associated diagnostic services and bed management
2	1 Apr 2014	Elective Surgery	Including theatres, ICU, some elective surgery and supporting wards and services
3	3 Apr 2014	ED/Emergency Surgery	Including associated medical specialties, all surgical specialties, burns
4	7 Apr 2014	All Surgery	All multi-day wards and associated support services operational
5	April/May	Fully Operational	Including hyperbaric unit and remaining clinical services

138 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 15 in Submission No. 4 from the Department of Health, 9 October 2013.

139 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, email to Professor Bryant Stokes, 7 May 2013, p. 1 in Submission No. 9 from the Department of Health, 22 November 2013.

140 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, pp. 17–18; Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, pp. 13–14.

141 South Metropolitan Health Service, *SMHS Reconfiguration and Fiona Stanley Hospital Commissioning*, in Submission No. 23 from the Department of Health, 24 February 2014.

4.43 When the issue of phased commissioning was revisited in January 2013, the expected timeframe was discussed in terms of months rather than weeks; Dr Russell-Weisz noted the need to determine whether the period “from a ground zero date to full commissioning” would be six, nine or 12 months.¹⁴²

4.44 Ms Liz MacLeod commenced in the role of Executive Director, Clinical Commissioning for FSH in November 2012. In January 2013, Ms MacLeod began working on the FSH commissioning schedule. It is a concern to the Committee that Mr Snowball told us that he had been asking for the schedule for “some considerable period of time”; in fact there is an email from Mr Snowball to Ms MacLeod stating that he had been asking for it for over 18 months.¹⁴³ This should have signalled that the clinical commissioning resourcing was inadequate.

Finding 17

By December 2012, DoH had been aware for 18 months that a commissioning plan was required. It was a significant failure of DoH that it did not produce the document earlier given its importance.

4.45 Ms MacLeod produced a “High-Level Sequencing Options Paper”, which outlined several commissioning options and their benefits and risks; throughout January 2013, this document went through several draft revisions in consultation with Mr Snowball and Dr Russell-Weisz. The key principles guiding the commissioning were the safety and quality of patient care; maintenance of service continuity; and minimisation of operations, financial and human resource impacts.¹⁴⁴

4.46 The 21 January 2013 draft outlined six sequencing options:

- Options 1, 2, 4 & 5 – commencing services in April 2014;
- Options 3 & 6 – commencing services in September/October 2014.

4.47 The first stated objective in this document was that “FSH services will begin to come on-line from April 2014.” “Political risk and negative public perception” were noted as factors relevant to a September/October 2014 commencement date, while most options were noted as being “sensitive to ICT readiness anticipated for September/October 2014.” Options 1, 2, 5 & 6 were shortlisted as preferred options;

142 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, email to Mr Kim Snowball, 14 January 2013, p.1 in Submission No. 9 from the Department of Health, 22 November 2013.

143 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 4; Mr Kim Snowball, Director General, Department of Health, email to Ms Liz MacLeod, 28 January 2013, p.1 in Submission No. 9 from the Department of Health, 22 November 2013.

144 Department of Health, *High-Level Sequencing Options for the Commissioning of Fiona Stanley Hospital*, 13 January 2013, p. 2 in Submission No. 9 from the Department of Health, 22 November 2013.

the others were not preferred due to insufficient allowance for testing causing risk to safety and quality of patient care.¹⁴⁵

4.48 The 24 January 2013 draft outlined the same six options. Option 6 was noted as carrying the “least risk for safety and quality of patient care due to the later timeframe for operations planning and transition and controlled sequencing of opening”, although it was not preferred due to the later timeframe. Option 5 was preferred, which was noted in the document history as occurring “following discussion with DG.” This proposed phasing the introduction of services over six months from April 2014 and was noted to provide a safe phased approach, enabling testing of facilities and ICT, although resource implications were expected due to the necessity to maintain dual site operations.¹⁴⁶

Finding 18

The January 2013 decision to select a six-month phased opening commencing in April 2014 was not the safest option considered, with the clinical commissioning team noting that the safest option was to phase over six months commencing in October 2014.

4.49 It was not until 10 June 2013 that an announcement was made regarding the new opening schedule for FSH commencing in October 2014; the need for a delayed opening date had been recognised in the interim. The current schedule is as follows:

Table 4.2: Current proposed staged opening¹⁴⁷

Phase	Proposed Date		Services
1	4 Oct 2014		State Rehab Services Pathology, pharmacy and medical imaging providing support as required
2	2A	17 Nov 2014	General medicine (one 24-bed ward) General surgical (one 24-bed ward) Orthopaedics, anaesthetics, some intensive care capability
	2B	2 Dec 2014	Obstetrics, gynaecology, neonates
3	3 Feb 2015		Emergency department, majority of all other specialties, outpatient services, burns
4	23 Mar 2015		Heart and lung transplant services

4.50 The four week transition period which was initially considered to be viable is obviously far-removed from the six month period that was ultimately decided to be safe and achievable. As stated above, the fact that such an inadequate transition period

145 Department of Health, *High-Level Sequencing Options for the Commissioning of Fiona Stanley Hospital*, 21 January 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

146 Department of Health, *High-Level Sequencing Options for the Commissioning of Fiona Stanley Hospital*, 24 January 2013, in Submission No. 9 from the Department of Health, 22 November 2013.

147 Department of Health, *Fiona Stanley Hospital Opening Schedule*. Available at: <http://www.fsh.health.wa.gov.au/About-us/Contact-us/Opening-Schedule>. Accessed on 1 April 2014.

to full operational capacity was specified in the FMSC raises serious concerns about the risk assessment conducted as part of the FMSC negotiations and the clear lack of clinical input at early stages of the FSH project.

Conclusion

4.51 The content of this chapter makes clear that DoH did not have the systems and structures in place to ensure that the 1 April 2014 opening date could be achieved. While we accept that the phased transition approach is the only logical way to safely open the hospital, there is no reason other than shortcomings of the Department's own making that stopped the April 2014 target being reached.

4.52 DoH set the terms of its engagement with Serco, based on the digital vision and the April 2014 opening date; therefore, it was incumbent on DoH to be prepared to meet those terms.

Finding 19

The Minister for Health signed a \$4.3 billion contract with Serco where the government was obligated to deliver an operational digital hospital on 1 April 2014. The Committee is not satisfied that the government had assured itself that it could achieve this before signing the contract.

Chapter 5

Increasing visibility

By December 2012, a range of reports in the possession of the Director General of the Department of Health were painting a clear picture: the commencement of operations at the Fiona Stanley Hospital would be delayed by at least six months. There was nothing that could be done to recover the original program and enable the April 2014 opening date, only actions that would minimise the extent of the delay.

The University Hospitals Birmingham Report was the first of a number of reports in the second half of 2012 identifying significant risks of delay to the opening of the hospital and attempting to quantify its extent. It marked a turning point in the life of the commissioning project, highlighting various program management and governance shortcomings that had, until that point, either been ignored or gone undiagnosed.

The reporting that came subsequent to the University Hospitals Birmingham Report confirmed the earlier reports' findings and were consistent with signs of trouble that were appearing in other reporting, including from the South Metropolitan Health Service. The information presented in these reports from December 2011 through to December 2012 was consistent; their messages did not lend themselves to an interpretation that the commissioning project was going well.

Consistent reporting: the hospital would be delayed

^{5.1} In chapters 2 and 3, we found that shortcomings with program management and governance, particularly issues of reporting, made it extremely difficult to gain an accurate understanding of the commissioning project's status. We also found that despite numerous problems with the quality and consistency of internal project reporting, these documents nonetheless contained warning signs for those paying attention about what was really happening. This reporting, when considered in conjunction with other signals coming from those associated with the project, was clearly sounding an alarm bell. It is therefore not surprising that by April 2012 Mr Snowball "had formed some personal but not substantiated concerns about some aspects to the commissioning".¹⁴⁸ It was on the basis of these concerns that Mr Snowball authorised funding for the University Hospitals Birmingham (UHB) to conduct a review of the status of Fiona Stanley Hospital's (FSH's) commissioning.

148 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, pp. 2–3.

Table 5.1: Reports advising on delay

Report	Author	Date	Length of delay identified	Comments about delay
Fiona Stanley Hospital Independent Review of Commissioning of the Hospital	University Hospitals Birmingham	11/07/12	n/a	When compared to the UHB Programme, a significant number of work streams were 12-18 months behind.
FSH HIN Project Delivery Review Report	Mr Omar Abdel-Alim	03/12/12	n/a	Unacceptable risk around the ability of HIN to deliver the work necessary to enable ICT for FSH by April 2014.
FSH ICT Status & Readiness Working Paper	Mr Jon Harrison	06/12/12	9-12 months	Even with a more pragmatic ICT approach, it would not be possible to safely commission FSH by the planned date.
Fiona Stanley Hospital Baseline Schedule Report	Dr David Russell-Weisz	08/12/12	9-12 months	Delay of between nine and 12 months expected even with a more basic approach to ICT.

5.2 The UHB Report marked an important turning point in the nature and quality of information that existed about the status of the commissioning project. It was the first of a number of reports to estimate the extent of the delays afflicting the project. It also starkly outlined the various shortcomings in project governance and program management that have been outlined in chapter 2. The final report was issued and provided to Cabinet in July 2012.

5.3 Over the following months, the UHB Report was followed by a number of other reports prepared by the commissioning project's senior leadership. This flurry of reporting activity culminated in December 2012, when Dr Russell-Weisz, the newly appointed executive in charge of the commissioning project, concluded that a delay of between of nine and 12 months was necessary.

5.4 We earlier characterised the period prior to July 2012 as one of ignorance about the true status of the commissioning project, arising from a degree of incompetence. For the six months that followed, it was a case of disregarding the true picture that had emerged.

Finding 20

Commencing in July 2012, a series of reports were completed that concluded a delay to the opening of the hospital was likely to occur.

University Hospitals Birmingham Report

5.5 In April 2012, the Director General of the Department of Health (**DoH**) engaged the University Hospitals Birmingham NHS Foundation Trust to undertake an independent review of the status of the commissioning of Fiona Stanley Hospital.¹⁴⁹ In 2010, UHB successfully transferred services from two hospitals into the 1,213-bed Queen Elizabeth Hospital Birmingham, the United Kingdom's newest and largest single site hospital.

5.6 Four representatives from UHB conducted the review over one week in May 2012 and the final report was submitted to the Director General on 11 July 2012. The terms of reference for the review were to:

- Provide an outline of the management model, phases, 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;
- Provide an outline of the approach being used at that time for FSH projects; and
- Compare and contrast the approach being used at FSH, identify the risks and recommend any action that may be required.

5.7 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.*¹⁵⁰

5.8 The review report identified some areas of good practice, including committed staff teams, establishment of a Project Management Office (**PMO**) and general recognition of the time constraints associated with such significant changes. However,

149 Mr Kim Snowball, Director General, Department of Health, letter to Ms Morag Jackson, University Hospitals Birmingham NHS Foundation Trust, 21 April 2012 in Submission No. 23 from the Department of Health, 24 February 2014.

150 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 12 in Submission No. 4 from the Department of Health, 9 October 2013.

a number of risks and concerns were also identified that, without immediate action, were expected to severely impact on the timely opening of FSH:

- Lack of a team solely dedicated to delivery of the FSH program, led by an experienced program director, as well as a skills deficit within the existing team to deliver a program of such complexity;
- Insufficient levels of role definition to ensure adequate governance arrangements, complicated by the number of agencies involved in the South Metropolitan Health Service (**SMHS**) reconfiguration;
- Insufficiently robust structures and tools to ensure the availability of all the information required to determine if the program was on track – formal reporting arrangements for the whole program were unclear and there was no evidence of monthly program reports being presented at Director General level;
- Lack of a master integrated program did not allow the SMHS to monitor and measure progress against significant milestones and critical interdependencies;
- Insufficient integration of work streams and a lack of awareness of the importance of the interdependencies between them;
- No evidence that detailed clinical strategies were being completed and transitioned to a detailed service plan within the appropriate time frames;
- No detailed workforce plan drafted at staff group level, providing no assurance on affordability;
- Unclear from SMHS financial planning how financial models will link to the clinical service models, particularly with the introduction of Activity Based Funding and a Nationally Efficient Price;
- General lack of confidence in the Information and Communications Technology (**ICT**) systems delivery, lack of understanding of what is to be delivered and little evidence of integration of ICT service elements between the Health Information Network (**HIN**) and Serco; and
- Risk management processes in development and not sufficiently mature to adequately identify, mitigate and manage risks inherent in such a complex program, particularly in relation to failure to deliver a full range of ICT solutions.¹⁵¹

151 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, pp. 10–11, 15–16 in Submission No. 4 from the Department of Health, 9 October 2013.

5.9 In comparing the approaches taken at UHB and FSH, the review report noted that when the Birmingham program was at the same stage as FSH, a much greater level of detailed planning had already been completed, including the workforce and clinical modelling.¹⁵² Evidence suggested that “a significant number of work streams [were] 12 to 18 months behind” when compared to the UHB program.¹⁵³

5.10 The report concluded that, given the risks, it could not provide assurance that FSH would be delivered on time or within budget, although it noted that this could be retrieved with “decisive and timely action.”¹⁵⁴ Eight key recommendations were made addressing the risks outlined above and suggesting specific timeframes for their completion.

Finding 21

The University Hospitals Birmingham Report provided to the Cabinet and the Department of Health in July 2012 found that a significant number of work streams associated with the commissioning of the Fiona Stanley Hospital were 12 – 18 months behind when compared to equivalent work streams at the University Hospitals Birmingham.

Finding 22

The findings of the University Hospitals Birmingham Report made clear that there were significant and wide-ranging deficiencies associated with the commissioning of the Fiona Stanley Hospital.

Why commission an independent report?

5.11 In relation to his reasons for commissioning the UHB Report, Mr Snowball said that despite having received assurances that the commissioning of FSH was on track, he felt it would be “prudent” to undertake an independent review of the project while sufficient time was still available to remedy any problems.¹⁵⁵ Mr Snowball went on to tell us:

[...] I had formed some personal but not substantiated concerns about some aspects to the commissioning and I wanted these tested by people with expertise and experience with a commissioning task of this

152 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 12 in Submission No. 4 from the Department of Health, 9 October 2013.

153 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, pp. 10–11 in Submission No. 4 from the Department of Health, 9 October 2013.

154 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 14 in Submission No. 4 from the Department of Health, 9 October 2013.

155 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 2.

*size. In particular, I was concerned about the workload that was developing and had seen some slippage in key deliverables[...] Although these slippages would not be irretrievable, I was concerned that I had one chief executive carrying the commissioning of Fiona Stanley Hospital, as well as reconfiguring all the other major hospitals – Fremantle, Royal Perth and so on – as well as the day-to-day running of the largest health service in the state. It was a pretty heavy workload, and it was increasing exponentially.*¹⁵⁶

5.12 Ms Feely said in her evidence that PricewaterhouseCoopers (**PwC**), having been involved in the SMHS reconfiguration since 2011, suggested that she engage the UHB group for advice and support and to otherwise assist in relation to commissioning the hospital. The Department characterised this as discussions in late 2011 regarding “partnering with external agencies including University Hospitals Birmingham”.¹⁵⁷ According to Ms Feely, the desire was to engage a group that “had actually done a commissioning”.¹⁵⁸ She told us that she conveyed this suggestion to Mr Snowball about six months prior to UHB’s eventual engagement and “nothing happened in the short term.”¹⁵⁹ Ultimately, Mr Snowball chose to engage UHB to review the status of the commissioning, rather than provide assistance to the team filling the role.¹⁶⁰

5.13 Mr Marney recollected that the UHB Report was initiated by DoH in response to concerns that had been raised by the Department of Treasury (**DoT**) as far back as late 2011¹⁶¹ and that the report “validated a lot of the issues that Treasury had been raising for a considerable period with respect to the ICT workforce and departmental service planning.”¹⁶² Indeed, Mr Marney told us that DoT raised its concerns around FSH project risk on numerous occasions through its recommendations to the Economic and Expenditure Reform Committee (**EERC**), which would have flowed through to Cabinet via the committee minutes¹⁶³; he also provided us with several items of correspondence dating back to November 2006 in which he raised concerns with the

156 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, pp. 2–3.

157 Submission No. 23 from the Department of Health, 24 February 2014, p. 2.

158 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 4.

159 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 4.

160 Submission No. 23 from the Department of Health, 24 February 2014, p. 2.

161 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 2.

162 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 5.

163 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 3.

then Director General of DoH, Dr Neale Fong, about the governance arrangements for FSH.¹⁶⁴

Earlier external reports also identified problems

5.14 The UHB Report was by no means the first independent report to identify problems with the progress of FSH and to recommend changes to ensure its timely and successful delivery. In late 2011, following a “protracted period of non-delivery or poor delivery of health ICT”¹⁶⁵, the Department of Finance, in conjunction with DoH, initiated a review of WA Health’s planned investment in ICT. The review panel was chaired by Mr Shane Solomon, a partner at KPMG, and the final report (**the Solomon Report**) was submitted on 16 December 2011. In relation to FSH, the review panel was particularly cognisant of the State’s obligations under its agreement with Serco for the provision of linked ICT systems; it specifically identified several priority projects which, if not ready for implementation, would jeopardise the State’s ability to meet its contractual obligations. It remarked that each priority project had tight timelines which, even with a reduction in the scope of other projects and further phasing of their implementation, represented a “challenging program of work” if the FSH imperatives were to be achieved.¹⁶⁶ The report noted that a detailed, integrated FSH ICT Plan had not yet been developed and recommended that this occur as a matter of urgency to ensure consistency with the Serco and construction critical paths.¹⁶⁷ It recommended that the clinical processes and “paperlite” workflows be defined and led by HIN following confirmation of the systems and applications to be implemented. Importantly, it commented that the panel did not believe that a “paperless” hospital was feasible at that stage.¹⁶⁸ It also noted the lack of robust governance structures with accountability and authority for FSH ICT and recommended that a steering committee be established, chaired by the SMHS Chief Executive and including senior HIN membership, as well as an ICT PMO.¹⁶⁹

164 Submission No. 11 from Department of Treasury, 4 December 2013, p. 2.

165 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, pp. 5–6.

166 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 5 in Submission No. 4 from the Department of Health, 9 October 2013.

167 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, pp. 7, 17 in Submission No. 4 from the Department of Health, 9 October 2013.

168 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

169 WA Health ICT Review, *Expert Review Panel: Advice to the Department of Finance, Government of Western Australia*, 16 December 2011, pp. 8, 17 in Submission No. 4 from the Department of Health, 9 October 2013.

Finding 23

In December 2011, the Solomon Report, an independent review of Information and Communications Technology projects across the Department of Health, concluded that the vision for a paperless hospital at Fiona Stanley Hospital was not feasible.

5.15 Several months later, on 8 May 2012, PwC submitted a report commissioned by the SMHS, assessing the FSH ICT Services Plan and the interfacing Serco ICT Solutions, which had been developed by that stage but not confirmed, funded or approved.¹⁷⁰ The report developed a common “roadmap” for ICT implementation, listing key actions and deadlines for SMHS, HIN and Serco; it also identified gaps and risks associated with the ICT plans and made recommendations to strengthen their alignment with each other and with clinical services. The report noted that the ICT plans outlined a significant “uplift” in the use of ICT intended for FSH versus the rest of the WA health system and that “significant schedule pressures” existed to design, procure, develop and implement the relevant ICT components in time for the opening of the hospital in early 2014.¹⁷¹ A preliminary integrated milestone plan was developed during the review, through to October 2012, capturing key interdependencies between SMHS, HIN and Serco; a plan beyond that was to be developed, managed and reported on monthly by the incumbent SMHS reconfiguration ICT working group.¹⁷² At the time of the report, key clinical processes had still not been designed and the report identified a list of priority processes with recommended dates for completion.¹⁷³ A preliminary ICT delivery risk register was also developed for key focus areas in scope of the review – key risks included interdependencies between HIN and Serco ICT projects causing resourcing conflicts and program delays.¹⁷⁴

5.16 Neither of these earlier reports was provided to Cabinet, although the Solomon Report was tabled and discussed with government central agencies.¹⁷⁵ The reports were distributed to the Taskforce on 25 March 2013.¹⁷⁶

5.17 The evidence suggests that the recommendations from these reports were not implemented with the requisite level of urgency, nor was the status of the arising actions adequately tracked. Following a resolution at the Taskforce meeting on

170 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 4 in Submission No. 4 from the Department of Health, 9 October 2013.

171 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, p. 4 in Submission No. 4 from the Department of Health, 9 October 2013.

172 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, pp. 13–15 in Submission No. 4 from the Department of Health, 9 October 2013.

173 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, pp. 25–28, 79–87 in Submission No. 4 from the Department of Health, 9 October 2013.

174 PricewaterhouseCoopers, *Fiona Stanley Hospital – Clinical Services and ICT Alignment*, 8 May 2012, pp. 15, 77 in Submission No. 4 from the Department of Health, 9 October 2013.

175 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 21.

176 Department of Health, *FSH Commissioning and Major Hospitals Transition Taskforce Actions – March 2013* in Submission No. 4 from the Department of Health, 9 October 2013.

28 March 2013, members were to be provided with status reports on all previous ICT report recommendations by 11 April 2013¹⁷⁷; these were ultimately provided by 15 April 2013.¹⁷⁸ Although many of the recommendations contained in the Solomon Report were exclusive to FSH, at the 24 April 2013 Taskforce meeting Dr Russell-Weisz “expressed concern at the number of open and ongoing recommendations.”¹⁷⁹ The recommendations from the PwC Report were specific to FSH and the April 2013 status report showed that some progress had been achieved. However, having explicitly noted the existence of “significant schedule pressures”, the PwC Report suggested most of their recommendations be completed in the period May – June 2012; notably, a significant proportion remained “open” almost a year later in April 2013.

What happened after the UHB Report?

5.18 A copy of the UHB Report accompanied the minute sent to Cabinet in July 2012 proposing the establishment of the Taskforce.¹⁸⁰ Neither the report nor the minute were circulated to members at the time of the Taskforce’s establishment; despite a resolution at the 6 February 2013 Taskforce meeting to provide these documents to members, the report was only provided following the 21 March 2013 meeting.¹⁸¹ Mr Snowball told us that, having discussed the report with the Under Treasurer, the State Solicitor and the Deputy Director General of the Department of the Premier and Cabinet before sending the Cabinet minute, he had assumed that the Taskforce members had copies of the documents.¹⁸² In his evidence, Mr Nicholas Egan described the failure to provide both the UHB and Solomon Reports to the Taskforce from the outset as “regrettable”.¹⁸³ We would agree and, as discussed below at paragraph 5.23, it is clear that the Taskforce members considered the UHB Report and its recommendations to be a sufficiently important benchmark against which to monitor the progress of FSH.

5.19 Mr Snowball told us that he asked the UHB Report team to provide “some rapid and high-level reviews – conducted very quickly” on the status of FSH and that the review was able to be completed quickly because the team was experienced in commissioning.¹⁸⁴ He was reliant in his evidence upon the UHB conclusion that slippage

177 Minutes of the FSH Taskforce Meeting, 28 March 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

178 Minutes of the FSH Taskforce Meeting, 11 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

179 Minutes of the FSH Taskforce Meeting, 24 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

180 Minutes of the FSH Taskforce Meeting, 25 September 2012 in Submission No. 4 from the Department of Health, 9 October 2013.

181 Minutes of the FSH Taskforce Meeting, 21 March 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

182 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, pp. 22–23.

183 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 7.

184 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 3.

in the FSH implementation program could be retrieved “with decisive and timely action”, which he told us he initiated.¹⁸⁵ The 6 February 2013 Taskforce minutes record that Mr Snowball repeated his summary that the UHB Report was a “short, quick review” and note that he hadn’t accepted all of the UHB findings and recommendations but accepted “some key ones which were subsequently put forward to government.”

5.20 The major actions triggered by the UHB recommendations were:

- Mr Jon Harrison was appointed as FSH Executive Lead ICT in July 2012, acting as the “dedicated accountable person” to deliver the ICT at FSH¹⁸⁶ and reporting to the HIN Executive and Mr Snowball. On 13 November 2013, Mr Snowball directed Mr Harrison “to take immediate and full control of all ICT related projects and operational areas at HIN required to deliver FSH.”¹⁸⁷
- The Taskforce was established in September 2012 following Cabinet approval in July 2012, with the first meeting held on 25 September 2012; and
- Dr Russell-Weisz was appointed as Chief Executive, FSH Commissioning in November 2012, reporting directly to the Director General.

Implementing the UHB Report’s recommendations

5.21 Consistent with the other inadequacies in governance and program management, the implementation and tracking of recommendations contained in the UHB Report was seemingly non-existent. Indeed, according to one DoH employee, there was “no evidence that the UHB Report had ever been distributed or provided to anyone to deliver the recommendations.”¹⁸⁸ In the months following the Taskforce meeting on 21 March 2013, at which members were told of the likelihood of delay, members were concerned by the difficulties encountered by DoH when attempting to provide an update on the status of the recommendations.

5.22 Several reports were prepared charting the status of responses to the UHB recommendations; the evidence suggests that these recommendations were not enthusiastically implemented or tracked. The first status report, circulated to the Taskforce following the 21 March 2013 meeting, noted that SMHS supported the recommendations, with the exception of recommendation 2, on the basis that it was “already delivering as suggested”.¹⁸⁹ Recommendation 2 related to the establishment

185 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 3.

186 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 8.

187 Submission No. 5 from Department of Health, 14 October 2013, p. 3.

188 Minutes of the FSH Taskforce Meeting, 24 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

189 South Metropolitan Health Service, *SMHS Response to UHB Recommendations*, Document 26 in Submission No. 4 from the Department of Health, 9 October 2013.

of a new, transparent governance structure. Ms Feely told us that she opposed separating the FSH program from the SMHS reconfiguration due to the complex interdependencies between the changes to SMHS sites required to facilitate the opening of FSH.¹⁹⁰ It was her strong view that changes in governance would create dual leadership, blur lines of accountability and add further complexity to an already complex process. In Ms Feely's opinion, the eventual split in governance that occurred in November 2012 was only successful due to the good working relationship that she had with Dr Russell-Weisz.¹⁹¹

5.23 It is clear from the Taskforce minutes later in 2013 that the Taskforce members considered the status of the responses to the UHB and Solomon recommendations to be sufficiently important to report progress against them in their Cabinet Submission and Status Report (**the Cabinet Submission**). This document would include the Taskforce's formal recommendation to Cabinet that the opening of the hospital be delayed. In relation to the first draft of the Cabinet Submission, circulated on 9 April 2013, Taskforce members specifically noted that "it needs to address whether the project has caught up on the delay identified by UHB (12 – 18 months delay in some work streams)".¹⁹² This led the Taskforce to request a second status report, which was circulated following the 11 April 2013 meeting. This report contained more detail than the first status report and recorded that all the UHB recommendations had been met.¹⁹³ At the following meeting on 24 April 2013, Ms Angela Kelly confirmed that this response to the UHB recommendations had been prepared by SMHS.¹⁹⁴

5.24 The accuracy of the second status report is drawn into question by a further status report circulated to the Taskforce at the 9 May 2013 meeting, in which the status of many of the recommendations was recorded as "still to be completed", "in progress" or "ongoing".¹⁹⁵ The recommendations that had been met were recorded as having been completed later than suggested. We asked DoH to provide an explanation for why the two documents were so different, particularly given that they were created only weeks apart. According to DoH, the first response, representing an optimistic view of the status of the recommendations, was prepared by SMHS and so therefore represented SMHS's view of the project. The later document, a significantly more

190 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 7.

191 Ms Nicole Feely, Former Chief Executive Officer, South Metropolitan Health Service, *Transcript of Evidence*, 29 January 2014, p. 12.

192 Minutes of the FSH Taskforce Meeting, 11 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

193 Department of Health, *Status of Recommendations from UHB Review*, Document 41 in Submission No. 4 from the Department of Health, 9 October 2013.

194 Minutes of the FSH Taskforce Meeting, 24 April 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

195 Department of Health, *Status of Recommendations from UHB Review*, May 2013, Document 55 in Submission No. 4 from the Department of Health, 9 October 2013.

accurate portrayal of the status of the project, was prepared as a “whole of health response” presumably created by DoH.¹⁹⁶ It is not clear to us why this would have any impact upon the accuracy of the information contained in the documents, particularly considering that the less accurate document was prepared by SMHS, the entity within DoH that was actually responsible on a day-to-day basis for the hospital.

5.25 The Taskforce ultimately agreed that a reconciliation of the UHB and Solomon recommendations should be undertaken and reported to the Taskforce following development of the integrated program. It was also agreed that it was unnecessary to attach the UHB status report to the Cabinet Submission created to advise of the delay.¹⁹⁷

5.26 Mr Egan told us that he was “concerned” when he first saw the UHB Report in March 2013 because the Taskforce had not been provided with any specific response to the recommendations, other than the establishment of the Taskforce itself, and that it took a number of meetings before any such response was provided.¹⁹⁸ He recalled that the UHB Report indicated that FSH was 12 to 18 months behind schedule and the Taskforce called for a status report “to ascertain whether or not any measures had been taken or employed to ensure that that 12 to 18-month period had been clawed back in some way.”¹⁹⁹ Mr Egan said that it became apparent that little work of that nature had been done and the Taskforce later took the decision to engage a PMO to ascertain, in particular, the status of ICT and “whether or not the milestones required to ensure any form of opening could be achieved.”²⁰⁰ Of this decision, he told us

*[w]hat was reassuring in part was that some action was being taken in order to properly advise the task force in relation to certain matters including, in particular, where ICT was at. But I had no confidence that health had the requisite information to properly form its own view as to where ICT delivery was at and how much longer it would require before it could be completed.*²⁰¹

5.27 Mrs Rebecca Brown also told us that, having seen the series of external reports, the Taskforce asked for a status report on the recommendations which ideally required a response from DoH, not just SMHS. However, she was less concerned that the UHB Report had never been distributed to anyone to deliver the recommendations. It was her understanding that Mr Snowball saw the report as “a piece of advice to his thinking, not the sole piece of advice” and it was within his remit to circulate the report

196 Submission No. 23 from the Department of Health, 24 February 2014, p. 6.

197 Minutes of the FSH Taskforce Meeting, 9 May 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

198 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 6.

199 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 6.

200 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 6.

201 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 7.

and implement the recommendations as he saw fit.²⁰² This view is not entirely consistent with Mrs Brown's comments at the 6 February 2013 Taskforce meeting that "with Cabinet having established a governance framework, there is an expectation going forward that milestones are being tracked and met."²⁰³

5.28 We would have expected that the UHB Report would be used by the Taskforce as a benchmark against which DoH's progress could be measured. That no response was provided to the Taskforce until 21 March 2013 represents a failure arising from two sources. The first is DoH, which had control of the Taskforce agenda, yet did not use the UHB Report recommendations as a framework for its reporting to the Taskforce. The second is the Taskforce itself, as the Taskforce members did not independently request an update on the implementation of the recommendations prior to the first status report on 21 March 2013.

5.29 The Committee is also concerned that, as the Taskforce was created by Cabinet in response to the alarming UHB Report, it appears that Cabinet did not seek a written report from the Taskforce outlining progress made since the UHB recommendations were tabled in Cabinet in July 2012.

Internal Reports

5.30 Immediately following his appointment to the role of Chief Executive, FSH Commissioning, Dr Russell-Weisz undertook a "stocktake" review of the status of the hospital's commissioning at Mr Snowball's request.²⁰⁴ This culminated in the creation of the *Fiona Stanley Hospital Baseline Schedule Report* (**the Baseline Report**), which was submitted to Mr Snowball on 8 December 2012, accompanied by an "FSH ICT Taskforce Pack" consisting of the *FSH ICT Status & Readiness Working Paper* (**the ICT Status Paper**) prepared by Mr Harrison in his capacity as ICT Executive Lead, plus appendices.²⁰⁵

FSH HIN Project Delivery Review Report

5.31 In August 2012, HIN commissioned an independent review (**the Fujitsu Review**) of a number of key ICT projects for FSH, conducted by Mr Omar Abdel-Alim and based on the Fujitsu Project Delivery Review Framework, which consists of a series of questions addressing the different stages of a project lifecycle. Mr Harrison told us

202 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 12.

203 Minutes of the FSH Taskforce Meeting, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

204 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 17.

205 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, letter to Mr Kim Snowball, 8 December 2012 in Submission No. 4 from the Department of Health, 9 October 2013.

that he commissioned the report when he “started to sense a lack of confidence in the information that [he] was receiving”, which he felt was not detailed enough “in order to validate that they were on time and that the tasks had been defined.”²⁰⁶ The findings of the independent review confirmed Mr Harrison’s concerns:

*The information received before and in looking where we [were] at, based on the appropriate practice associated with project management, there was not enough information to give the same sense of confidence that we were on time and that we would be delivering on time.*²⁰⁷

5.32 The review was completed on 3 December 2012 and was attached as Appendix 3 to Mr Harrison’s ICT Status Paper. It formed two major conclusions:

The large majority of HIN projects reviewed are not in a position to provide reliable information to the review with regards to what work needs to be delivered for FSH, the time and effort required to complete the work, and the cost associated with it.

*This uncertainty of Scope for FSH coupled with inconsistent engagement model between HIN and FSH, and the current implementation of the internal HIN Project Governance present an unacceptable risk around the ability of HIN to deliver the work necessary to enable the provision of a Functional and Clinically Safe ICT Solution for FSH by April 2014.*²⁰⁸

5.33 In relation to ICT scope management, the review found that in an attempt to define the scope of work for FSH, various documents had been produced by internal and external parties, including Solution Design documents, Business Process maps, Patient Flows, Solution Briefs and Statements of Work. The documents were at varying levels of development and approval; however, none had reached a degree of comprehensiveness that could be translated into an effort, schedule and budget by the project managers, many of whom could not provide key information on the schedule, expected tasks and associated effort required to complete their respective projects.²⁰⁹ This late definition of scope introduced a risk that vendors would not agree to effecting

206 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 29 January 2014, pp. 8–9.

207 Mr Jon Harrison, Executive Director, Corporate & Strategic Services, Health Information Network, *Transcript of Evidence*, 29 January 2014, p. 9.

208 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

209 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, pp. 4, 8–9 in Submission No. 4 from the Department of Health, 9 October 2013.

changes to their packaged software and, even if they did, such changes would not be released in time for implementation at FSH.²¹⁰

5.34 The review also found that the uncertainty around the scope of ICT requirements negatively impacted schedule management, as the dates provided by HIN project managers for FSH-specific tasks could not be relied upon, posing significant risk to the successful delivery of the overall program.²¹¹

5.35 Key recommendations from the review included:

- Consolidating the teams responsible for delivery of the ICT program for FSH under the direction of a single FSH Program Director reporting to the HIN FSH Executive Sponsor;²¹²
- Establishing a clinical readiness group to remedy the lack of continuity of work between HIN project teams and the FSH clinical commissioning teams;²¹³
- Reviewing the prioritisation of work within HIN to ensure that resource and budget focus is maintained on FSH-specific activities in line with the recommendations of the clinical readiness group;²¹⁴ and
- Implementing strict project governance control to ensure quality and adherence to the agreed scope and timeframes.²¹⁵

Finding 24

An independent review conducted by Fujitsu consulting in December 2012 concluded that there was an unacceptable risk around the ability of the Health Information Network to deliver the work necessary to enable the provision of a functional and clinically safe Information and Communications Technology solution for Fiona Stanley Hospital by April 2014.

210 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 10 in Submission No. 4 from the Department of Health, 9 October 2013.

211 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 11 in Submission No. 4 from the Department of Health, 9 October 2013.

212 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 5 in Submission No. 4 from the Department of Health, 9 October 2013.

213 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, pp. 5–6 in Submission No. 4 from the Department of Health, 9 October 2013.

214 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 14 in Submission No. 4 from the Department of Health, 9 October 2013.

215 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

FSH ICT Status & Readiness Working Paper

5.36 The ICT Status Paper dated 6 December 2012 was submitted to Mr Snowball together with Dr Russell-Weisz's Baseline Report. It summarised how the overall FSH ICT program (incorporating both HIN and FM elements) was being delivered, identifying the key streams of work, timescales and resources. It also discussed key risks, their impact on the program and how these were being managed to deliver a safe, functioning hospital that minimised the impact on the FM provider. Finally, it made recommendations to ensure the key risks were clearly identified and appropriate treatments implemented and managed.²¹⁶ The report is footnoted as "HIN FSH Taskforce Paper for discussion and deliberation" and its recommendations are addressed to "the Taskforce", although the report and appendices were not provided to the Taskforce until 28 March 2013.²¹⁷

5.37 The ICT Status Paper noted that the initial FSH ICT Service Plan reflected the aspirations of the original FSH digital vision, rather than the achievable deliverables; this plan had been reviewed by the FSH ICT Commissioning Governance Group in November 2012 to define the final ICT "landscape and architecture" and reach a position as to what could be realistically delivered to safely open FSH, ultimately resulting in a reduced ICT scope.²¹⁸ Despite the progress in this regard, the report warned that "the massive scope of the task ahead cannot be underestimated."²¹⁹

5.38 The report's key findings were that there was:

- Lack of coordination between ICT projects within HIN, the FM and with other commissioning streams;
- A need for a dedicated FSH ICT team;
- Insufficient recognition of the unique needs of FSH and the requirement for some tailoring of ICT solutions;
- A number of critical core applications behind schedule and unable to be delivered by the target date of April 2014;
- Insufficient time built into programs for testing and commissioning of ICT components (both from the HIN and FM perspective); and

216 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 4 in Submission No. 4 from the Department of Health, 9 October 2013.

217 Minutes of the FSH Taskforce Meeting, 28 March 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

218 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, pp. 7–8 in Submission No. 4 from the Department of Health, 9 October 2013.

219 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 13 in Submission No. 4 from the Department of Health, 9 October 2013.

- A need to work more in partnership with the FM to achieve the planned benefits.²²⁰

5.39 The report concluded that “the risk of slippage is inevitable, the progress to date not nearly advanced enough (from a program baseline that is already well behind timelines), with little contingency in time or resources available to make this up.”²²¹ It was recommended that the Taskforce note that, even with a “more pragmatic approach”, it would not be possible to safely commission FSH by the planned date of April 2014 and that the opening of FSH would need to be delayed by nine to 12 months in order to have all core ICT systems functioning and to reduce risk to patients.²²² It noted that the priority across WA Health was to ensure an operational hospital from the beginning and establish a clear roadmap for achieving a digital landscape over time; delivering the fully digital hospital was estimated to take a further five years.²²³ Alternative technical options, including replicating the same technical setup as in Royal Perth Hospital, were being reviewed by HIN to determine if a more basic ICT solution could be delivered by April 2014; however, the flow-on effects of these options on hospital operations/workflows, the physical facility design, the FM contract and workforce attraction may result in an equal or greater delay, as well as an inferior ICT solution.²²⁴

Finding 25

A review undertaken by the Health Information Network in December 2012 concluded, with respect to the Information and Communications Technology (ICT) elements of the commissioning project, that even with a more pragmatic and less ambitious approach, a delay of between nine and 12 months was required in order to have all core ICT systems functioning and to reduce risk to patients.

Fiona Stanley Hospital Baseline Schedule Report

5.40 Following the transition of FSH governance from SMHS to a dedicated commissioning team under Dr Russell-Weisz’s leadership in November 2012, the Baseline Report was prepared to summarise the status of the project and identify key issues impacting the schedule for the hospital’s commissioning. Issues and risks were categorised into five core work streams, with each stream rated on a scale of one to

220 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 5 in Submission No. 4 from the Department of Health, 9 October 2013.

221 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 21 in Submission No. 4 from the Department of Health, 9 October 2013.

222 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, pp. 21–22 in Submission No. 4 from the Department of Health, 9 October 2013.

223 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 8 in Submission No. 4 from the Department of Health, 9 October 2013.

224 Department of Health, *FSH ICT Status & Readiness Working Paper*, 6 December 2012, p. 21 in Submission No. 4 from the Department of Health, 9 October 2013.

five to illustrate the level of risk to the FSH commissioning schedule, with a rating of five meaning that the work stream would delay the opening of the hospital.

5.41 The Infrastructure and Corporate work stream, encompassing the practical completion of the hospital building, was assigned the lowest risk severity of one and judged to be on track to enable the opening of FSH on schedule. The Facilities Management work stream was rated as two; it was noted to be mainly on target but requiring some focussed attention on key relationships and interdependencies to enable opening of the hospital on schedule.

5.42 The Workforce work stream was rated as three; despite significant planning having been undertaken, there was still uncertainty over the type and number of staff required. There had been no action on recruitment for the majority of staff, posing a risk that FSH and other SMHS hospitals would be left short-staffed at the key transition point when FSH opened. The one week induction and orientation planned for all staff prior to the hospital's opening was considered too short to allow staff to relinquish their responsibilities at other sites and to adopt the new processes as FSH.²²⁵

5.43 Clinical Commissioning was assessed to be running significantly behind schedule, although recovery was considered possible if sufficient resources were applied. Its risk severity was rated as four and noted as likely to delay the hospital's opening unless significant restructuring was undertaken. Resourcing of this work stream was noted to have been "too few, too late and with too much emphasis away from clinical services in favour of infrastructure."²²⁶ Insufficient engagement with clinicians posed a risk that outputs would be misaligned to contemporary clinical practice and detailed operational planning at a department and service level was behind schedule. The need to incrementally phase the hospital's commissioning, potentially over a number of months from the date of opening its first service, was also noted.

5.44 The report's conclusions in relation to resourcing and scheduling accord with the evidence of Ms Liz MacLeod, Executive Director, Clinical Commissioning. Ms MacLeod told us that when she commenced in the role in November 2012, only eight of about 90 departmental service plans had been commenced; there was no formal program in place to complete the work and a team of six or seven people were tasked with doing so – although, "they were also responsible for a range of other things so they knew they had, I think, no real capacity to deliver the quantum of work."²²⁷

225 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, pp. 12–13 in Submission No. 4 from the Department of Health, 9 October 2013.

226 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 14 in Submission No. 4 from the Department of Health, 9 October 2013.

227 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p.2.

5.45 The Information and Communication Technology work stream was assessed as the most significant risk to the FSH commissioning schedule, rated five on the severity scale. Schedule slippage, misaligned work schedules, lack of clarity and insufficiently comprehensive outputs were all cited as problems, with reference to the attached Fujitsu Review and ICT Status Paper as well as the PwC Report. The technology plan for FSH was noted to be “extremely ambitious” and the report concluded that it was not possible to deliver the originally envisaged ICT vision for a digital hospital in the required timeframe.²²⁸ Further, and more significantly, it concluded that even a “basic, safe, functional, and only partially digital hospital” (the alternate “Basic Plus” model) could not be delivered in the required timeframe; however, this model did represent a “more pragmatic and realistic approach” to opening FSH with some delay, expected to be between nine to 12 months from 1 April 2014.²²⁹

Finding 26

The review undertaken by Dr David Russell-Weisz in his capacity as Chief Executive, Fiona Stanley Hospital Commissioning in December 2012, concluded that deficiencies in the workforce and clinical commissioning work streams were likely to delay the opening of the Fiona Stanley Hospital. In relation to the Information and Communications Technology (ICT) work stream, Dr Russell-Weisz concluded that a delay of between nine and 12 months was almost unavoidable, even if a scaled-back ICT solution was deployed.

5.46 Viewed as a continuum, the series of external and internal reports which examined the FSH project from December 2011 through to December 2012 formed a substantial body of evidence which catalogued the problems with the project and warning about the risk of delay. It is apparent that very little, if any, attention was given to tracking the implementation of the various recommendations arising from the external reports. This is a cause for concern not only because it represents numerous missed opportunities to improve the performance of the project, but also raises questions about the significant financial resources that were wasted in commissioning a series of reports that were effectively ignored.

5.47 Amongst the common problems raised by the reports, ICT was consistently noted to be an area of concern. The advice regarding the risk it posed effectively reached a peak with the submission of the Baseline Report and the accompanying ICT reports prepared by those closest to the project.

228 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, pp. 9–10 in Submission No. 4 from the Department of Health, 9 October 2013.

229 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, pp. 9–10 in Submission No. 4 from the Department of Health, 9 October 2013.

Finding 27

When viewed against the background of the earlier reports, it is difficult to see how the final advice about the risk of delay could have come as a surprise to the then Director General of the Department of Health, Mr Kim Snowball.

The Director General's response

5.48 We are of the view that by December 2012, the significant risk of delay to the opening of the hospital had been communicated very clearly in the series of reports that had been produced in the second half of 2012.

5.49 There is little doubt that Mr Snowball took these reports seriously and that he accepted many of the conclusions they reached regarding the risks posed to the project by the ambitious ICT vision. However, he considered the advice from Dr Russell-Weisz to be "flawed" for three key reasons:

- It did not recognise that a staged commissioning of services would require a changed schedule of ICT applications, hence the basic finding in respect of ICT readiness was incorrect.
- It offered no remedy to mitigate the ICT risks of any projected delayed opening, despite there being 17 months still available to do so.
- It was inconsistent with regular advice he had received from other senior Health executives up until that point.²³⁰

5.50 Mr Snowball was confident that the known risks could be managed. At that stage, he considered the most important task to be completing the detailed commissioning schedule for the hospital. Until that was done, he was of the view that it was "premature" to conclude that a "delay caused by ICT was inevitable or that other alternative approaches could not ensure that the hospital would open within the staged opening proposed."²³¹

5.51 Mr Snowball asked HIN to provide him with a series of options describing what resources were needed to deliver an ICT solution allowing the hospital to open in accordance with the newly-developed clinical commissioning schedule.²³² These options were contained in the ICT Options Paper, which has been tabled with this report. The option endorsed by Mr Snowball was Option 2, which involved partially establishing the foundations of a digital hospital, as well as replicating some of the ICT components in use at Royal Perth Hospital. This represented a significant reduction in

230 Submission No. 32 from Mr Kim Snowball, 4 April 2014, p. 1.

231 Submission No. 32 from Mr Kim Snowball, 4 April 2014, p. 2.

232 Submission No. 32 from Mr Kim Snowball, 4 April 2014, p. 7.

the scope of the ICT vision, including abandoning many of the features previously envisaged for the “paperless” facility.

5.52 On the basis of these actions, Mr Snowball concluded that it was unnecessary to report to either the Taskforce or the Minister for Health that he had received advice that a delay to the opening of the hospital was necessary.

5.53 Mr Snowball presented these views in detail at a public hearing before the Committee in November 2013. We also asked him to respond to a summary of our draft findings. His response reiterated the views that he had expressed during the earlier public hearing. An edited form of our draft findings and Mr Snowball’s responses are included in Appendix 5.

The Director General’s response was flawed

5.54 The Committee ultimately disagrees with the basis for Mr Snowball’s response to the advice received in December 2012.

5.55 The advice received from Dr Russell-Weisz and Mr Harrison canvassed the possibility of simplifying the ICT solution and still concluded that a delay would be necessary. Indeed, even in the Options Paper, HIN advised that a delay of nine to 12 months was envisaged even if Option 2 was selected. Ultimately, this advice was removed from the final version of the Options Paper for reasons that are unclear to us. Nonetheless, there is no doubt that Mr Snowball saw this earlier version of the document, that it was discussed with him and that, after the conclusion of these discussions, the advice regarding delay was removed.²³³

Finding 28

The Health Information Network advised Mr Snowball in an earlier version of the ICT Options Paper that a delay of nine to 12 months was still anticipated to successfully open the hospital, even with the de-scoped Information and Communications Technology solution proposed in Option 2. This advice was later removed from the ICT Options Paper following a meeting with the Director General.

5.56 Mr Snowball also stated that Dr Russell-Weisz failed to take into account that a staged implementation of clinical services at FSH would mean that not every ICT application would need to be ready from the scheduled opening date in April 2014. While the Baseline Report is largely silent on this issue, Dr Russell-Weisz did acknowledge the need for the development of a phased clinical commissioning plan.²³⁴ Furthermore, Dr Russell-Weisz had held discussions with Mr Snowball prior to taking on

233 Submission No. 12 from Department of Health, 20 December 2013, p. 2.

234 Department of Health, *Fiona Stanley Hospital Baseline Schedule Report*, 8 December 2012, p. 21 in Submission No. 4 from the Department of Health, 9 October 2013.

the role during which the need for phasing was canvassed.²³⁵ Even with the extended phased commissioning schedule, commencing with the State Rehabilitation Service, we have received evidence that the majority of ICT applications will still need to be ready prior to opening.²³⁶

5.57 Mr Snowball also rejected the advice regarding delay on the grounds that it was inconsistent with the information he had previously received from HIN about the status of ICT. As discussed earlier, the advice coming from HIN prior to December 2012 was problematic – so problematic that Mr Harrison commissioned an independent review that confirmed that HIN projects were not in a position to provide reliable information about the time and effort required to complete the work.²³⁷

Conclusion

5.58 Ultimately, it is clear that Mr Snowball's response was wrong given that the opening of the hospital has been significantly delayed. It is our opinion that he was obliged to report two things to both the Taskforce and the Minister: first, that he had received advice that a delay was necessary and, second, that in response to that advice, he had endorsed a significant departure from the previously envisaged ICT vision for the hospital.

235 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, pp. 13–14.

236 Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 9; Dr David Russell-Weisz, FSH Commissioning Chief Executive, email sent to Mr Kim Snowball, 9 January 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

237 Department of Health, *FSH Coordination Project: Project Delivery Review Report*, 3 December 2012, p. 6 in Submission No. 4 from the Department of Health, 9 October 2013.

Chapter 6

Reporting to the Taskforce

Regardless of whatever Mr Snowball chose to do in response to the content of the December reports from Dr Russell-Weisz and the Health Information Network, he had an obligation to inform the Taskforce of the advice he had received in those reports. This obligation arose out of the oversight function granted to the Taskforce by Cabinet. By failing to fully disclose all information in his possession about the status of the hospital, he undermined the Taskforce and the purpose for which it had been established.

The oversight function of the Taskforce

6.1 The role set by Cabinet for the Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce (**the Taskforce**) was one of oversight, guidance and advice in relation to the commissioning of Fiona Stanley Hospital (**FSH**). Even the most cursory examinations of the Taskforce's Terms of Reference makes clear the oversight role that it was intended to fulfil. The most pertinent elements of these Terms of Reference are reproduced below. The Taskforce shall:

- *Oversee the commissioning of the FSH;*
- *Monitor the progress of the FSH project against key milestones including information communications technology (ICT), workforce and transition planning, clinical commissioning and facilities management;*
- *Provide advice on emerging issues or risks for FSH project delivery and commissioning, including remediation strategies;*
- *Monitor transition planning and system preparedness across other major Perth hospital sites which will be impacted by FSH coming online;*
- *Monitor budget parameters authorised by the Economic and Expenditure Reform Committee (EERC) and Cabinet for the infrastructure (including ICT), facilities management, transition planning and operation of FSH; and*

- *Report to the Premier and Cabinet via the Minister for Health on a six-monthly basis,²³⁸ or as requested or resolved by the Taskforce.²³⁹*

6.2 The Terms of Reference are entirely consistent with the conclusion that the Taskforce had been established to provide a valuable oversight role on behalf of the “Premier and Cabinet via the Minister for Health”. The Taskforce itself had been created as a result of a Cabinet decision made in early September 2012.²⁴⁰ The Cabinet was responding to a recommendation made in the University Hospitals Birmingham (UHB) Report that a “transparent governance arrangement” be put in place setting out “clear roles and responsibilities” and “clear reporting arrangements”.²⁴¹

Finding 29

The Taskforce was created with the intention of improving the governance arrangements, and providing inter-departmental oversight, of the commissioning project.

Composition of the Taskforce

6.3 The Director General of the Department of Health (DoH) was appointed Chair of the Taskforce. The other members were the Under Treasurer, the Deputy Director General of the Department of the Premier and Cabinet, the State Solicitor, the Chief Executive of the South Metropolitan Health Service and, after November 2012, the Chief Executive FSH Commissioning. Other senior officers would attend at the invitation of the Chair.²⁴²

6.4 Meetings were to be held as determined by the Taskforce. However, they were to occur no less than every two calendar months. A report was to be provided to the Premier and Cabinet every three months.

6.5 The initial Taskforce meeting took place on 25 September 2012. Despite the fact that the Taskforce was created in response to the UHB Report recommendations, Taskforce members were not provided with a copy of the report. The Taskforce did not

238 The requirement to report every six months to the Premier and Cabinet was revised at the first meeting to provide a report every quarter.

239 Department of Health, *Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce Terms of Reference*, in Submission No. 4 from the Department of Health, 9 October 2013.

240 Minutes of the FSH Taskforce, 25 September 2012 in Submission No. 4 from the Department of Health, 9 October 2013.

241 University Hospitals Birmingham NHS Foundation Trust, *Fiona Stanley Hospital Independent Review of Commissioning of the Hospital*, 11 July 2012, p. 17 in Submission No. 4 from the Department of Health, 9 October 2013.

242 Department of Health, *Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce Terms of Reference*, in Submission No. 4 from the Department of Health, 9 October 2013.

meet again until 6 February 2013, despite the requirement that it meet at least once every two months.

Second meeting: 6 February 2013

Limited information was provided to the Taskforce

^{6.6} The 6 February 2013 Taskforce meeting (**the February meeting**) marked the first time the Taskforce convened following the completion of separate reports from Dr Russell-Weisz and Mr Harrison highlighting the likelihood of delay. Given the extent of the information that had become available to Mr Snowball in December 2012, and given that he had been required to make a number of significant decisions with respect to the project on the basis of that information, we would have expected that full disclosure of all relevant information and related developments would have occurred at this meeting. This did not occur.

^{6.7} Instead, according to Mr Snowball, it was at the February meeting that “everything [he] had in terms of delivery” across all the commissioning streams was put to the Taskforce.²⁴³ It was the “full update” in relation to the status of the hospital at the time “from [his] view” and it was his responsibility as Director General “to make a judgement call as to whether [he] felt, based on the advice [he] was getting, that you could actually still deliver this with some changes to the ICT applications”.²⁴⁴

^{6.8} Much hinges on the view expressed by Mr Snowball in the paragraph above. Its importance derives from two elements. Firstly, it can be seen that Mr Snowball was of the view that it was his role to control the information that flowed to the Taskforce. The “full update” left out the fact that by that stage several of DoH’s most senior personnel working on the project had told him that the hospital could not be safely opened by April 2014. The “full update” omitted any mention of Dr Russell-Weisz’s or Mr Harrison’s reports; it failed to mention the existence of the ICT Options Paper; and it failed to acknowledge that advice had been received indicating that the scaled-down ICT solution being pursued at the time would also be impossible to deliver by April 2014.

^{6.9} Secondly, the role of the Taskforce was being undermined by the manner in which Mr Snowball managed it. Cabinet established the Taskforce in response to a recommendation in the UHB Report to improve the governance of the project. The Taskforce’s own terms of reference require it to “oversee the delivery and clinical commissioning” of FSH.²⁴⁵ Meaningful oversight and improvements to governance

²⁴³ Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 17.

²⁴⁴ Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 19.

²⁴⁵ Department of Health, *Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce Terms of Reference*, in Submission No. 4 from the Department of Health, 9 October 2013.

processes require scrutiny, thorough questioning of decisions and full disclosure of all relevant information that formed the basis for those decisions.

Finding 30

The ability of the Taskforce to fulfil its oversight role was hindered due to the limited information Mr Snowball provided to the Taskforce.

The information provided to the Taskforce is difficult to reconcile with what was actually happening

6.10 The fact that information was withheld from the Taskforce is not the sole cause for alarm; the information that actually was presented did not correspond particularly well with what had emerged in the months prior. Dr Russell-Weisz told us that it was a “pretty uncomfortable meeting” and that it was “an extraordinary, difficult one”.²⁴⁶

6.11 Mr Snowball delivered a presentation to the Taskforce that outlined his view of the following factors relating to the project: governance changes; key appointments; financial management; the phased opening of the hospital; the reconfiguration of the South Metropolitan Health Service; and, the four key FSH “enablers” of workforce, Information and Communications Technology (ICT), facilities management and infrastructure.²⁴⁷ With respect to the four key enablers, Mr Snowball reported the following to the Taskforce:

*Considerable effort has also centred on ensuring that the 4 key enablers that will allow for the successful and timely opening (and commissioning) of FSH are on target and in place.*²⁴⁸

6.12 Mr Snowball’s use of the phrase “on target” is difficult to reconcile with the information that was in his possession by this stage. The Project Management Office (PMO) reporting for workforce in December 2012 reported that “many tasks in this work stream are slipping and this has the potential to impact the commissioning schedule”.²⁴⁹ The following month, workforce had gone from amber to a red rating and the PMO concluded that:

There are key risks to finalisation of staff structures, roles and numbers that may further delay recruitment. The phased commissioning of FSH

246 Dr David Russell-Weisz, FSH Commissioning Chief Executive, Department of Health, *Transcript of Evidence*, 4 December 2013, p. 21.

247 Presentation given by the Director General to the FSH Taskforce, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

248 Presentation given by the Director General to the FSH Taskforce, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

249 Fiona Stanley Hospital Program Management Office, *December 2012 PMO Report*, p. 2 in Submission No. 10 from the Department of Health, 29 November 2013.

*will introduce several challenges around workforce transition but does allow additional time for recruitment into some positions. Local FSH workforce coordination and implementation is a key risk that needs to be actioned.*²⁵⁰

6.13 In December 2012, the PMO assessed ICT as having a red rating on its rating scale and reported:

*ICT faces a number of key risks to its deliverables and delivery timelines. These risks stem from hampered development of FSH applications, inability to test the systems, and ultimately a lack of clarity regarding what will actually be deliverable for opening. These will also pose a reputational risk to WA Health if not managed.*²⁵¹

6.14 The following month, the PMO reported that concerns with respect to ICT were continuing:

*There have been delays to the testing program that is required to map out the new approach to ICT deployment at FSH. Without the results from this program, the final schedule for deployment of ICT to FSH cannot be determined.*²⁵²

6.15 Whilst it is true that the reporting from the PMO with respect to the other two of Mr Snowball's four "key enablers" largely corresponded to Mr Snowball's description of being "on target", it is patently obvious that describing either ICT or workforce in the same fashion was misleading. Similarly, Mr Snowball's depiction of the status of the clinical commissioning activities did not correspond with the information then in the possession of the Department. Although Mr Snowball did not include clinical commissioning as one of the hospital's key enablers, its importance was equal to that of workforce and ICT. Indeed, Mr Snowball's presentation was oddly silent on clinical commissioning, focusing instead on the (admittedly important) impact of the decision to phase the opening of the hospital. If Mr Snowball had chosen to provide additional information about the status of the clinical commissioning activities, he might have highlighted:

250 Fiona Stanley Hospital Program Management Office, *January 2013 PMO Report*, p. 2 in Submission No. 10 from the Department of Health, 29 November 2013.

251 Fiona Stanley Hospital Program Management Office, *December 2012 PMO Report*, p. 2 in Submission No. 10 from the Department of Health, 29 November 2013.

252 Fiona Stanley Hospital Program Management Office, *January 2013 PMO Report*, p. 2 in Submission No. 10 from the Department of Health, 29 November 2013.

- That the clinical commissioning team’s preferred option for opening the hospital was a six month phasing period commencing in October 2014;²⁵³
- That of the 91 departmental service plans (**DSPs**) needed to outline how the services will be delivered at the hospital across the various clinical areas, work had only started on eight of them by November 2012;
- That the original schedule had called for the completion of all DSPs by December 2012;
- That a substantial ramp-up in the number of staff was required in order to recover the schedule. In November 2012, seven staff members were working on DSPs; at the end of 2013 that number had increased to over 50 – with access to 50 more when needed – and even in early 2014, these plans had still not yet been fully completed.²⁵⁴

Finding 31

The briefing Mr Snowball provided at the 6 February 2013 Taskforce meeting omitted any reference to the advice he had received in December 2012 about the need to delay the hospital’s opening.

Finding 32

Mr Snowball’s decision to tell the Taskforce at the 6 February 2013 meeting that the Workforce and Information and Communications Technology work streams were “on target” is inconsistent with the information made available to him in various reports, including Dr Russell-Weisz’s Baseline Report, but also the Project Management Office reporting.

Mr Snowball’s comments about ICT readiness

^{6.16} It is worth recounting the various developments that occurred with respect to ICT at the hospital between the February meeting and the last time the Taskforce gathered in September 2012:

- In September 2012, HIN completed the ICT Solution document based on the original digital vision for FSH as a paperless hospital.
- In November 2012, the ICT Solution was “realigned” by the Commissioning Governance Group (**CGG**) in order to “reach a position” as to what could be

²⁵³ Department of Health, *High-Level Sequencing Options for the Commissioning of Fiona Stanley Hospital*, 24 January 2013, in Submission No. 9 from the Department of Health, 22 November 2013.

²⁵⁴ Ms Liz MacLeod, Executive Director, Clinical Commissioning, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 2.

achieved that was safe for patients and “achievable in terms of technical capacity”.²⁵⁵

- This realigned ICT position was developed into what became known as “Option 2” and was initially agreed to at a meeting on 13 December 2012.
- It was identified that additional funding would be required to implement this solution, and on 20 December 2012, Mr Snowball was presented with a briefing note outlining the level of funding being sought and the proposed solution that was to be implemented.
- This culminated in the Options Paper, presented to Mr Snowball on 10 January 2013 in which three different ICT options were outlined. Option 2, representing the culmination of the work of the CGG was authorised by the Director General on 25 January 2013.

6.17 In addition, Mr Snowball was presented with reports from both Mr Harrison and Dr Russell-Weisz in early December 2012. It was these two reports, indicating that a delay would be necessary even if a substantially simplified ICT solution was adopted, that prompted the actions that culminated in the ICT Options Paper. As has already been noted, Mr Harrison, the author of the Options Paper, was so unconvinced that Option 2 could deliver the hospital by April 2014 that he stated as much in an earlier draft of the Options Paper.

6.18 Despite the clear significance of these events, and despite receiving clear advice from the man he appointed to head the team delivering ICT at the hospital, Mr Snowball did not report any of these issues or events to the Taskforce at the February meeting. Admittedly, his own presentation was followed by a presentation from the Health Information Network (HIN), and this subsequent presentation did provide additional detail, but Mr Snowball chose not to use his own presentation as a means through which he could communicate what had happened in the preceding months. Instead, Mr Snowball reported the following in relation to ICT:

- *Change to the governance arrangements with the appointment of a Director, ICT, FSH to ensure accountability and service delivery.*
- *A further detailed review and stocktake of the proposed ICT program has been undertaken in the past 8 weeks and a way*

255 Memorandum from Dr Andy Robertson, Acting Chief Information Officer, Health Information Network, to Mr Kim Snowball, Director General, 20 December 2012 in Submission No. 12 from the Department of Health, 20 December 2013.

forward mapped to enable the phased commencement of clinical services at SRS.

- *All applications have been identified and implementation strategies are being prepared.*
- *Risks to timeframes are being managed with a clear mitigation and deployment strategy developed.*²⁵⁶

6.19 As noted earlier, in his evidence to the Committee Mr Snowball described his briefing as premised on his view of the project at that time. When compared against the weight of information that had been presented to him in the preceding months, it becomes clear that Mr Snowball's view was singularly optimistic and unsupported by subordinates charged with the difficult task of getting the hospital open in the safest manner possible as early as possible.

Finding 33

Mr Snowball told the Taskforce at the 6 February 2013 meeting that risks to the ICT delivery schedule were being managed. This claim was difficult to reconcile with the advice that had been provided to him since December 2012, and advice in January 2013 that a nine to 12 month delay was envisaged.

The Health Information Network's ICT presentation

6.20 By nature of the fact that Option 2 represented a radical departure from what had previously been identified with respect to ICT for the hospital, HIN's presentation (delivered by Dr Andy Robertson and Mr Harrison) is necessarily more detailed than the very brief gloss provided by Mr Snowball. The February meeting was the first time that the Taskforce was told that the original digital vision would not be delivered.²⁵⁷

6.21 It should also be noted that Taskforce members did not know that Option 2 was in fact one of three options put to Mr Snowball by HIN. There is no evidence of it being presented to members at the 6 February meeting. Mr Harrison told us that it was not presented and Mrs Brown reported that she had never seen the Options Paper.²⁵⁸
259

256 Presentation given by the Director General to the FSH Taskforce, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

257 Dr Andy Robertson, Acting Chief Information Officer, Department of Health, *Transcript of Evidence*, 20 November 2013, p. 7.

258 Mr Jon Harrison, Executive Director, Corporate and Strategic Services, Health Information Network, *Transcript of Evidence*, 27 November, pp. 4–5.

259 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 6.

How did Taskforce members interpret the meeting?

6.22 We have spoken to the three non-DoH members of the Taskforce about their impressions of the February meeting. Obviously, their recollections of this meeting, coming many months after it had taken place, might be coloured with the benefit of the additional information in their possession since that time. Nonetheless, it is clear that none of those non-DoH members at the February meeting were given any cause to believe that the April 2014 opening date would not be achieved.

6.23 Mr Alistair Jones represented Mr Marney at the February meeting. According to Mr Jones, “at that 6 February meeting, the director general asserted that it would still be an April opening”.²⁶⁰

6.24 Mrs Brown recalled that Mr Snowball expressed the view that the hospital would be functioning by the originally intended date:

On 6 February it was very clear at that point that the director general and HIN considered that the ICT elements of the project were achievable.

[...]

*The meeting of 6 February was focused on the opening date: what ICT needed to be in place—the bare minimum—to have a functioning hospital? That was the advice of Kim Snowball. His view was they could have the bare minimum in place to have a functioning hospital in April.*²⁶¹

6.25 Mr Nicholas Egan, the Deputy State Solicitor, told us that it was only after Dr Russell-Weisz was acting as Director General of DoH that he became aware of any concerns about the ability to deliver the hospital according to the original schedule:

*Up until that point I was not advised that Health had any concerns about Health achieving the 1 April 2014 opening date.*²⁶²

6.26 Notwithstanding Mr Snowball’s assurances, many of the Taskforce members were unwilling to accept what was being reported to them. The minutes for the meeting record that Mrs Brown sought further information on what had been meant by the description “on target” in relation to the four “key enablers”. Unfortunately, Mrs Brown’s question about “on target” was asked in conjunction with a series of other

260 Mr Alistair Jones, Acting Executive Director, Strategic Policy and Evaluation, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 14.

261 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 6.

262 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 7.

questions and the minutes do not record Mr Snowball's answer. The minutes do record, however, that a little later in the meeting Mrs Brown notes that "with Cabinet having established a governance framework, there is an expectation going forward that milestones are being tracked and met."²⁶³

6.27 It was this concern that guided Mrs Brown to request that briefings be held to assist members gain a better understanding of the project.²⁶⁴ These briefings, which Mr Snowball did not attend, are probably best described as being more frank and more detailed than the discussions facilitated during the February meeting.

Finding 34

Each of the non-Department of Health members of the Taskforce recollect that no disclosure was made at the 6 February 2013 meeting about the possibility of a delayed opening to the Fiona Stanley Hospital.

What *should* have been presented at the February meeting?

6.28 Mr Nicholas Egan, the Deputy State Solicitor and a Taskforce member, succinctly captured the problem with not being provided this information at the February meeting:

*In my view, it would have been prudent for the task force at the initial meeting to have been provided with a copy of, firstly, the Solomon report and, secondly, the UHB report, and for it to have been briefed in relation to not only the infrastructure delivery by Brookfield Multiplex, but, in particular, Health's readiness to achieve a 1 April 2014 opening. It is regrettable that that did not occur until a later time. Certainly by February [2013], my view is that the Taskforce should have been provided [...] with a copy of Dr Russell-Weisz's report, together with any correspondence passing between the then director general and Dr Russell-Weisz concerning the ability of Health to open the facility on 1 April. Had that been done, then concerns would have been significantly heightened and action, no doubt, taken.*²⁶⁵

6.29 Mr Egan's conclusion is difficult to refute: had the Taskforce been provided with these reports at that meeting, it would have had the knowledge it needed to carry out the functions it had been created for – namely, monitoring and overseeing progress and advising on strategies to remediate risks.

263 Minutes of the FSH Taskforce, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

264 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 4.

265 Mr Nicholas Egan, Deputy State Solicitor, *Transcript of Evidence*, 4 November 2013, p. 7.

The oversight function of the Taskforce was undermined

6.30 As we have already observed, there is no ambiguity as to the Taskforce's primary role to oversee and provide advice about the commissioning of FSH. The Taskforce's position as an oversight body placed DoH in a subordinate position in only one respect: the provision of information about the commissioning. The Taskforce had no other powers outside of its Cabinet-assigned role as an oversight body. Given the nature of this subordinate relationship, there was a clear obligation owed by DoH to the Taskforce with respect to the provision of information about the commissioning. Without access to all information about the status of the hospital, the Taskforce was constrained in its ability to carry out its role. Wittingly or not, Mr Snowball's decision to withhold information from the Taskforce prevented it from carrying out the role that had been assigned to it by Cabinet, namely the provision of oversight of DoH's activities.

6.31 A series of choices were presented to Mr Snowball when he received the two reports from Dr Russell-Weisz and Mr Harrison in December 2012. Ultimately, Mr Snowball chose to reject the advice that a delay was necessary. Whatever Mr Snowball may have chosen to do in response to those reports, he was obliged to report his actions against the content of the findings and recommendations that were in the reports. The oversight exercised by the Taskforce extended even to the actions taken by the Director General, otherwise the Cabinet would not have asked for reports to be made to the Minister and Cabinet but rather to the Director General. Mr Snowball told us that the information he provided to the Taskforce at the February meeting was the "full update" from his point of view. This obviously is a filtered update rather than a full one.

Finding 35

Arising from the Cabinet decision to create the Taskforce, the Department of Health, and by extension Mr Snowball in his capacity as Director General, had an obligation to disclose to the Taskforce information on matters concerning the commissioning of the hospital.

Finding 36

Mr Snowball ought to have provided the Taskforce with copies of Dr Russell-Weisz's Baseline Schedule Report, the HIN Status & Readiness Working Paper and the ICT Options Paper. Without these documents, the ability of the Taskforce to carry out its oversight function was undermined.

The Taskforce was a good idea poorly implemented

6.32 Although it is clear that the Taskforce was created as a means through which Cabinet's visibility to and oversight of the commissioning project was to be increased,

there were a number of flaws that prevented it from carrying out its role as effectively as the Cabinet may have envisaged.

It did not meet or report often enough

6.33 It was an obvious failure of the Taskforce that it did not meet or report to Cabinet regularly enough during its first six months of existence. The terms of reference required that the frequency of the meetings be no less than every two calendar months and that reports be submitted quarterly. More than four months passed between the initial Taskforce meeting on 25 September 2012 and the next meeting on 6 February 2013. The Taskforce's first report was only provided in June 2013. By that time, the Taskforce's terms of reference suggest that three reports should have already been provided to Cabinet.

It did not have independent access to information

6.34 The ease with which Mr Snowball was able to control the flow of information to the Taskforce suggests that its structure was flawed. The Taskforce terms of reference stated that project reporting would occur primarily via the FSH Project Team. The most straightforward way for this to occur would have been for the PMO reports to be provided directly to the Taskforce; however, the evidence provided to us indicates that this did not occur until after Mr Snowball's departure. The Taskforce was reliant on the Director General, in his capacity as chair, to provide the information that would allow it to achieve its oversight function. Given that it was the Director General's own actions that formed a large part of the activity which the Taskforce was supposed to be monitoring, a situation was effectively created whereby "the fox was guarding the henhouse."

Finding 37

To truly achieve independent oversight, the Taskforce should not have been structured with the Director General as chair.

It did not independently control its reporting

6.35 We are also concerned by evidence that suggests that the Taskforce's ability to report to the Minister as intended had the potential to be easily fettered. This is not so much a structural flaw, although we would simply wish to note that any similar Taskforce should be structured so as to ensure that the independent voice of the oversight body is preserved. It is clear from the Taskforce terms of reference that reports were to be submitted directly to the Minister; inherent in the Taskforce's stated mandate of oversight is a degree of independence, which would have been negated by any requirement that Taskforce reports be filtered through the Department of Health or the Director General.

6.36 Yet, in practice, it is not clear whether the Taskforce's independent voice was entirely respected. When questioned on the ability of the Taskforce to report fully and frankly to Cabinet, Mr Marney described the dilemma as such:

*Ultimately, the task force reports to the minister, and it reports to the minister through his director general as chair. You have got the DG telling the minister that everything is fine.*²⁶⁶

6.37 On one hand, Mr Snowball acknowledged the Taskforce's mandate and the formal structure in place by which it was to independently report to Cabinet via the Minister for Health. In his response letter to Dr Russell-Weisz's Baseline Report, he referred to the upcoming need for the Taskforce to prepare a report for the incoming minister:

*I have asked Ms Angela Kelly, in her role as Executive Support to the FSH Taskforce, to prepare a progress report that I can submit to the Minister for Health when government is formed after 9 March 2013. This report will capture the update we provided to the Taskforce (including governance and ICT) and will be signed off before being submitted to Cabinet through the Minister. This is the process established to ensure government understands the risks inherent in the reconfiguration of hospital services in the South Metropolitan Health Service and of course the Commissioning of FSH and the actions taken to address those risks.*²⁶⁷

6.38 Mr Snowball also told us that although Dr Russell-Weisz asked for his incoming government brief to be submitted directly to government, the appropriate channel for that advice was through the Taskforce as that was the arrangement established by the government.²⁶⁸

6.39 However, the evidence regarding the preparation, circulation and ultimate rejection of the status report in March 2013, discussed in more detail in Chapter 7, shows that Mr Snowball was prepared to substitute his own views in place of those of the Taskforce and effectively circumvent the established reporting structure. Not only was the intended report channelled through the Director General in his capacity as chair, but it is clear that he was prepared to submit a report to the incoming Minister with or without Taskforce support – it was only after the Taskforce members objected that Mr Snowball agreed not to submit the unendorsed report to the incoming

266 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 9.

267 Memorandum from Mr Kim Snowball, Director General, to Dr Russell-Weisz, FSH Commissioning Chief Executive, 5 March 2013, p. 2 in Submission No. 4 from the Department of Health, 9 October 2013.

268 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 5.

minister. Mr Marney's response to the circulation of the status report at the eleventh hour summarises the problem with this situation, which Mr Snowball failed to see until he was challenged: submission of an unendorsed report to the Minister would have rendered the Taskforce "totally irrelevant."

Conclusion

6.40 The aim of the Taskforce was to create proper oversight, provide intelligence and perspectives from other agencies and ensure more coherent and timely reporting. Unfortunately, the structure did not guarantee this and DoH and the Taskforce members did not seem to go about their responsibilities with the urgency required given the stage and status of the project.

Recommendation 1

For projects of significant cost and importance, where deficiencies have been identified, the Department of the Premier and Cabinet must ensure that any cross-government Taskforce being established has:

- a finite lifespan with strict reporting and meeting obligations;
- an independent or co-chairing arrangement; and
- a requirement that reports be submitted to the Economic and Expenditure Reform Committee, not solely to the individual responsible Minister.

Chapter 7

Reporting to the Minister and Government

In earlier chapters, we concluded that Mr Snowball's rejection of the advice about the need for a delay was without foundation. Regardless of whatever Mr Snowball chose to do in response to the content of those reports, the information contained within them was of such significance – politically, financially and for the potential impact on the health system – that it should have by necessity been communicated to the Minister for Health.

This obligation arose as a matter of convention and out of deference to the overarching requirement that ministers be kept fully informed of activities within their departments in order to provide meaningful accountability in Parliament.

The Minister's submission to the Committee

7.1 The Committee extended an invitation to the Minister for Health to attend a public hearing and provide input to the inquiry. The Minister declined the invitation and instead provided written responses to a series of questions from the Committee. These have been tabled in conjunction with this report.

7.2 In his correspondence, the Minister acknowledged that, in hindsight, he regretted accepting the April 2014 opening date and that he was "clearly in a position to change that date".²⁶⁹ The Minister also accepted that the decision to phase the opening of the hospital over a period of six months should have been made prior to the completion of the contract with Serco.²⁷⁰

The Minister was aware of risks to FSH

7.3 The Minister for Health took the UHB Report to Cabinet in July 2012 and was aware of the significant issues relating to the project identified in that report. In the months subsequent, we are not aware of any other formal reports being provided to the Minister by the Director General. We are aware of fortnightly meetings between the Minister and the Director General where Fiona Stanley Hospital (FSH) was

269 Submission No. 29 from Hon. Dr Kim Hames, MLA, Deputy Premier; Minister for Health, 20 March 2014.

270 Submission No. 29 from Hon. Dr Kim Hames, MLA, Deputy Premier; Minister for Health, 20 March 2014.

discussed. As a result of these meetings the Minister has stated that “the challenges around the delivery of services were well known and understood.”²⁷¹

7.4 The only other written information the Minister for Health apparently received on the issue was by way of a briefing note prepared by Mr Brad Sebbes on 5 December 2012 in response to media queries about a possible delay to the FSH opening in April 2014 on account of “significant ICT readiness issues.”²⁷² The briefing note advised that a review was currently underway to determine the specific status of ICT readiness and, if the ICT functionality was not comprehensive enough for the hospital opening in April 2014, then a delay would need to be considered.²⁷³

7.5 Mr Sebbes told us that he considered the briefing note to be a “warning that there may be an issue coming.”²⁷⁴ DoH advised us that no additional formal correspondence was provided to the Minister on the issue of ICT readiness.²⁷⁵ In his correspondence to us, the Minister acknowledged that he did not take further action about the content of the 5 December 2012 briefing note and that it was the view of the Director General at that time that the ICT issues could be resolved.²⁷⁶

7.6 DoH also advised us that there is no documentary evidence that Mr Snowball informed the Minister when he endorsed Option 2 in January 2013, which marked the first time that the original digital vision for FSH was abandoned.²⁷⁷ Mr Snowball’s decision in this regard represented a substantial deviation from the original ICT plan for FSH, which ultimately formed part of the renegotiation of the contract with Serco later in 2013.

7.7 Mr Snowball did not forward Dr Russell-Weisz’s or the HIN reports to the Minister for Health, nor the Options Paper, nor inform the Minister that he had received any advice raising the possibility of delay.

Finding 38

Particularly given the content of the 5 December 2012 briefing note, we would have expected the Minister to seek significantly more information about the status of the commissioning project.

271 Submission No. 29 from Hon. Dr Kim Hames, MLA, Deputy Premier; Minister for Health, 20 March 2014.

272 Briefing Note prepared for the Minister for Health by Mr Brad Sebbes, 5 December 2012 in Submission No. 12 from the Department of Health, 20 December 2013.

273 Briefing Note prepared for the Minister for Health by Mr Brad Sebbes, 5 December 2012 in Submission No. 12 from the Department of Health, 20 December 2013.

274 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 10.

275 Submission No. 12 from the Department of Health, 20 December 2013, pp. 2–3.

276 Submission No. 29 from Hon. Dr Kim Hames, MLA, Deputy Premier; Minister for Health, 20 March 2014.

277 Submission No. 14 from Department of Health, 2 January 2014, p. 1.

The Minister should have been told about the abandonment of the digital vision

7.8 Although Mr Snowball had decided that he was comfortable that the solution embodied in Option 2 would ensure the ability of FSH to open on schedule, we are of the opinion that he nonetheless had an obligation to disclose the advice he had received and the actions he had taken to the Minister for Health. The basis for this obligation lies not only in the material and contractual significance of the decision to authorise a significantly de-scoped ICT solution, but also in the context of broader principles of responsible government which require that ministers are kept fully informed of the activities within their departments. Our basis for this conclusion is twofold: first, our system of government requires that Ministers are kept fully informed of the activities undertaken by their departments, and secondly, the material significance of the decision to de-scope FSH ICT was such that it automatically warranted ministerial disclosure.

Ministerial Responsibility

7.9 The Westminster system of government requires that ministers are answerable through Parliament to the people:

*It is through ministers that the whole of the administration - departments, statutory bodies and agencies of one kind and another - is responsible to the Parliament and thus, ultimately, to the people.*²⁷⁸

*In a general sense, the department is the arm of the minister, and its administration is his responsibility, for which he must answer in Parliament...*²⁷⁹

7.10 In their role as part of executive government, it is the responsibility of ministers to make policy decisions and administer government. Ministers have both individual responsibility for the administration of the departments, authorities and statutes under their control, as well as collective responsibility through Cabinet for the whole conduct of government administration.²⁸⁰

7.11 The responsibility of ministers for the administration of their departments is reflected in the *Public Sector Management Act 1994 (WA) (PSM Act)*, which refers to the relevant minister as the “responsible authority” of the department.²⁸¹

278 Royal Commission on Australian Government Administration, *Report*, 1976, p. 59.

279 Royal Commission on Australian Government Administration, *Report*, 1976, p. 61.

280 Government of Western Australia, *Ministerial Code of Conduct*, April 2013, pp. 1–2.

281 *Public Sector Management Act 1994 (WA)*, s. 3.

7.12 Ministerial responsibility to the Parliament is a matter of convention rather than law and, as such, the underlying principles and values are subject to change. Just as the range of functions undertaken by government has increased over time and Parliament has accordingly delegated wider and more important decision-making power to agencies and public servants, so too have traditional conceptions of ministerial responsibility changed. Current evidence suggests that a minister's responsibility no longer requires them to bear the blame for all the faults of their department, regardless of their own involvement; rather, while ministers continue to be held accountable in Parliament, they are not personally culpable unless the fault was theirs, or occurred at their direction, or involved some matter over which they should have been quite obviously concerned.²⁸²

It is important that there be trust between ministers and public servants, and each must contribute to the establishment and maintenance of the trust [...]. The secretary of a department is [...] responsible "under the Minister" for the general working of the department and for advising the minister in all matters relating to the department.

This does not mean that ministers bear individual responsibility for all actions of their departments. Where they neither knew, nor should have known about matters of departmental administration which come under scrutiny it is not unreasonable to expect that the secretary or some other senior officer will take the responsibility.

*Ministers do, however, have overall responsibility for the administration of their portfolios and for carriage in the Parliament of their accountability obligations arising from that responsibility.*²⁸³

Communication between Ministers and their Departments

7.13 The system of ministerial responsibility requires that ministers are kept fully informed of the activities undertaken by their departments²⁸⁴; indeed, it is an established convention.²⁸⁵ The Committee sought advice from the Public Sector Commissioner, Mr Mal Wauchope, on the legislative provisions which enshrine the corresponding duties of public sector Chief Executive Officers (CEOs) to provide such information to their ministers.

282 Royal Commission on Australian Government Administration, *Report*, 1976, pp. 59–60.

283 *A Guide on Key Elements of Ministerial Responsibility*, Prime Minister, Canberra, December 1998, p. 13.

284 Public Sector Commissioner's Circular 2010-03.

285 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 3.

7.14 Section 7 of the PSM Act sets out various principles of public administration and management, including:

*the Public Sector is to be so structured and organised as to achieve and maintain operational responsiveness and flexibility, thus enabling it to adapt quickly and effectively to changes in government policies and priorities.*²⁸⁶

7.15 The general duties of CEOs are also contained in the PSM Act. Section 29 of the PSM Act deals with the functions of CEOs in managing their department or organisation, including “to provide policy advice to the responsible authority of that department or organisation.”²⁸⁷

7.16 Section 30(a) of the PSM Act provides that, in performing their functions, CEOs shall “endeavour to attain performance objectives agreed with the responsible authority of the department or organisation.” Section 47 provides for CEOs to enter into a performance agreement with their minister and the Public Sector Commissioner as the employing authority, which sets out the performance criteria to be met by the CEO and the minimum requirements for the assessment of a CEO’s achievement of targets under the agreement.²⁸⁸

7.17 Section 32 of the PSM Act provides that a CEO shall comply with all lawful directions and instructions from their minister as the responsible authority of the department.

7.18 Section 74 of the PSM Act requires that ministers make arrangements setting out the manner and circumstances in which communications are to be made between ministerial officers and departmental employees.

7.19 The Public Sector Commissioner’s *Good Governance Guide for Public Sector Agencies* contains nine principles which assist agencies to have appropriate systems and structures to meet accountability obligations and achieve a high level of organisational performance. Of these, principles 1, 2, 7 and 8 are relevant to the relationship between ministers and their departments:

- Principle 1: Government and public sector relationship – the agency’s relationship with the government is clear.
- Principle 2: Management and oversight – the agency’s management and oversight are accountable and have clearly defined responsibilities.

286 *Public Sector Management Act 1994* (WA), s. 7(b).

287 *Public Sector Management Act 1994* (WA), s. 29(1)(b).

288 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 2.

- Principle 7: Finance – the agency safeguards financial integrity and accountability.
- Principle 8: Communication – the agency communicates with all parties in a way that is accessible, open and responsive.

What kinds of matters should be communicated to ministers?

7.20 As can be seen, the provisions which govern the relationship between ministers and their departments are not prescriptive and leave scope for the parties to determine how to achieve the required outcome. Of course, we appreciate that ministers are not engaged in the direct, day-to-day administration of their departments and need not be informed of each and every departmental activity; particularly given the increased scope of government that has occurred over time, it would be unrealistic and impractical to expect this and the burden created by a requirement for such total disclosure would quickly render the process unmanageable. It is also easy to see the difficulties that might arise in attempting to exhaustively define the nature of information that warrants ministerial attention.

7.21 On the other hand, any action by a department or public servant that results in the withholding of or failure to provide information to a minister undermines the operation of our system of government and reduces the ability of Parliament to hold executive government to account. Because the minister speaks for the department and defends its actions in Parliament, he or she is entitled to expect that they will be kept fully informed of the department's activities.

7.22 The need for balance between these competing priorities was considered by the Royal Commission on Australian Government Administration in 1976:

*Clearly there is a dilemma here which must be faced. On the one hand, if ministers involve themselves in decisions to a degree necessary for them to accept responsibility for them, officials are likely to feel less personally responsible and the outcome may therefore be less efficient. On the other hand, attempts to acknowledge and give precision to the responsibility of officials and to hold them accountable for its exercise may be seen as weakening direct ministerial responsibility and therefore political control.*²⁸⁹

7.23 Nevertheless, it is our view that this balance must favour the underlying principles of accountability; to this end, information of sufficient materiality ought to be disclosed to the minister so that he or she can meaningfully provide accountability to the Parliament. The Committee also sought advice from Mr Wauchope regarding the factors to be considered in determining what departmental activities might be

289 Royal Commission on Australian Government Administration, *Report*, 1976, p. 13.

considered “sufficiently material” to warrant disclosure to the minister and whether this is a matter solely left to the discretion of departmental CEOs or informed by particular principles.

7.24 Mr Wauchope advised that evaluating and deciding what information will warrant ministerial attention, and when, is to be considered on a “case-by-case” basis, depending on the established arrangements and working relationship between the minister and the CEO and on an evaluation of each particular circumstance. While it is to be expected that “systemic faults in administration would be brought promptly to a minister’s attention”, the decision to disclose ultimately involves a degree of informed judgment by the CEO.²⁹⁰ What is considered material to warrant disclosure to a minister will vary depending on a range of factors, including the:

- Nature of the portfolio (degree of public importance, size and complexity);
- Relationship between the minister and the CEO (degree of confidence that the minister has in the relevant CEO);
- Experience of the CEO and expertise within the department;
- Operational preference of the minister (the extent to which the minister wishes to maintain strategic oversight or involve themselves in operational detail);
- Sensitivity of the particular matter at hand.²⁹¹

7.25 The legislative provisions dealing with performance agreements and communications arrangements allow for ministers and CEOs to decide key deliverables, a regime of reporting or briefings on important matters and the level of detail required in order for the minister to be appropriately informed. In the absence of specific direction from the minister, the CEO’s judgment is crucial although still to be informed by the above factors. Mr Wauchope suggested that a broad test of “no surprises, good or bad” is a useful guide for disclosure.²⁹²

7.26 We posed the specific question to Mr Wauchope whether information with significant contractual and financial implications for the State would be automatically deemed to be of sufficient materiality to warrant disclosure to the minister. He responded that such information would not of itself necessarily demand ministerial disclosure if the implications were contingent on factors which had not yet crystallised – for example, if legal advice were being sought on the prospective liability of the State of a particular contractual obligation, a CEO may judge that they will wait for that

290 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 2.

291 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, pp. 3–4.

292 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 4.

advice before informing the minister of the potential liability. However, he concluded that the extent of the variables involved in deciding this question were such that it was “not productive” to speculate on it without regard to the context and particular circumstances of each individual instance.²⁹³

7.27 While we accept that, as a general rule, determining what information warrants ministerial attention is best considered on a “case-by-case” basis in light of the many variable factors listed above, we are of the view that there must be certain categories of information of such material importance that automatic ministerial disclosure is the only prudent course of action.

7.28 We have received evidence that although the Minister was advised in December 2012 that a review of the status of FSH Information and Communications Technology (ICT) readiness was being undertaken, Mr Snowball did not further inform or seek authorisation from the Minister when he endorsed Option 2 in January 2013, which marked the first time that the original digital vision for FSH was abandoned. Mr Snowball’s decision in this regard represented a substantial deviation from the original ICT plan for FSH, which would ultimately require renegotiation of the contract with Serco. The contractual and financial significance of this decision for both the FSH project and the State should not be underestimated; it is this inherent significance that leads us to conclude that the decision was of such material importance that it automatically warranted immediate disclosure to the Minister. In our view, Mr Snowball’s election not to do so represents a failure on his part.

7.29 When we put this position to Mr Snowball in our draft findings, he rejected the finding as “factually incorrect” and went on to state that he rejected:

*the assertion that I acted inappropriately by endorsing this solution without reference to the Minister or government when I had clearly endorsed it **subject** to further work and analysis. Indeed the final decision, made on 18 March 2014, on this issue was not made by me.*²⁹⁴

293 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 4.

294 Submission No. 32 from Mr Kim Snowball, 4 April 2014, pp. 2, 8.

Finding 39

It was a failure of accountability in government that the decision to de-scope the Fiona Stanley Hospital Information Communications Technology vision was not communicated in a formal briefing note to the Minister for Health. This decision was of such material significance that it demanded disclosure.

The Minister's role

7.30 Mr Wauchope also advised that “[a] minister is, of course, always free to request more detailed information or if he or she believes there are emerging problems to raise issues or seek reconsideration of matters.”²⁹⁵ Mr Sebbes prepared a briefing note for the Minister on 5 December 2012 in response to media reporting of concerns regarding the timelines for the opening of FSH and ICT readiness; it advised that a review of ICT readiness was underway and warned that a delay to opening would need to be considered if ICT functionality was not comprehensive enough for the opening of the hospital in April 2014.²⁹⁶ As far as we have been able to ascertain, there was no “follow up” or further formal correspondence with the Minister regarding this issue.²⁹⁷ In our view, the fact that the Minister did not apparently seek any update to this advice is concerning, particularly given Mr Sebbes’ evidence that the briefing note was, in his view, a “warning that there may be an issue coming” and that the FSH project team was “obviously worried about [ICT readiness] because we wouldn’t be looking at it otherwise.”²⁹⁸

7.31 The briefing note also advised that Dr Russell-Weisz was due to brief the Taskforce the following week on the key issues around FSH commissioning. Unfortunately, this scheduled briefing did not occur, nor was Dr Russell-Weisz’s Baseline Report presented to the Taskforce until after Mr Snowball’s departure.

7.32 We acknowledge that there are potentially two failures here. The first relates to DoH’s failure to ensure that the Minister was updated about the status of the commissioning project, particularly the ICT aspects, either from a direct briefing from the Director General or via an update from the Taskforce. The second relates to the failure of the Minister to independently seek confirmation of the outcome of the ICT review, regardless of whether he expected that an update would be forthcoming.

295 Submission No. 20 from Mr Mal Wauchope, Public Sector Commissioner, 7 January 2014, p. 3

296 Briefing Note prepared for the Minister for Health by Mr Brad Sebbes, 5 December 2012 in Submission No. 12 from the Department of Health, 20 December 2013.

297 Submission No. 12 from Department of Health, 20 December 2013, p. 2; Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, pp. 10–11.

298 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, Department of Health, *Transcript of Evidence*, 29 January 2014, p. 10.

7.33 These failures must, however, be considered in the context in which both the Minister and the Department operate. The Director General and DoH as a whole have the benefit of access to the full range of information about the operations of the Department; the Minister, to a great extent, is beholden to the Department and the Director General for the provision of this same information. There is, therefore, an unavoidable degree of information asymmetry that exists between a public sector agency head and his or her responsible minister.²⁹⁹

7.34 Should the provision of information from a government department to a Minister be reliant upon the Minister asking the “right” questions? Does a Minister’s failure to ask the right questions excuse the Department from sharing materially relevant information? We are strongly of the view that the answers to these questions must be “no”. There should therefore be no doubt that Mr Snowball in his capacity as Director General had a duty to inform the Minister of the information and advice that was in his possession in December 2012.

7.35 This does not, however, excuse the Minister’s failure to ask questions, particularly given that he had previously been warned of risks to the project.

Finding 40

The Minister for Health had signed a \$4.3 billion contract on behalf of the State, which contained obligations for the State to deliver a digital hospital in April 2014. We are not convinced that the Minister adequately satisfied himself that the obligations of the contract were being met.

Political sensitivities and the proximity to the election

7.36 When Mr Snowball was advised that delay to the opening of FSH would be likely, the State Election was approximately three months away. The pre-election period is a sensitive time for public sector agencies, even before the issuing of the writs and the commencement of the caretaker period in February 2013.

7.37 It is hard not to take into consideration the timing of the election in respect of how this issue was handled across government. It is our view that the information should have been treated seriously, regardless of the timing of the election.

Should differences of opinion be reported?

7.38 Mr Snowball told us that by January 2013, having satisfied himself that ICT could be delivered in time for the scheduled opening in April 2014, he did not see that

299 Other parliamentary committees in Western Australia have also considered the issue of information asymmetry between Ministers and heads of public sector agencies; see Public Administration Committee, *Public Discussion Paper: Public Sector Reform*, 13 November 2012, p. 18.

a report to government to delay the project was required at that time.³⁰⁰ The evidence we have received suggests that this was because Mr Snowball had previously been receiving “mixed messages” regarding the ability to deliver ICT on time; he later rejected the advice of the Health Information Network (**HIN**) that a nine to 12-month delay was likely on the basis that their assumptions needed to be “validated”. To some extent, this seems to be an example of the kind of information Mr Wauchope referred to as not of itself necessarily demanding ministerial disclosure because “the implications were contingent on factors which had not yet crystallised.”

7.39 In short, it appears that Mr Snowball was of the opinion that any advice to the minister regarding delay ought to represent a unified and singularly-held view and that, as Director General, his view should take precedence. This understanding of the hierarchy within government reporting was repeatedly invoked in the evidence we received regarding the propriety of challenging a Director General’s discretion and decisions, both from within departmental structures as well as inter-agency involvement. According to Mr Snowball:

*While it may be represented that there was a difference of opinion between myself and a subordinate, ultimately, it is the director general who makes the judgement call and I had insufficient evidence to convince me that the project would be delayed.*³⁰¹

7.40 Mr Marney:

*In essence, the director general was the accountable party for advice to his minister and for a determination as to whether or not April 2014 was on track. It was my strong view that it was not; however, he disagreed with that view and maintained the view that April 2014 was indeed achievable... up until his departure from the Department.*³⁰²

7.41 Mr Marney again:

*Ultimately, the accountability rests with the director general and the minister [...] I, on occasion, will go around the director general, but that subverts those lines of accountability and compromises governance in a range of ways. I raised the issues with my minister and in turn it is his job to raise those with the Minister for Health [...].*³⁰³

300 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 5.

301 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 6.

302 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 7.

303 Mr Tim Marney, Under Treasurer, Department of Treasury, *Transcript of Evidence*, 4 November 2013, p. 7.

7.42 Mrs Rebecca Brown:

*But it is not, I think, odd that, as the director general is the accountable authority, we would take his advice. It would be, I think, challenging if central agencies were to start to undermine director generals in terms of the decisions that they make.*³⁰⁴

7.43 Dr Russell-Weisz:

*[d]o you go over the top of your boss's head because you have a different view? I do not think you do that. He was taking other advice and he said, 'No, that is not my view,' and I respected that [...].*³⁰⁵

7.44 We find the singularity of ministerial reporting in this instance to be problematic on several fronts. First, in the case of differences of opinion within a department, serious observance of the convention that ministers be kept fully informed of activity within their department demands that such differences be reported, particularly where they exist between senior personnel. This very issue was considered by the Royal Commission on Australian Government Administration, particularly in relation to provisions of the *Public Service Act 1922* (Cth) which required the departmental head "to advise the Minister in all matters relating to the department."³⁰⁶ The Commission report concluded that while the head of a department must be in a position to coordinate the advice offered to the minister and make arrangements with the minister that will best suit the efficient working of the department, reporting of differences of view within a department was to be encouraged:

*Particularly where there are differences of view within the department, we consider the best course is for practices to be adopted whereby the minister becomes aware of those differences.*³⁰⁷

Finding 41

Regardless of Mr Snowball's view that the risk of delay to the opening of the hospital had been mitigated, he nonetheless had a duty to advise the Minister for Health that he had received advice from the Chief Executive appointed to oversee the commissioning of the hospital that a delay was to be expected.

304 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, *Transcript of Evidence*, 27 November 2013, p. 11.

305 Dr David Russell-Weisz, Chief Executive, Fiona Stanley Hospital Commissioning, Department of Health, *Transcript of Evidence*, 4 December 2013, pp. 5–6.

306 *Public Service Act 1922* (Cth), s 25(2).

307 Royal Commission on Australian Government Administration, *Report*, 1976, p. 65.

7.45 It is our view that differences of opinion, where they relate to matters of significance, must at least be reported at ministerial level as part of a Director General's duty to keep their minister fully informed. This is particularly the case where a Chief Executive had been appointed to commission the hospital. Reporting the Chief Executive's advice would have strengthened accountability, and allowed the Minister to determine whether a delay was necessary.

The Incoming Government Brief

7.46 Given that these events occurred in close proximity to a State Election, the Incoming Government Brief (IGBs) was another means through which Mr Snowball was required to report the status of the hospital to the Minister and Cabinet. Unfortunately, Mr Snowball's IGB represented another missed opportunity for him to provide full disclosure to the Minister of the advice he was receiving about the likelihood of delay.

7.47 IGBs are amongst the most important documents prepared by government agencies. In Western Australia, as in all Australian jurisdictions, a newly elected government and its ministers are effectively in power from the day the election results become known.

7.48 The IGB is an important means through which new ministers can quickly get across the significant issues impacting upon their agency, and to gain departmental advice on policy issues the government might wish to pursue during the early stages of the new administration. Understandably, the effectiveness of these briefs relies in no small part on their candour. Indeed, given the entirely understandable pressures that new ministers and new governments typically experience during early periods of administration, the candour of IGBs has been linked to ensuring a smooth transition to a new administration.³⁰⁸

Dr Russell-Weisz's Incoming Government Brief

7.49 On 19 February 2013, all members of the State Health Executive Forum (SHEF) were asked to prepare an IGB relating to their areas of responsibility. As part of this request, a list of "immediate", "medium term" and "Commonwealth-State issues" that had been identified by Mr Snowball was provided. According to this list, FSH was merely a medium-term issue and would not require attention within the first 100 days of any new government.³⁰⁹ A draft template was also provided; it is clear from this template that providing detail under the proposed format would be a difficult proposition, as the format only seems suited to a one-page summary. Dr Russell-Weisz, as a member of SHEF, was asked to prepare the IGB for FSH. He completed his version,

308 Crowe and Department of the Treasury [2013] AICmr 69 (29 August 2013), p. 7.

309 Submission No. 19 from the Department of Health, 31 January 2014.

which consisted of some 16 pages, on 1 March 2013. It had been drafted with assistance from the FSH Program Management Office (PMO), Ms MacLeod and Mr Harrison.³¹⁰ The FSH Executive reviewed the document and presumably endorsed its contents prior to Dr Russell-Weisz providing it to Mr Snowball on 8 March 2013, one day before the state election.

7.50 Perhaps unsurprisingly, the content of Dr Russell-Weisz's IGB repeats much of what had been said in the Baseline Report he completed in December the previous year. He provides the incoming Minister with a list of the reviews highlighting "issues facing the program" that had been conducted in the previous nine months. The role of the FSH PMO is described and a summary of the reporting from January 2013 is included. That summary is reproduced in figure 7.1 below. The inclusion of the PMO report is significant because it makes clear that problems with both ICT and workforce were likely to lead to the delayed opening of the hospital.

Figure 7.1: Extract from Dr Russell-Weisz's Incoming Government Brief³¹¹

Corporate	Green	Infrastructure	Green	Workforce	Red
The corporate workstream is on track. Key risks are primarily related to the economics of commissioning and operations at FSH, as well as timely inputs from the ICT and Clinical Commissioning Teams.		The Infrastructure workstream is on track. Key progress this period has been readying the admin building for the commissioning team transition and resolution of several CCR access issues.		Workforce faces a number challenges. There are key risks to finalisation of staff structures, roles and numbers that may further delay recruitment. The phased commissioning of FSH will introduce several challenges around workforce transition but does allow additional time for recruitment into some positions. Local FSH workforce coordination and implementation is a key risk that needs to be actioned.	
Facilities Management	Amber	Clinical Commissioning	Amber	ICT	Red
The relationship between WA Health and the FM continues to improve however the FM has submitted delay notices in 2 areas. Key challenges remain in ICT, particularly given the change in scope of HIN ICT that will be delivered and the flow on effects to FM technology and service delivery.		The clinical commissioning team has nearly completed on-boarding of new resources which will allow rapid progression of service planning. There are ongoing challenges achieving alignment of ICT, FM and Clinical Commissioning planning processes that will require close collaboration between areas.		There have been delays to the systems testing program that is required to map out the new approach to ICT deployment at FSH. Without the results from this program, the final schedule for deployment of ICT to FSH cannot be determined and it is unlikely any of FSH can be opened in April 2014.	

7.51 The report also provides an explanation for why a phased opening of the hospital will be required. It is worth reiterating that the decision to phase the opening is entirely separate from the delay. Even if FSH had not encountered any problems during the commissioning process, there is no feasible way that the hospital could have been operating at full capacity only four weeks after the initial opening. We explore this issue in significantly greater detail in Chapter 4.

310 Submission No. 19 from the Department of Health, 31 January 2014.

311 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, p. 6 in Submission No. 15 from the Department of Health, 9 January 2014.

Clinical commissioning

7.52 Dr Russell-Weisz then goes on to provide a candid appraisal of the four commissioning streams not rated green in the January PMO report. With respect to clinical commissioning, he reported to the Minister that “significant additional resources” had been put in place to “recover the timetable” and that there was “significant momentum to tangible results”.³¹² Having said that, Dr Russell-Weisz also provided an honest accounting of challenges that lay ahead, noting that:

- by November 2012 only eight of the 91 Department Service Plans (DSPs) had been completed;
- progress against revised milestones was on track, but that the “tight timeframes” and “magnitude of work” would limit the opportunity and potential for service reform to be achieved;
- operational plans for outpatient activity at FSH required a substantial amount of work from SMHS and FSH to achieve timeframes; and
- significant work remained to develop specific plans and policies for FSH.³¹³

Information and Communications Technology

7.53 With respect to ICT, Dr Russell-Weisz provided a summary of the strategy adopted by DoH in January arising from the ICT Options Analysis Paper developed by HIN. In terms of his analysis of the situation with respect to ICT at the time, Dr Russell-Weisz reported the following:

- testing of ICT systems should have commenced in 2012, thus allowing any interface issues with Serco to be managed and resolved through 2013;
- timelines were not met due to the complexity of ICT issues including challenges from competing ICT programs across WA Health;
- in the absence of a clinical reference group during 2011 and 2012, changes to ICT solutions were being led by HIN and Serco;
- the appointment of clinicians to the ICT program in preceding months had resulted in the need to re-scope and redirect some projects in order to ensure that they were clinically safe and functional;

312 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, p. 9 in Submission No. 15 from the Department of Health, 9 January 2014.

313 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, p. 9 in Submission No. 15 from the Department of Health, 9 January 2014.

- that a ‘critical clinical risk’ existed if the overall ICT program involving projects managed by both HIN and Serco was not aligned and allocated sufficient time for clinical testing of processes, workflows, procedures, protocols and systems; and,
- ICT remained the key risk to the FSH program and was likely to delay the opening of the hospital by between six and nine months.³¹⁴

Workforce

7.54 Dr Russell-Weisz noted the progress that had been made with respect to workforce, but noted that a number of key challenges remained, particularly around the creation and execution of a comprehensive operational based workforce model and implementation strategy across FSH and SMHS to address the major staff transition and relocation challenges that will occur as part of commissioning FSH. He also reported that SMHS had completed the top down workforce modelling, but it was required to be urgently operationalised.³¹⁵

Facilities Management (Serco)

7.55 Dr Russell-Weisz emphasised the importance of administering the contract along the lines of a partnership-style arrangement and noted that a significant amount of work was required to ensure that Serco’s facilities management services support the requirements of the clinical services as they are being operationally developed.³¹⁶

Finding 42

Dr Russell-Weisz’s Incoming Government Brief was an accurate and frank appraisal of the status of the Fiona Stanley Hospital commissioning project providing detailed information about the commissioning project as at March 2013.

Dr Russell-Weisz’s Incoming Government Brief was not provided to the Government

7.56 Dr Russell-Weisz was told on 1 March 2013 that his IGB would not be required. In his 5 March 2013 memorandum responding to Dr Russell-Weisz’s *Baseline Report* from December the previous year, Mr Snowball reported that Ms Angela Kelly, in her role as executive support to the FSH Taskforce, would be preparing a “progress report” that could be submitted to the Minister for Health once government was formed following the election. Mr Snowball went on to describe the report in the following terms:

314 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, pp. 9–11 in Submission No. 15 from the Department of Health, 9 January 2014.

315 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, p. 11 in Submission No. 15 from the Department of Health, 9 January 2014.

316 Department of Health, *Fiona Stanley Hospital Incoming Government Brief (Draft)*, 1 March 2013, p. 11 in Submission No. 15 from the Department of Health, 9 January 2014.

*This report will capture the update we provided to the Taskforce (including governance and ICT) and will be signed off before being submitted to Cabinet through the Minister. This is the process established to ensure government understands the risks inherent in the reconfiguration of hospital services in the South Metropolitan Health Service and of course the Commissioning of FSH and the actions taken to address those risks.*³¹⁷

7.57 In his response to Mr Snowball's memorandum, Dr Russell-Weisz attached a copy of his IGB and indicated he would forward it to Ms Kelly as he was of the view that his version should "form the basis of that report to the Minister".³¹⁸ In respect of Dr Russell-Weisz's request that his IGB form the basis for whatever was presented to the Minister for Health, Mr Snowball told us:

*He responded back to me, in an attached report, repeating his view that delay was inevitable, but reduced it from nine to 12 months, to six to nine months, and asking that his subsequent report be submitted to the incoming government directly. The appropriate channel for such advice is in fact through the taskforce. That is the governance arrangement that we had established for the purpose...*³¹⁹

7.58 In relation to his own proposal for what should be included in the previously mentioned progress report, Mr Snowball told us that the content of the 6 February 2013 Taskforce meeting formed the basis for a report to the new government. According to Mr Snowball, this was "developed and submitted to the members in early March 2013".³²⁰

Two different documents were created to brief the incoming Minister

7.59 Two separate documents were created for the purpose of briefing the incoming government and minister. The first was an IGB that conformed to the template previously described in paragraph 7.49. Ms Kelly was asked to complete this document by Mr Snowball at the time the email was sent to members of SHEF requesting they complete IGBs. Its content was to conform to the briefing given by Mr Snowball at the February meeting. This particular IGB is remarkable only inasmuch as it says absolutely nothing of any use to any incoming government and has been reproduced in figure 7.2. It does, however, mention a "detailed report" on FSH

317 Memorandum from Mr Kim Snowball, Director General, to Dr Russell-Weisz, FSH Commissioning Chief Executive, 5 March 2013, p. 3 in Submission No. 4 from the Department of Health, 9 October 2013.

318 Dr David Russell-Weisz, FSH Commissioning Chief Executive, letter to Mr Kim Snowball, Director General, 8 March 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

319 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 5.

320 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 5.

commissioning and SMHS reconfiguration that would be made available to the incoming government and minister.³²¹

7.60 This detailed report is the same document that Mr Snowball described as a progress report in his 5 March 2013 memorandum to Dr Russell-Weisz. This report had been discussed at the February meeting and Mr Snowball had undertaken to convene a Taskforce meeting later that month where the report could be reviewed and the validity of various assumptions tested.³²² This meeting never took place; however, members were given the opportunity to comment on the report via email a late email sent the day before the report was to be provided to the Minister for Health.

Taskforce members rejected Mr Snowball's status report

7.61 Indeed, members of the Taskforce were provided via email at 4.29pm on 14 March 2013 with a copy of the status report. Taskforce members responded negatively to the content of the report. The information monopoly that Mr Snowball had enjoyed at the February meeting had been circumvented in the weeks following. As previously noted, Mrs Brown requested that briefings be held to assist members gain a better understanding of the status of the various work streams of the commissioning project. Three such meetings were held:

- The first, held on 18 February 2013, dealt with ICT issues and was attended by a range of senior executives from the Departments of Treasury and the Premier and Cabinet in addition to Mr Jon Harrison, Dr Russell-Weisz, and Mrs Brown.³²³
- The second, held on 25 February 2013, dealt with facilities management – in other words, the contract with Serco.
- The third, held on 11 March 2013, dealt with clinical commissioning.³²⁴

321 Submission No. 19 from the Department of Health, 31 January 2014.

322 Minutes of the FSH Taskforce Meeting, 6 February 2013 in Submission No. 4 from the Department of Health, 9 October 2013.

323 Submission No. 6 from Department of Health, 25 October 2013, p. 2.

324 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, email sent to Mr Kim Snowball, 15 March 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

Figure 7.2: Incoming Government Brief regarding Fiona Stanley Hospital

Briefings for Incoming Government 2013

TYPE OF BRIEFING (select one)

- ☒ **Immediate (first 100 days)**
- ☐ **Medium-term**
- ☐ **Commonwealth-State matter**

ISSUE: Commissioning of the Fiona Stanley Hospital and reconfiguration of the South Metropolitan Health Service

BACKGROUND:

- In June / July 2012 a review of all aspects of the commissioning of the Fiona Stanley Hospital (FSH) and reconfiguration of the South Metropolitan Health Service (SMHS) was undertaken and a submission was provided to Government in August 2012.
- Government approved the establishment of the FSH Commissioning and Major Hospitals Transition Taskforce, with representatives from the Department of the Premier and Cabinet, State Solicitors Office, Department of Treasury and Department of Health.
- The Taskforce has met in September 2012 and February 2013.

CURRENT STATUS:

The following key actions have been taken since August 2012:

- New governance arrangements in WA Health have been implemented and key appointments made. Dr David Russell-Weisz took up the role of Chief Executive FSH Commissioning on 12 November 2012
- An activity based pricing approach for FSH is being developed to ensure that budget settings can be accommodated within the FSH budget. The approach will be consistent with efficient pricing and within the WA Health current budget parameters.
- A staged / sequenced opening plan for FSH has been prepared, ensuring consistent delivery of safe, quality clinical care.
- The reconfiguration of SMHS is well advanced, with 50% of Clinical Service Briefs completed, key clinical appointments made and first draft site commissioning plans prepared.
- The integrated program is being updated to reflect the key milestones, dependencies and risks of the four key enablers – Workforce, ICT, Facilities Management and Infrastructure.
- A detailed report will be provided on the Commissioning of the FSH and reconfiguration of the South Metropolitan Health Service will be provided to the incoming government and Minister in March 2013.

RECOMMENDED ACTION:

For noting.

PREPARED BY:

Angela Kelly, Director Program Integration

SIGN OFF:

Patsy Turner, Director, Office of the Director General

7.62 These briefings, which Mr Snowball did not attend, effectively broke the information monopoly that he had enjoyed over the Taskforce until that time. Perhaps unsurprisingly, and in light of the information that had been provided at these briefings, Taskforce members responded particularly negatively to Mr Snowball's report. According to the email sent to Taskforce members by Ms Kelly, the report was being provided in order to gain "support" from the Taskforce; if this support was not forthcoming, then it would be "made clear to the Minister that the report [had] not yet been endorsed by Taskforce members."³²⁵

7.63 In an email sent to Mr Snowball, all Taskforce members and the Director General of the Department of the Premier and Cabinet, Mr Marney made his view particularly clear:

I object to this report going to the Minister in any form without being considered and endorsed by the Taskforce. I am strongly of the view that the Minister should not be briefed without the nature and content of the briefing being considered by the Taskforce. Otherwise the Taskforce is totally irrelevant and I would seriously consider the validity of my involvement.

*Ta
tim³²⁶*

7.64 In an email to the same audience, Mrs Brown sets out her objections in a slightly more detailed format:

Kim,

My recollection of the last taskforce meeting was that a number of papers were tabled for discussion, but that it was clearly established up front in the meeting that the papers were tabled as work in progress.

Given the volume and complexity of issues around the project, it was agreed that the CE FSH (Russ) would hold a series of briefings with interested taskforce members to work through the detail associated with the project, progress against milestones and key risks.

325 Ms Angela Kelly, Department of Health, email to Taskforce members, 14 March 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

326 Mr Tim Marney, Under Treasurer, Department of Treasury, email sent to Mr Kim Snowball, Taskforce members and Mr Peter Conran, 15 March 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

Those briefings have now been held on 18 and 25 Feb, and 11 March on ICT, facilities management and clinical commissioning. I note that the detail of the briefings and openness around progress and risks have been very useful in expanding our understanding of the project but unfortunately do not correlate with the content of the attached report.

I would also note that the attached report refers to the existence of an integrated programme which has not yet been presented to the Taskforce or discussed in any detail.

Accordingly, I do not support the report proceeding in its current form and would welcome the opportunity for the taskforce to discuss its content in more detail.

Regards

Rebecca³²⁷

7.65 Mrs Brown's email, although carefully worded, is particularly clear in establishing that the information provided at the briefings contradicted the content of the update that Mr Snowball intended to present to the Minister. As this update was based on the presentation Mr Snowball provided to the Taskforce at the February meeting, it is also clear that whatever had been presented at that meeting also did not correspond to what had emerged during the briefings that occurred in the weeks following.

7.66 In his response to our draft findings, Mr Snowball agreed that the material presented at the February meeting and contained in the proposed status update was different to the information presented at the additional briefings attended by Taskforce members. He attributed this difference "to progress since the Taskforce had earlier met or because individuals wished to brief based on their own views."³²⁸

Finding 43

Dr Russell-Weisz's Incoming Government Brief was not provided to the Minister. Mr Snowball's preferred briefing paper was rejected by Taskforce members on account of its failure to report accurately about the status of the Fiona Stanley Hospital commissioning project.

327 Mrs Rebecca Brown, Deputy Director General, Department of the Premier and Cabinet, email sent to Mr Kim Snowball, Taskforce members and Mr Peter Conran, 15 March 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

328 Submission No. 32 from Mr Kim Snowball, 4 April 2014, p. 10.

What was reported to the Minister?

7.67 In his written interactions with Dr Russell-Weisz and his responses to Mrs Brown and Mr Marney, Mr Snowball made clear his commitment to the reporting process established through the Taskforce – namely, that reports to government on the status of the hospital would be signed off by the Taskforce. This, according to Mr Snowball, was the “process established to ensure government understands the risks” associated with the project. As noted earlier, Mr Snowball told us that adherence to this structure was his justification for rejecting Dr Russell-Weisz’s request that his briefing form the basis of the report to government. Our concern is that Mr Snowball’s stated adherence to the process established for the Taskforce is largely inconsistent with his actions once the Taskforce members had rejected his proposed IGB.

7.68 In his response to the emails from Mr Marney and Mrs Brown, Mr Snowball agreed that the status update prepared by Ms Kelly would not be provided to the Minister without the consent of the Taskforce.³²⁹ DoH has told us that this status report was never provided to the Minister for Health and that Mr Snowball’s planned meeting on 15 March 2013 never went ahead.³³⁰ However, there remains some indication that, despite objections from the Taskforce about the accuracy of the information contained in the status report, Mr Snowball still presented his view of the status of the commissioning project to the Minister in the week following the election.

7.69 Firstly, Mr Snowball himself told us that on the day he left his position as the head of DoH (his last day as Director General was 15 March 2013), he was reporting to the Minister that there was no evidence of a delay:

*I am talking about what I was seeing at that time right in March, the day I left, I was still advising my minister that yes, we have got a risk with ICT and we have got other risks as well with Fiona Stanley Hospital, but I had no evidence to say we will be delayed by ‘X’ months.*³³¹

7.70 Secondly, the Minister for Health has indicated in Parliament that Mr Snowball told him in the week after the election that he was of the view that FSH would open in April 2014.³³²

7.71 Although the Minister for Health did not indicate which day following the election Mr Snowball provided him with the assurances, it is entirely believable that

329 Mr Kim Snowball, email sent to Taskforce members and Mr Peter Conran, 15 March 2013 in Submission No. 9 from the Department of Health, 22 November 2013.

330 Submission No. 21 from the Department of Health, 21 February 2014, p. 1.

331 Mr Kim Snowball, *Transcript of Evidence*, 4 November 2013, p. 19.

332 Hon. Dr Kim Hames MLA, Deputy Premier; Minister for Health, Legislative Assembly, Western Australia, *Parliamentary Debates* (Hansard), 27 November 2013, p. 6741.

they were conveyed on Mr Snowball's last day in the role, particularly given Mr Snowball's comments to the Committee at its public hearing.

7.72 If, as seems likely, Mr Snowball did tell the Minister on his final day in the role of Director General that he had no evidence that the hospital would be delayed, then his adherence to the various governance processes that he had used as an explanation for not sharing Dr Russell-Weisz's report can be seen as particularly hollow. Whilst the objections of the Taskforce members might have prevented Mr Snowball from presenting his preferred version of events in a formal "status report", these same objections did not stop him from verbally relaying the same information.

Chapter 8

Systemic problems

The issues with the governance of the project extended to unclear legislative responsibilities and authority.

The Department of Health labours under an out-dated legislative structure that is unduly complex and no longer reflects current practice. Lines of authority, delegation and accountability are easily blurred. Particularly where a Director General is faced with altering a decision previously made by Cabinet, it is appropriate for that decision to be elevated, regardless of any other authority the Director General may seek to exercise.

Due to the absence of a permanently appointed Chief Information Officer, the Health Information Network lacked strong leadership at a time when it was supposed to be undertaking its most challenging and ambitious program of work to date. This also effectively removed an element of independence that would have ordinarily contributed to a robust governance structure.

Legislative Structure of the Department of Health

8.1 In addition to our findings above about Mr Snowball's duty to fully inform the Minister about the activities of the Department in relation to FSH, the contractual and financial significance of Mr Snowball's decision to endorse "Option 2" led us to examine the authority under which Mr Snowball acted when he made this decision. In doing so, we have also had cause to scrutinise the legislative structure of the Department of Health, which has revealed that it is unduly complex and no longer reflects current practice.

Hospital and Health Services Act 1927 (WA)

8.2 Parliament has granted various statutory powers to the Minister for Health in relation to hospitals and health services in Western Australia, many of which are contained in the *Hospitals and Health Services Act 1927 (WA)* (**the HHS Act**). The HHS Act was created at a time when public hospitals were managed by local hospital boards in a devolved structure. More recently, local hospital boards have been dissolved and the functions and powers of the boards centralised. Where there is no board for a public hospital, s 7 of the HHS Act vests the management and control of the hospital in the Minister.

8.3 The Minister may, on advice, declare institutions to be public hospitals by publishing such notice in the Gazette, pursuant to s 3 of the HHS Act. However, FSH is apparently unique in its current status as a non-commissioned hospital and has not yet been declared by the Minister to be a “public hospital”; consequently, management and control of FSH has not yet vested in the Minister pursuant to s 7 of the HHS Act.³³³ Section 5A(1) of the HHS Act states that it is the duty of the Minister to provide hospital accommodation, hospital services and health services.³³⁴ The construction and commissioning of FSH falls within the portfolio of the Minister for Health in this capacity.

8.4 The authority of the Director General of the Department of Health within the HHS Act is limited largely to the regulation and monitoring of private health facilities³³⁵ and the collection of information about health services.³³⁶ That the Director General has no direct capacity to control the State’s hospital and health services is anachronistic. Any capacity he has is derived by way of delegation of authority from the Minister.³³⁷

Delegation structure

8.5 Delegation of power is the mechanism by which governments distribute power and responsibility to achieve effective and efficient administration. When Parliament creates a statutory power, it vests that power in some individual or body who is then able to exercise it.³³⁸ They are generally required to exercise the power personally, although often the demands imposed on these individuals render it impossible for them to do so. This necessitates the delegation of power to other officers.³³⁹

8.6 The HHS Act makes few provisions for delegation of authority; rather, s 9(1) of the *Health Legislation Administration Act 1984* (WA) provides for the Minister, CEO or other official upon whom a power is conferred to delegate their authority “either generally or as otherwise provided by the instrument of delegation, by writing signed by him.” By way of a written instrument dated 3 December 2008, in relation to the hospitals listed in the schedule to the instrument, the Minister delegated all of his

333 Submission No. 13 from Department of Health, 7 January 2014 p. 1.

334 “Hospital” and “hospital service” are defined in s 2 of the HHS Act.

335 *Hospitals and Health Services Act 1927* (WA), Parts IIIA & IIIB.

336 *Hospitals and Health Services Act 1927* (WA), Part IIIC.

337 Minister for Health, *Report on the Statutory Review of Hospitals and Health Services Act 1927*, Tabled Paper No. 2618, 8 May 2007, p. 8.

338 Australian Public Service Commission, *Foundations of Governance in the Australian Public Service*, September 2010, p. 20. Available at: http://www.apsc.gov.au/__data/assets/pdf_file/0019/5527/Foundations-2010.pdf. Accessed on 1 April 2014.

339 Department of Health, *Authorities, Delegations and Directions Schedule*, March 2013, p. 5 in Submission No. 12 from Department of Health, 20 December 2013.

powers under the HHS Act to the CEO of the Department of Health.³⁴⁰ However, due to the status of FSH as a non-commissioned hospital which has not yet been declared to be a “public hospital”, it is not listed in the schedule to the instrument of delegation.

Director General’s authority

8.7 In examining Mr Snowball’s authority to make the decision to endorse Option 2, we sought advice from the State Solicitor’s Office (**SSO**), which has informed our conclusions below.

8.8 The Director General derives most of their authority to control hospital and health services by way of delegated capacity from the Minister. However, it is well recognised that the duties and powers of ministers are often exercised by the departments for which they are responsible. This is because the functions given to ministers are so multifarious that they cannot be expected to attend to them personally unless a statute is clear in its intent that they are required to do so.³⁴¹ It is a convention of Westminster executive governments that while a minister is responsible for the administration of their department, it is the departments that undertake service delivery and the implementation of policy determined by executive government.³⁴² The Director General has certain authority in their capacity as the CEO of the Department assisting the Minister in discharging their obligations. The functions of CEOs as enshrined in s 29 of the PSM Act are consistent with the function of a department being to implement the decisions of government.³⁴³

8.9 The most directly relevant provisions of s 29 of the PSM Act to Mr Snowball’s actions in endorsing Option 2 are:

- (1) *Subject to this Act and to any other written law relating to his or her department or organisation, the functions of a chief executive officer or chief employee are to manage that department or organisation, and in particular...*
- (c) *to plan for and undertake financial, information and other management in relation to that department or organisation and to monitor the administrative or financial performance of that department or organisation; and*

340 Submission No. 12 from Department of Health, 20 December 2013. This instrument of delegation relates to the Metropolitan Health Service Board; separate instruments of delegation exist for the WA Country Health Service Board and the Peel Health Service Board.

341 Submission No. 31 from State Solicitor’s Office, 4 March 2014, pp. 2–3. See also *Carltona Ltd v Commissioner of Works* [1943] 2 All ER 560 at 563.

342 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

343 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

(d) to ensure the appropriate deployment and redeployment of resources within that department or organisation...³⁴⁴

8.10 Further, s 29(2) of the PSM Act grants power to a departmental CEO to “do all things that are necessary or convenient to be done for or in connection with the performance of his or her functions.”

8.11 The Minister for Health signed the facilities management contract with Serco based on the paperless vision. Given that the delegation of powers to the Director General is not transparent, the Committee sought advice from the SSO as to the authority of the Director General to vary contractual undertakings without recourse to the Minister or Cabinet.

8.12 According to the SSO advice, in the absence of any express delegation of authority from the Minister, the Director General had the authority under the PSM Act. Underlying this advice was the assumption that the Option 2 decision “simply involved an adjustment of what was initially thought to be possible in the circumstances as they presented themselves” in relation to FSH ICT.³⁴⁵

8.13 Further, the SSO maintained that “if that decision involved or involves entering or varying contracts as chief executive of the Department of Health then the Director General has the authority to enter, and vary, contracts that are within the Department of Health’s portfolio.”³⁴⁶

8.14 Under the *Financial Management Act 2006* (WA), a Director General is also the accountable authority “responsible to the Minister for the financial management of the services under the control of the agency.”³⁴⁷ Consequently, if a service is included within the Department’s budget, the Director General is responsible to the Minister for the financial management of the service and has all necessary authority to undertake financial measures for the administration of that budget.³⁴⁸

8.15 The advice we received explained that the arrangements by which departmental CEOs exercise authority support the framework of departments assisting ministers in performing their duties and reflect the “dichotomy between ministerial responsibility and the practical administration of executive government.”³⁴⁹ Clearly, the legislative provisions granting general powers to CEOs are intended to have broad

344 *Public Sector Management Act 1994* (WA), s 29(1)(c) & (d).

345 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

346 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

347 *Financial Management Act 2006* (WA), s 52.

348 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

349 Submission No. 31 from State Solicitor’s Office, 4 March 2014, p. 3.

application. Nevertheless, the Committee still holds some concerns over some aspects of the advice we have received on the scope of a Director General's authority.

8.16 The first of these concerns is that if a Director General's authority is as broad as suggested, is there any need for the Minister to expressly delegate their powers in order for the Director General to be sufficiently empowered to perform their functions? In the 2007 Statutory Review of the HHS Act, it was noted that in July 2002 the then Minister delegated his authority to act to the Director General; this enabled the Director General to use a combination of authority to manage and direct the public hospital and health services of the State, derived from the delegated authority from the Minister, his capacity as the CEO and his authority under the PSM Act.³⁵⁰ DoH was not able to provide us with a copy of any legal advice regarding the delegation. It remains unclear to us why such a delegation was considered to be necessary, particularly if the general powers of the Director General under the PSM Act are as broad as we have been advised.

8.17 This patchwork of authority not only highlights that the current legislative structure of the Department of Health is unduly complex, but also raises concern about the possibility for lines of authority and accountability to be blurred. It is important to remember that ministers are ultimately responsible for anything that departmental officers do under their authority. If officers fail to act with due respect for this structure of accountability, or if the structure creates confusion, there is a risk that the ultimate accountability of ministers and governments will be compromised by the actions of unelected bureaucrats.

8.18 Our second concern regarding Mr Snowball's authority to endorse Option 2 arises from email correspondence received by the Committee in response to a request for information submitted to the Department of Health. In answer to a query from Dr Russell-Weisz in May 2013 about the strategy to be employed when responding to a Serco enquiry about the status of the phased commissioning plan for FSH, Mr Nicholas Egan of the SSO said that Serco ought to be advised that the decision on delay and phased opening was to be "necessarily made by Cabinet, on advice from the Taskforce, which is charged with the responsibility of advising Government on the Hospital's commissioning." He also said that certain information should not be shared with Serco "in the absence of some approval from the Minister."³⁵¹

8.19 The decision to delay and phase the opening of FSH arguably fell into the same category as the decision to endorse Option 2 – namely, "an adjustment of what was initially thought to be possible in the circumstances as they then presented

350 Minister for Health, *Report on the Statutory Review of Hospitals and Health Services Act 1927*, Tabled Paper No. 2618, 8 May 2007, p. 5.

351 Mr Nicholas Egan, Deputy State Solicitor, email to Taskforce members, 27 May 2013 in Submission No. 22 from Department of Health, 21 February 2014.

themselves”, which ultimately required variation of a contract within the portfolio of the Department of Health. According to the advice we have received, this would have placed the decision squarely within the authority of the Director General. However, the deference to Cabinet and ministerial approval in this instance, not only by the Taskforce but also by the current Acting Director General of the Department of Health, Professor Bryant Stokes, is in stark contrast to Mr Snowball’s approach in endorsing Option 2.

8.20 The disparity between these two approaches is concerning and contributes little towards convincing us that Mr Snowball’s response to the advice regarding ICT readiness and delay was at all appropriate. Given that the decision to endorse Option 2 effectively altered a decision that had previously been made by Cabinet – namely, the decision to commission a fully digital hospital – it is our view that it would have been more appropriate for Mr Snowball to elevate the decision, rather than endorsing it himself. In this case, particularly given that the decision was likely to incur additional expenditure, it would have been more appropriately submitted to the Minister and Economic and Expenditure Reform Committee of Cabinet.

Finding 44

The decision to endorse a significantly de-scoped ICT vision via Option 2 for Fiona Stanley Hospital ought to have been submitted to the Minister for Health, and appropriately elevated to the Economic and Expenditure Reform Committee and Cabinet process.

The need for reform

8.21 The amendment of the HHS Act over time is consistent with the current government emphasis on a state-wide approach to the delivery of health services and integrating services to include all levels of government and private facilities. Accommodating this approach has required adaptation of the original legislation which now provides for two structures, namely the hospital board or the Minister in place of the board. However, the subsequent result has been that neither structure functions as the Act originally intended and the HHS Act no longer reflects the current departmental arrangements; the structures that have evolved to accommodate this legislative regime are unduly complex and ultimately limit the development of a unified state-wide health system, which was identified in 2004 as a strategic goal of the government’s health reform agenda.³⁵² This situation is at odds with the principles of public administration

352 Minister for Health, *Report on the Statutory Review of Hospitals and Health Services Act 1927*, Tabled Paper No. 2618, 8 May 2007, pp. 3, 11. See also Department of Health, *A Healthy Future for Western Australians, Report of the Health Reform Committee*, March 2004 (**Reid Report**).

and management outlined in the PSM Act, which require that the public sector be structured so as to “achieve and maintain operational responsiveness and flexibility”.³⁵³

8.22 A statutory review of the HHS Act was conducted in 2007, which identified a need for legislative reform “to alleviate the uncertainties to these arrangements under the legislation and provide for an efficient, flexible legal and administrative structure for the [delivery] of hospital and health services across the State.”³⁵⁴ The primary recommendations were for a new Health Services Bill to be drafted and for the removal of the board structure to ensure the legislation reflected current practice and corresponded with the goal of creating a single, unified public health system.³⁵⁵ It appears that none of the recommendations contained in the 2007 statutory review have been implemented.

8.23 Section 38 of the HHS Act, inserted in 1985, requires that the Minister undertake a review of the operation of the Act as soon as practicable after 1 January 1991 and every fifth anniversary after that date, and that a report of the review be prepared and tabled in both houses. The 2007 statutory review identified that no such report had previously been tabled. A further review of the HHS Act is overdue not just according to the requirements of the HHS Act, but also to further assess the need for legislative reform to rectify what is clearly an unduly complex regime which no longer adequately serves its intended purpose.

Recommendation 2

The Minister for Health should repeal and replace the *Hospitals and Health Services Act 1927* (WA), with legislation that accurately reflects the Department of Health’s current operations.

Acting appointments

8.24 The lack of permanent leadership at the Health Information Network (HIN) when it was undertaking the ambitious program of work intended for FSH could only have contributed to the significant difficulties that arose in the ICT work stream of the commissioning project.

8.25 In March 2010, the then permanent Chief Information Officer (CIO) of HIN resigned. His resignation coincided with the decision by DoH to release an ICT “services scope” to shortlisted bidders, thus commencing the process through which the “digital vision” for the hospital would be included in the contract eventually signed with Serco.

353 *Public Sector Management Act 1994* (WA), s 7(b).

354 Minister for Health, *Report on the Statutory Review of Hospitals and Health Services Act 1927*, Tabled Paper No. 2618, 8 May 2007, p. 5.

355 Minister for Health, *Report on the Statutory Review of Hospitals and Health Services Act 1927*, Tabled Paper No. 2618, 8 May 2007, p. 3.

8.26 In the four years since March 2010, a series of acting appointments have been made to fill this important position at a time when DoH has been embarking on an ambitious ICT renewal program. DoH was unable to tell us why a permanent appointment had not been made to the position, and explained that all of DoH's corporate functions – HIN included – were undergoing review. It was anticipated that, as a result of the review, HIN's functions would change. These changes would require a different skill set for the HIN leader once the immediate past and current major capital works projects are operational.³⁵⁶

8.27 Mr Alan Piper was the first acting appointee to the role of CIO, filling the position from early 2010 through to October 2012. His appointment was made on the recommendation of the then Under Treasurer, Mr Tim Marney, who was of the view that Mr Piper had the skills and ability to lead a complex part of the organisation through a time where significant leadership was needed.³⁵⁷ At the time of his appointment, Mr Piper was also the Executive Director of Procurement for the FSH project. He remained in this role for the entire duration of his time as Acting CIO. Mr Piper's responsibilities also included filling the role of Chief of State Negotiator during the negotiations with Serco, which stretched from October 2010 through to July 2011.

8.28 These are obviously an extensive range of responsibilities. It could be argued that they are sufficiently complex to constitute three separate full time positions. Instead, all three positions were filled simultaneously by the same individual. DoH told us that Mr Piper was "enthusiastic" about delivering the digital vision at FSH and it was "assumed" that he appreciated the complexity of holding multiple roles.³⁵⁸

8.29 It is important to note that we are not making any comments here about Mr Piper's suitability for the role. We are, however, concerned that DoH's senior management felt that HIN could be managed through a period of significant investment and change by an individual who was also leading the delivery of the \$2 billion hospital infrastructure whilst also leading negotiations with Serco for the \$4.3 billion contract to provide facilities management services at the hospital.

8.30 We are also concerned that DoH has failed to make a permanent appointment to the position for over four years. In our view, such a sustained string of acting appointments is undesirable, particularly when HIN was supposed to be leading its most ambitious and challenging program of work undertaken to date. Dedicated leadership was needed in this period more than ever, yet this was compromised by the failure to appoint a permanent head for HIN. Indeed, Mr Giles Nunis told us that leadership within HIN was "left wanting" and "inexperienced" with regard to developing, program managing and implementing the technology component of the

356 Submission No. 28 from Department of Health, 18 March 2014, p. 3.

357 Submission No. 28 from Department of Health, 18 March 2014, p. 2.

358 Submission No. 28 from Department of Health, 18 March 2014, p. 3.

commissioning project; with his 20 years of ICT experience, it took him just two days to work out what the problems with FSH were and identify a path forward.³⁵⁹

8.31 Additionally, the appointment of Mr Piper to multiple roles removed an important layer of “check and balance” that is inherent in good governance and compromised the independence of advice being provided about a critical dependency. We are inclined to believe that HIN provided advice in early 2010, prior to Mr Piper’s appointment, that it could not deliver the full digital vision for FSH. It is difficult to see how Mr Piper could have been in a position, at the time of his appointment to the CIO role, to independently form a view on this fundamental aspect of the commissioning project and to provide the requisite level of rigour. Ultimately, diversity of input on the question of HIN’s ability to deliver the full digital vision for FSH would have ensured that the final position on this matter was as robust as it could have been.

Recommendation 3

The Department of Health must ensure that a permanent appointment be made to the position of Chief Information Officer, Health Information Network, as soon as possible.



DR G.G. JACOBS, MLA
CHAIRMAN

359 Mr Giles Nunis, Deputy Director General, Department of State Development, *Transcript of Evidence*, 29 January 2014, pp. 6–7.

Appendix One

Inquiry Terms of Reference

That the Education and Health Committee inquire into and report on the organisational response within the Department of Health to the challenges associated with commissioning the Fiona Stanley Hospital. In particular, the Committee will examine:

1. the arrangements made by the Department to plan for and manage the transition to and commissioning of the new facility;
2. the oversight and governance of the project, particularly with respect to the communication of important information about progress with the commissioning of the hospital within the Department and to external stakeholders and the Executive; and
3. any implications for the commissioning of the Midland Health Campus and the Perth Children's 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

No.	Date	Name	Position	Organisation
1	8 July 2013	Prof Bryant Stokes	Acting Director General	Department of Health
2	12 August 2013	Prof Bryant Stokes	Acting Director General	Department of Health
3	15 August 2013	Prof Bryant Stokes	Acting Director General	Department of Health
4	9 October 2013	Prof Bryant Stokes	Acting Director General	Department of Health
5	14 October 2013	Prof Bryant Stokes	Acting Director General	Department of Health
6	25 October 2013	Prof Bryant Stokes	Acting Director General	Department of Health
7	15 November 2013	Prof Bryant Stokes	Acting Director General	Department of Health
8	20 November 2013	Mr Tim Marney	Under Treasurer	Department of Treasury
9	22 November 2013	Prof Bryant Stokes	Acting Director General	Department of Health
10	29 November 2013	Prof Bryant Stokes	Acting Director General	Department of Health
11	4 December 2013	Mr Tim Marney	Under Treasurer	Department of Treasury
12	20 December 2013	Prof Bryant Stokes	Acting Director General	Department of Health
13	7 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
14	2 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
15	9 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
16	14 January 2014	Hon. Dr Kim Hames, MLA	Deputy Premier; Minister for Health	
17	31 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
18	31 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
19	31 January 2014	Prof Bryant Stokes	Acting Director General	Department of Health
20	7 January 2014	Mr Mal Wauchope	Public Sector Commissioner	Public Sector Commission
21	21 February 2014	Prof Bryant Stokes	Acting Director General	Department of Health
22	21 February 2014	Prof Bryant Stokes	Acting Director General	Department of Health
23	24 February 2014	Prof Bryant Stokes	Acting Director General	Department of Health

No.	Date	Name	Position	Organisation
24	4 March 2014	Prof Bryant Stokes	Acting Director General	Department of Health
25	8 March 2014	Prof Bryant Stokes	Acting Director General	Department of Health
26	10 March 2014	Prof Bryant Stokes	Acting Director General	Department of Health
27	18 March 2014	Prof Bryant Stokes	Acting Director General	Department of Health
28	18 March 2014	Prof Bryant Stokes	Acting Director General	Department of Health
29	20 March 2014	Hon. Dr Kim Hames, MLA	Deputy Premier; Minister for Health	
30	3 February 2014	Mr Paul Evans	State Solicitor	State Solicitor's Office
31	4 March 2014	Mr Paul Evans	State Solicitor	State Solicitor's Office
32	4 April 2014	Mr Kim Snowball		

Appendix Four

Hearings

Date	Name	Position	Organisation
4 November 2013	Mr Timothy Marney	Under Treasurer	Department of Treasury
	Mr Alistair Jones	Acting Executive Director, Strategic Policy and Evaluation	
	Ms Natasa Spasic	Acting Policy Analyst	
4 November 2013	Mr Paul Evans	State Solicitor	State Solicitor's Office
	Mr Nicholas Egan	Deputy State Solicitor	
4 November 2013	Mr Kim Snowball		
20 November 2013	Dr Andy Robertson	Acting Chief Information Officer, Health Information Network	Department of Health
27 November 2013	Mrs Rebecca Brown	Deputy Director General	Department of the Premier and Cabinet
27 November 2013	Mr Jon Harrison	Executive Director, Corporate and Strategic Information Services, Health Information Network	Department of Health
4 December 2013	Dr David Russell-Weisz	Chief Executive, Fiona Stanley Hospital Commissioning	Department of Health
29 January 2014	Ms Nicole Feely	Former Chief Executive, South Metropolitan Health Service	Department of Health
29 January 2014	Mr Jon Harrison	Executive Director, Corporate and Strategic Information Services, Health Information Network	Department of Health
29 January 2014	Mr Brad Sebbes	Executive Director, Fiona Stanley Hospital	Department of Health
29 January 2014	Ms Liz MacLeod	Executive Director, Clinical Commissioning, Fiona Stanley Hospital	Department of Health
29 January 2014	Mr Giles Nunis	Deputy Director General, Resources and Industry Development	Department of State Development
13 February 2014	Mr Tim Marney	Under Treasurer	Department of Treasury
	Mr Alistair Jones	Acting Executive Director, Strategic Policy and Evaluation	

Appendix Five

Mr Snowball's response to the Committee's draft findings

Committee's draft findings

Assertions based on your evidence:

1. In December 2012, you received reports from Dr Russell-Weisz and the Health Information Network (HIN) advising that there would be a nine to 12 month delay to the opening of FSH, largely attributable to ICT. You were surprised by this advice, as it did not accord with information you had previously received, and you sought to satisfy yourself that the advice was accurate.
2. You told us that you disagreed with this advice on three bases:
 - a) The expected delay related to opening a fully digitalised paperless hospital;
 - b) The expected delay related to commencing all clinical services on 1 April 2014, which did not take into account that a decision had already been made to phase the introduction of services over a period of time; and
 - c) The advice gave the impression that nothing could be done to retrieve the situation, even though the planned opening was 17 months away.
3. You met frequently with HIN during December 2012 and January 2013 to establish the validity of the advice and see if anything could be done to retrieve the expected delay. You directed HIN to prepare the ICT Options Paper, which recommended the implementation of "Option 2"; this would partially establish the foundations of a digital hospital as well as replicating some of the ICT components in use at Royal Perth Hospital.
4. By the end of January 2013, you were satisfied that "de-scoped" ICT services could be delivered in time to support the staged opening of FSH from April 2014; consequently, you did not report to the Minister at that time on the advice you had received in December 2012 regarding delay or the actions you had taken in January 2013.
5. You briefed the FSH Taskforce on 6 February 2013 on the status of all aspects of the hospital's commissioning, including that the four key "enablers" of workforce, ICT, facilities management and infrastructure were "on target". The Taskforce members requested a series of additional briefings on ICT, facilities management and clinical commissioning, which were held in February and March 2013.
6. Dr Russell-Weisz prepared an Incoming Government Brief (IGB) which advised that there would be a six to nine month delay to the FSH opening. This was provided to you on 8 March 2013, although you had told him that it was not required. Ms Angela Kelly prepared a status report to be provided to the incoming government, largely based on the information you presented to the Taskforce at the 6 February 2013 meeting. This was circulated to the Taskforce members on 14 March 2013.
7. When you left the position of Director General in 15 March 2013, you were of the opinion that the FSH commissioning project was "on track" and you had not advised the Minister that there would be any delay to the scheduled opening in April 2014.

Our Findings:

1. The three bases upon which you disagreed with the advice regarding delay were not supported by the content of the reports:
 - a) The need for delay was not contingent on establishing a fully digital hospital; the reports clearly state that the expected nine to 12 month delay would be required even if a simplified, partially digital ICT solution was adopted.
 - b) Dr Russell-Weisz was aware when he commenced in the role of Chief Executive, FSH, that that the introduction of clinical services would be phased and he acknowledged the need for the development of the clinical commissioning plan in his Baseline Report; therefore, it is unlikely that he failed to take account of this in assessing the need for delay.
 - c) Your solution to retrieve the situation – namely, endorsing a de-scoped ICT solution – had already been considered by those advising you that a delay was necessary. Indeed, in November 2012 the FSH ICT Services Plan had already been subject to realignment by the Commissioning Governance Committee; this was acknowledged in the HIN report.
2. Despite your endorsement of Option 2, uncertainty remained regarding the ability to deliver ICT in time for the April 2014 opening date. In January 2013, HIN maintained its advice that a nine to 12 month delay was expected to achieve Option 2. Your refusal to accept the advice being provided about the scale of the problem and the need for delay extended to you directing that this advice be removed from the final version of the ICT Options Paper.
3. You endorsed Option 2 in January 2013 without seeking authorisation from the Minister or informing the Minister of your decision. Given that this decision effectively altered a decision that had previously been made by Cabinet, it would have been more appropriate for you to elevate this decision to that level, rather than endorsing it yourself.
4. Regardless of the efficacy of Option 2 in alleviating the need for delay to the opening of FSH, the Minister is the “responsible authority” over the Department of Health (DoH) and you were obliged to keep him fully informed of the activities within DoH. This included informing the Minister that you had:
 - a) received advice that a delay to the opening of the hospital would be necessary; and
 - b) endorsed the substantially simplified ICT approach outlined in Option 2, particularly given the material and contractual significance of that decision.
5. At the 6 February 2013 Taskforce meeting, you did not inform the Taskforce that you had received advice in December 2012 that a delay was to be expected. Given the oversight function granted to the Taskforce and its mandate to report directly to the Minister and Cabinet, you were obliged to disclose this information the Taskforce. You ought to have provided the Taskforce with copies of Dr Russell-Weisz’s report, the HIN report and the ICT Options Paper; your failure to do so undermined the oversight function of the Taskforce.
6. Your briefing at the Taskforce meeting on 6 February 2013 that workforce and ICT were “on target” was inconsistent with the advice being provided by Dr Russell-Weisz and HIN at that

time; it also did not accord with the reports coming from the FSH Project Management Office.

7. Dr Russell-Weisz's IGB was an accurate and frank appraisal of the status of the FSH commissioning project at that time. By March 2013, the Taskforce members had become aware of the true status of the commissioning project through the information presented at the additional briefings in February and March 2013; they objected to Ms Kelly's status report being provided to the incoming government on the basis that it did not correlate with the information provided at these briefings.

ings

FSH Sub 3 2

Mr Snowball's response to the draft findings



Attention Mr Mathew Bates
Principal Research Officer

Dr G.G. Jacobs, MLA
Chairman
Education and Health Standing Committee

Dear Dr Jacobs,

Thank you for providing me with an opportunity to make any corrections or comment on the draft findings associated with the inquiry into the Commissioning of Fiona Stanley Hospital (FSH).

There are a number of factual inaccuracies contained in the draft findings, which I have outlined in the attached documents.

- **In respect to the overall Committee view that I had received advice from within the Department of Health that a delay to the opening of FSH of nine to 12 months was to be expected and should have subsequently advised the Minister for Health and Taskforce I advise as follows:**

It should be noted that Dr David Russell-Weisz changed his original view of a nine (9) to 12 month delay in December, 2012 to a six (6) to nine (9) month delay in March, 2013 due to ICT issues, after the actions I had taken in the interim period.

I have been clear in my evidence that the original advice from Dr Russell-Weisz in the form of a document marked "first draft not for circulation" I consider was flawed for three key reasons:

1. It did not recognise a staged commissioning of services would require a changed schedule of ICT applications, hence the basic finding in respect to ICT readiness was incorrect.
2. It offered no remedy to mitigate the ICT risks of any projected delayed opening despite there being 17 months available to do so.
3. It was inconsistent with regular advice I had been receiving from other senior Health executives.

After I assessed the risks Dr Russell-Weisz identified, I was confident that the Department of Health was able to manage the known risks at that time and that we had put actions in place that would further highlight any emerging risks, especially in ICT.

Of greater importance, in my view, was the completion of the detailed work to establish the clinically safe sequence of services to stage the opening of FSH over subsequent months. This was not contained in the draft report prepared by Dr Russell-Weisz, dated December 2012.

It was premature, without this further work, to make a clear judgement, based only on his draft report, that a delay caused by ICT was inevitable or that other alternative approaches could not ensure that the Hospital would open within the staged opening proposed.

Rather than table Dr Russell-Weisz's draft report of December 2012 with the newly formed FSH Taskforce, I briefed the Taskforce with the overall status of the Fiona Stanley Hospital Commissioning in its entirety as at 6 February 2013.

This briefing included work conducted subsequent to Dr Russell-Weisz's report. This was a full and frank assessment of the status of the project from my perspective as the Director General. The Taskforce was also provided further specific briefings over subsequent weeks to fully understand the status of the project.

My briefing to the Taskforce on 6 February 2013 advised that because of patient safety issues (not ICT) the FSH would not accept acute patients until July/August 2014. In fact a clear schedule for the opening of services was provided to the Taskforce at this time. (Appendix 1)

This satisfied my obligation to fully inform the Taskforce of the status of the project and included advice on the process the Department was following in respect to readiness of ICT, further testing was being conducted at this time to determine if a delay from ICT readiness was inevitable or could be mitigated, this was not expected to be completed until the end of March 2013.

Based on my assessment of the project at the time my advice to the Minister for Health at our regular discussions was that while there were major risks to the commissioning of the FSH, especially ICT, I remained of the view that these risks were identified and could be mitigated by the Department and its central agency colleagues.

I was fully conversant with my obligations and responsibilities to the Minister for Health at this time, which I believe I properly fulfilled. I would also like to draw the Committee's attention to the fact that the relationship with the Minister for Health and Government changed on 6 February 2013 with the introduction of the Caretaker Conventions (Premiers Circular 2013/01) prior to the State Election.

- **The overall Committee view that I should have informed the Minister for Health and the Taskforce that I had endorsed a significantly de-scoped ICT solution for the hospital is factually incorrect.**

The approval for the de-scoped ICT solution was in fact given after I left the position of Director General on 15 March 2013 and was approved by the A/Director General, Dr Russell-Weisz on 18 March 2013, after the State Election and after the Caretaker Conventions had ceased.

I have attached a copy of the approval for your information (Appendix 2). While I had endorsed option 2 on 11 February 2013 in order to deliver a suitable ICT solution that allowed FSH to open within the staged and sequenced commissioning schedule, I had made that endorsement subject to further work by the Department of Health, Resource Strategy Division.

As I would expect this further work refined the financial allocation and recommended to Dr Russell-Weisz, the Acting Director General on 18 March 2013, an appropriate process for government approval. That is, submission to EERC and hence to Cabinet for their approval.



Kim Snowball
**Former Director General
WA Health**

4 April, 2014

Assertions based on my evidence

1. Agreed.
2. The description of three bases upon which I disagreed with the report are not correct. As stated in my evidence to the Committee on 4 November 2013 there were three reasons I did not support the report, these are different to those cited by the Committee. I quote from my evidence:

"I fundamentally disagreed with this view (Dr Russell-Weisz's expected delays to opening FSH) in the first draft report for several reasons:

- A conclusion had already been reached that a staged implementation of the clinical services to be delivered from FSH was needed. Meaning every service would not be in place 1 April 2014. This had already been conveyed to the FSH Taskforce, the Minister for Health and the central agencies advised and indeed included in subsequent media release. The stock-take did not reflect this fact.
 - While the opening of the hospital was some 17 months away the report gave the impression that nothing could be done to retrieve this situation other than delay the hospital. Effectively it was saying we should just do nothing but just delay the opening, not manage the risk. This did not make logical sense to me when we were satisfactorily running approximately 100 public hospitals with effective but perhaps outdated ICT.
 - The view being expressed was contradictory to the advice being routinely received from HIN."
3. Agreed.
 4. I did not report to the Minister of Health that I had received a draft report from Dr Russell Weisz because I did not agree with his report findings, not because I was satisfied with "de-scoped" ICT.

As I described to the Committee in my evidence in November 2013, I disagreed with the report findings on ICT because it did not include a staged commissioning, it gave the impression that nothing could be done to address the ICT concerns over the subsequent 17 months and it was inconsistent with other advice I had received. During January, 2013, a period when Dr Russell-Weisz was on annual leave I ensured:

- HIN completed an options paper including additional resources needed to deliver sufficient ICT to allow the staged opening of FSH, including a further process to test their readiness,
- The FSH Commissioning Team completed a schedule for the safe clinical commissioning of the Hospital.
- A draft purchasing plan completed by the Health Department effectively describing the budget settings for FSH.

This further work was the basis for my briefing to the Taskforce on 6 February 2013 on the status of FSH and my advice to the Minister that while the FSH Project contained significant

risk, this risk was being managed by the Department of Health and its central agency partners.

5. I reject the notion that at the Taskforce briefing on 6 February 2013, I simply advised that ICT and Workforce were "on target". This is simplistic and inaccurate. The summary of the briefing of the Taskforce makes clear that I informed them that the status of ICT was, "ICT is identified as a key risk but a clear plan to enable the required suite of applications to be tested and delivered in a phased approach has been prepared."

The briefing further advised in respect to workforce that "health was to undertake a system wide review and analysis of the workforce required to staff FSH as well as determine the distribution of staff needed across WA health facilities following the opening of FSH and reconfiguration of SMHS."

6. I asked Ms Angela Kelly, Acting Director Infrastructure to prepare a status report based on my briefing to the Taskforce as at 6 February 2013 as the Taskforce was the formal vehicle through which government was to be informed about the FSH Commissioning and the wider reconfiguration of major hospitals. It would not be sensible to provide a different briefing. This briefing for government was circulated to Taskforce members on 14 March 2013 for their consideration.
7. In summary, I had clear response from HJN that indeed it seemed (at that time) that ICT could be delivered to allow the opening of FSH and this would be further assessed in coming weeks. I had also been able to keep the Project moving by establishing the basic budget parameters for FSH (in draft form), a clear staged commissioning approach and the HJN options paper for ICT.

This clearly did not require a report to Government to delay the entire Project at this time.

My advice to the Minister for Health was that major risks existed in the FSH commissioning, but that at the time I left the role of Director General, these risks were being managed by the Department and its partners and that a program had been established to further examine the readiness of ICT and other components of the Project as described at the FSH Taskforce meeting.

Committee Findings

1 The findings of the committee describing three bases upon which I disagreed with the report are not correct. As stated in my evidence to the Committee on 4 November 2013 there were three reasons I did not support the report, these are different to those cited by the Committee. I quote from my evidence:

"I fundamentally disagreed with this view (Dr Russell-Weisz's expected delays to opening FSH) in the first draft report for several reasons

- A conclusion had already been reached that a staged implementation of the clinical services to be delivered from FSH was needed. Meaning every service would not be in place 1 April 2014. This had already been conveyed to the FSH Taskforce, Minister for Health and central agencies advised and indeed included in subsequent media releases. The stock-take did not reflect this fact.
- While the opening of the hospital was some 17 months away the report gave the impression that nothing could be done to retrieve this situation other than delay the hospital. Effectively it was saying we should just do nothing but just delay the opening, not manage the risk. This did not make logical sense to me when we were satisfactorily running approximately 100 public hospitals with effective but perhaps outdated ICT.
- The view being expressed was contradictory to the advice being routinely received from the Department of Health's Health Information Network (HIN)."

In addition to this correction I have also responded to each of the points in the Committee findings as follows:

- a) I accept that the delay described by Dr Russell-Weisz in his draft report related to the partial digitalised ICT solution not the fully digitalised solution.
- b) The completion of a proposed staged implementation of services at Fiona Stanley Hospital for patient safety reasons was not completed until 28 January, 2013. As a result the staged implementation of services at Fiona Stanley could not have been factored into either Dr Russell-Weisz's draft report in December, 2012 or into the HIN ICT advice in November 2012.

Dr Russell-Weisz acknowledges this in his memo to me dated 8 March 2013 and I quote, "I concur with you that since the change in governance to the FSH Project in mid November 2012 there has been progress and better understanding of the tasks that have to be completed. As you state one of these has been agreement to phase the commissioning of the hospital and we now have a macro level phasing schedule from an initial opening date."

This is important because the phasing schedule described when key clinical services would be needed and their associated ICT applications. For example as emergency department services were not to commence until September/October then the ICT applications associated with EDIS would not be required until some five (5) to six (6) months later than originally planned.

Put simply the phasing schedule should have been completed before any baseline audit was conducted against it.

Indeed the real starting point for analysing the readiness of ICT and other enabling services was the staged implementation of clinical services at Fiona Stanley Hospital and the State Rehabilitation Centre concluding with the full suite of services operating in November/December 2014 not the purported 1 April 2014 commencement date. As I presented in my evidence to the Committee this scheduled opening was not based on ICT readiness nor any other factor other than sensible timing that we were certain would ensure patient safety.

- c) On receiving Dr Russell-Weisz's report I asked HIN to provide me with a series of options that would effectively describe what resources were needed to deliver an ICT solution that would allow the Fiona Stanley Hospital to commence in accordance with the newly developed clinical commissioning schedule.

I asked them to describe these options ranging from the fully digitalised vision through to simple adoption of existing ICT already in operation in the States hospitals. The further criteria I gave them was that whatever system was proposed needed to have equal or better functionality than already in place. In essence this was a different purpose to the FSH ICT service plan.

- 2 I have never been advised of any allegation that I directed an Officer to remove advice from the ICT Options report. The subsequent information from the Committee does not include any evidence that I so directed and as agreed with the Committee I have conferred with the Health Department who also confirm that no such direction has been made.

Any change to the ICT Options report, and there were at least 4 versions, all needed to be signed off by the senior executives involved. The final version, endorsed by me, was signed off by the appropriate Officers. It should also be noted that the final approval for this paper was given by Dr Russell-Weisz, A/Director General on 18 March 2013 after I had left the role as Director General.

The committee draft findings describe the opening date as April, 2014, as explained in previous evidence this changed to a staged opening over a period of months for patient safety reasons. As a result any delay caused by ICT readiness needed to be measured against the staged opening of clinical services and not an April opening with all services available.

My endorsement of Option 2 and the need for additional funding was based on the premise that the ICT solutions for the scheduled opening could be met by HIN under that option. Based on their advice it required additional FTE and additional capital funding.

I can recall being firm with the HIN executives that I expected that HIN would work weekends, add extra staff to deliver the project if that was needed, and I wanted that fully costed so the system could consider redirecting funding to support the effort needed to provide adequate ICT for the commissioning of FSH.

3 and 4

As described in my evidence to the Committee in November 2013, whilst I endorsed option 2 of the report from HIN in February 2013 this endorsement was subject to full assessment of the work plan and cash flow across 2012/13 and 2013/14. Financial requirements were to be assessed by the Executive Director, Resource Strategy.

Once this was completed the Executive Director, Resource Strategy made a recommendation to the A/Director General, Dr Russell-Weisz on 18 March 2014 that he confirm approval of additional expenditure consistent with my endorsement of the briefing paper (ie. Option 2) and that ultimately EERC approval, hence Cabinet approval, be sought for additional capital expenditure for ICT linked to the commissioning of FSII.

Dr Russell-Weisz approved the recommendations on 18 March 2014.

As a result, I reject the assertion that I acted inappropriately by endorsing this solution without reference to the Minister or government when I had clearly endorsed it **subject** to further work and analysis. Indeed the final decision, made on 18 March 2014, on this issue was not made by me.

A copy of the relevant documentary evidence is attached at Appendix 2.

- 5 As I described in my evidence to the Committee, the document produced by Dr Russell Weisz on December 8, 2012, prior to his annual leave between 17 December 2012 and 25 January 2013, was marked "*confidential first draft not for circulation*." Its purpose was to document the status of the Fiona Stanley project from Dr Russell-Weisz perspective, 6 weeks after he was appointed as the Chief Executive FSH Commissioning. So his report to me was completed very quickly and was for the purpose of providing a baseline for his subsequent work on the project.

The report had some fundamental flaws most notably the assessment of readiness of ICT for the Commissioning was based on an April, 2014 commencement date for all services rather than a staged, sequenced commissioning of services.

The report also was taken at a point in time and gave the impression that nothing could be done to address the risk of delays in the commissioning despite it being some 17 months before the opening of the Hospital was planned.

This was inconsistent with routine regular reporting I had been receiving on the project from a variety of sources including HIN and South Metropolitan Health Service at my regular meetings with them and also from previous independent reports most notably the WA Health ICT Review, commissioned by the Department of Finance in December, 2011.

I took quick action to seek to validate the risks identified in his draft report and to seek alternative approaches that would mitigate the confirmed risks to the commissioning of the Hospital.

At the conclusion of this work a status report was prepared for the Taskforce meeting (February 6, 2013) based on my assessment of the status of the project, including my assessment of the risks described by Dr Russell-Weisz.

This report made very clear that significant risks remained in the Project, especially ICT risks and provided the members with both a summary of the actions being taken to address the risks including contingency plans in the event that services could not be delivered in a timely way.

The full staged and sequenced commissioning plan was also provided, the description of the purchasing plan and budgeting process were all provided to the Taskforce. Given the comprehensive nature of the briefing additional detailed briefings were made to Taskforce members.

It is my view that I provided a full briefing of the status of the Fiona Stanley Hospital and major metropolitan hospitals commissioning to the Taskforce, based on my assessment at that time.

I saw no reason to provide a copy of Dr Russell-Weisz's report given that so much had moved on since his draft report was provided to me. These subsequent actions were acknowledged by Dr Russell Weisz in his memo to me dated 8 March 2013.

It was premature to reach a conclusion at this time that the Commissioning of Fiona Stanley Hospital would be delayed. However, as Director General I had put in place processes that would further validate concerns, especially ICT, where the IJIN Division was continuing to test applications and determine if they could be delivered effectively. This testing could not be completed until the end of March 2013.

My advice to the Minister for Health at the time was consistent with my status report to the Taskforce, effectively, that while there were major risks to the Commissioning of the Fiona Stanley Hospital, especially ICT, I remained of the view that these risks were identified and could be mitigated by the department and its central agency partners.

I have attached a copy of my letter to Dr Russell-Weisz dated 5 March 2013 responding to his draft report in December, 2012 and his response to me dated 8 March 2013 at Appendix 3. I have assumed the Committee has a copy of the material delivered to the Task Force on 6 February 2013.


- 6 I reject the notion that at the Taskforce briefing on 6 February 2013, I simply advised that ICT and Workforce were "on target". This is simplistic and inaccurate. As I provided in my evidence to the Committee in November 2013, the summary of the briefing to the Taskforce makes clear that I informed them that the status of ICT was, "ICT is identified as a key risk but a clear plan to enable the required suite of applications to be tested and delivered in a phased approach has been prepared."

The briefing further advised in respect to workforce that "health was to undertake a system wide review and analysis of the workforce required to staff FSH as well as determine the distribution of staff needed across WA health facilities following the opening of FSH and reconfiguration of the South Metropolitan Health Service (SMHS)."

The report to the Taskforce at this time made clear the risks to the project and actions the Department was taking to address these risks.

- 7 The status report prepared by Ms Kelly was drawn from the material presented at the formal Taskforce meeting on 6 February 2013. Not subsequent briefings held with Taskforce members, which were clearly different either due to progress since the taskforce had earlier met or because individuals wished to brief based on their own views, hence the different content.

As I concluded in my statement to the Committee while it may be represented that there was a difference of opinion between myself and a subordinate, ultimately it is the Director General who makes the judgement call and I had insufficient evidence at that time to convince me that the project would be delayed. My advice to the Minister for Health was that whilst risks remained on the project and ICT was a significant risk, I was confident that these risks could be managed in the period remaining before the opening of the facility.

Service Delivery – Staging of FSH		
• Stage 1	State Rehabilitation Service	
April 2014	<i>(Date subject to full defect rectification and no associated delays, ie Licensing)</i>	
	May/June 2014	Diagnose and rectify any faults – approx 8 weeks.
• Stage 2		
July/Aug 2014	Medical & surgical (planned – low acuity level), outpatients.	
	Test all theatres and wards and step up associated support services.	
	Diagnose and rectify any faults.	
• Stage 3		
Sept/Oct 2014	Emergency department, ICU & medical and surgical (unplanned)	
• Stage 4		
Nov/Dec 2014	All other areas fully operational	
	 Government of Western Australia Department of Health	

Service Delivery – Staging of FSH

Benefit

- Test some facilities management services and the integration with clinical services with a dedicated patient cohort
- Potential reduction of risk by enabling clinical staff to become familiar with new surgical environment in actual operating mode (as opposed to scenario testing).
- HIN ICT systems (outpatient and clinical support service systems) can be tested in a non-acute setting
- Phased approach to introduction of clinical services that are dependent on other services being in place but have no other significant interrelationships (paediatrics, maternity, neonates, mental health, hyperbaric)
- Integration of HIN and Serco ICT systems can be tested
- Allows more time for planning including:
 - Redesign of clinical services to align with ABF/ABM
 - Workforce recruitment.
 - Comprehensive transition planning and scenario testing.
- Tests most aspects of the hospital in a controlled way before opening the emergency department.
- Likely reduced cost risk due to uptake of greater proportion of FM services with introduction of planned cases in Stage 2 at earlier stage (however, this needs to be balanced against cost risk as stated below).
- ED not opened in the middle of ED Surge (open beds to relieve other Hospitals).
- Junior doctor rotations and accreditation can be better planned.





Government of Western Australia
Department of Health
RESOURCE STRATEGY

RECEIVED

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18 MAR 2013

APPENDIX

DIRECTOR GENERAL'S

OFFICE

FOR APPROVAL

Internal Memorandum

TO:	Dr Russell-Weisz A/DIRECTOR GENERAL	DATE: 18 March 2013 <i>Dr J Russell-Weisz A/Director General</i>
FROM:	Wayne Salvage EXECUTIVE DIRECTOR RESOURCE STRATEGY	
SUBJECT:	FUNDING FOR ICT LINKED TO THE FIONA STANLEY HOSPITAL PROJECT	

In January advice was provided to the Director General by the A/Chief Information Officer concerning the approach to ICT delivery linked to the FSH project. The memorandum, and accompanying briefing, noted a need for additional approved expenditure in 2012/13 on core clinical and corporate systems development, enabling technologies and infrastructure. The current estimate by HIN of the additional expenditure required in 2012/13 is \$10 million, a significantly lower estimate than included in the original briefing.

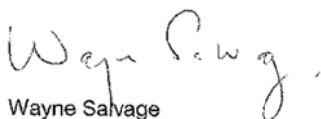
My understanding is that an estimate of additional expenditure on FSH-related ICT of \$13.5 million in 2012/13 has been advised to the FSH Commissioning Taskforce, with an undertaking by the Department of Health to fund this additional expenditure in 2012/13 without recourse to budget supplementation from Government.

The A/CIO requires certainty in relation to the additional expenditure approval in order to maintain and extend the momentum currently being built in relation to ICT developments linked to FSH commissioning.

Accordingly I recommend the following:

1. That you confirm approval of additional expenditure to a maximum of \$10 million in the remainder of 2012/13 on ICT linked to FSH commissioning and consistent with the Director General's endorsement of the briefing paper *Fiona Stanley Hospital ICT Options Discussion Paper* dated 9 January 2013;
2. That you note that Health Finance will quarantine all remaining funds in the DG's Reserve (\$7.8 million currently uncommitted, which is net of \$2.1 million being held for unbudgeted commissioning activities at FSH in 2012/13) against this additional expenditure approval, and will identify and quarantine other savings in DOH approved 2012/13 expenditure equivalent to the balance.

3. That you agree that the ICT update to the 2013/14 Budget which is currently being finalised by HIN and Health Finance:
 - a. Note the additional expenditure commitment in 2012/13, to be internally financed by the DOH.
 - b. Seek EERC's approval of additional capital expenditure in 2013/14 (to be confirmed at \$20 million) for ICT linked to the commissioning of FSH.



Wayne Salvage
**EXECUTIVE DIRECTOR
RESOURCE STRATEGY**

BRIEFING NOTE

BACKGROUND

- In November 2012, new governance and management arrangements for the commissioning of the Fiona Stanley Hospital (FSH) were introduced and an intensive stocktake of the ICT component undertaken.
- A rebaselined ICT implementation approach, which partially establishes the foundations of a digital hospital, as well as replicating some of the ICT components currently being used at an existing tertiary hospital, was recommended by the FSH ICT Commissioning Control Group (CCG).

CURRENT STATUS

- HIN has subsequently proceeded with the recommendation of the FSH ICT CCG, based on verbal approval from the Director General on the 13 December 2012, which included the assumption that additional funding would be made available and that a series of parallel activities needed to be undertaken immediately.
- The parallel activities included:
 - progressing urgent and essential major work on PACS and LIS, as well as upgrades to EDIS and iPharmacy;
 - progressing projects required (that are already funded);
 - developing an options paper that considered alternatives if any time related delays during the upgrading and/or virtualising process occurred; and
 - testing and validating the alternative/risk mitigation options.
- The attached discussion paper outlines the three options considered by the FSH ICT Commissioning Control Group and an update on the progress of the FSH ICT program.
- Within the estimated additional budget request and in order to deliver the recommended Option 2, HIN will require an additional 20 project related (level G7 to G9) Full Time Equivalents short term contract positions (up to two years), external resources and ICT service/supplier contracts.
- Following the discussion on 09 January 2013, and based on recommended Option 2, HIN will:
 - ensure individual project schedules include critical gateways, timelines and resourcing requirements;
 - develop a critical path report that includes each application and tracks issues, risks, achievements, and planned activities;
 - fully assess the options/alternatives by mid February 2013 (at the latest), ensuring that the options/alternatives proposed are cognisant of, and aligned with, the FSH Clinical Service Commissioning Schedule; and
 - identify any impacts resulting from the options/alternatives analysis that will require changes to the envisaged hospital operations/workflows, physical facility design (workstation, storage requirements, etc.); FM contract and workforce attraction.

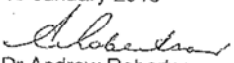
RECOMMENDATION

That the Director General:


1. notes the FSH ICT options outlined in the attached discussion paper;
2. notes the progress of Option 2, that Option 2 remains the recommended option and endorses that option;
3. approves "in principle" the creation of 20 additional project FTE short term contract positions, subject to detailed project resource plans; and
4. progresses the allocation of the estimated additional \$20 M in the 2012/2013 Financial Year (above the current \$60 M allocation) and an estimated additional \$14.4M in the 2013/2014 Financial Year (above the \$60 M forward estimate allocation) to deliver the HIN FSH ICT solution.


Prepared by: Jon Harrison
HIN FSH ICT Lead
Executive Director, Corporate & Strategic Services

Date: 10 January 2013

Sign off: 
Dr Andrew Robertson
A/CIO
Health Information Network

Sign off: Brad Sebbes
A/Chief Executive
FSH Project

Approved: ☒ — In association with options discussion paper
Version 4 issued 9/1/2013. Option 2 selected.
Not Approved: ☐ 
Noted: ☐ 11/2/13.

Comments: Copy to Wayne Selwage & Dr Wang.
Approve \$20m allocation subject to full assessment
of workplan and cash flow across 2012/13 and
2013/14. Financial requirements to be assessed by ED Resource
Strategy.  12/2/13

Signed: 
KIM SNOWBALL
DIRECTOR GENERAL

Date: 25/1/13

5429
18-Mar-13
Wayne Salvage

DOH

BN regarding funding for ICT
linked Fiona Stanley Hospital
Project (FSH), for A/DGs
approval

18/3/13 with A/DG
19/3/13 Approved and returned.

28-Mar-13
Yes



Government of Western Australia
Department of Health
Office of the Director General

MEMORANDUM

TO: Dr D Russell-Weisz
CHIEF EXECUTIVE
FIONA STANLEY HOSPITAL COMMISSIONING

FIONA STANLEY HOSPITAL COMMISSIONING

Thank you for providing me with your "confidential draft" status report (8 December 2012) on the commissioning of Fiona Stanley Hospital (FSH), and in particular your personal observations on the readiness of ICT to support the commissioning.

As you are aware, much work has been conducted since you wrote that report and went on leave. I am sure you will agree that an enormous amount of progress has been made across a number of fronts to identify and address the risks associated with this project.

While your report focused particularly on the readiness of ICT, it also needed to be focused on the commissioning schedule for FSH as the starting point. This is something that I had been asking for almost 18 months without success. I simply kept getting the response that FSH was being scheduled to open in April 2014 with four to six weeks to become fully operational, something that was clearly risky and unlikely from every perspective.

I am pleased that this has now been properly addressed with a sensible scheduling and staging program sketched out. I am sorry I had to press on this while both yourself and Ms MacLeod were overseas (and you had to respond while on leave) however I think the final product will now ensure a safe commissioning of services at FSH. While work is still required at the detailed level of each service, it is the right basis for us to then assess and deliver the associated support services and enablers such as ICT and workforce transitioning to match the commissioning schedule.

Having now described the safe staging of the commissioning of FSH we are in a good position to further assess the readiness of the associated services. I did not think it was appropriate to only focus on the readiness of ICT without a clear commissioning plan, so really this needed to go first.

While you were on leave I agreed with HIN a process and a preliminary budget to achieve and deliver all of the necessary ICT to support clinical services. This nominally assigned \$20m, subject to their provision of a workplan and detailed costing. As you know, this focussed especially on the clinical systems required to support the commissioned services.

As explained at the recent Taskforce meeting, further refinement of this plan is due to be completed by HIN on each application with the necessary critical path and decision points for the degree of digitalisation of each application determined. This now gives me clear perspective on what HIN needs to achieve and monitoring the progress HIN is making will be transparent to all parties, something that I think has been missing to date.

I share some of your concerns about the capacity for HIN to deliver across the agenda set for them. This has been made even more difficult by the attitude from Treasury not to support the expert panel's assessment of ICT funding required across WVA Health, instead simply funding ICT for FSH, Albany and WebPas. This ignores the fact that both new hospitals need ICT applications that are integrated with the rest of Health, we cannot deliver them in isolation.

I think it is timely in the next budget to seek fuller financial support from Treasury for the critical clinical systems and bearing mind that Treasury had made it clear that successful implementation of WebPas would represent a litmus test of our ability to successfully implement new systems. We have passed that test and they should be reminded of that.

I also acknowledge that there is considerable variability in the project management capability within HIN, an issue not lost on any of us when we seemed to get push-back from the project managers recently. Dates for delivery seem optional to the project managers as do constraints on the scope of projects. The meeting we had with HIN project managers recently needs to be repeated at key intervals to make sure the message is understood and they are held strictly accountable for deliverables. Having said this, I think my appointment of Mr Harrison as exclusive FSH lead gives greater attention to the project and both he and Dr Robertson have embraced the priority we have all given to the project.

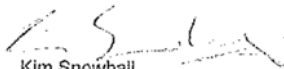
With all of the intervention we have initiated since you wrote your original status report I think we have substantially mitigated the risk, or at least have a clear direction and process to do so. The residual but not insubstantial risks remain with the integration of the commissioning with the other South Metropolitan Health Services (and the wider system), the acquisition of the required workforce in a manner coordinated with other sites and finally, but by no means least, the relationship and rescheduling requirements with Serco.

It was pleasing to note that the briefing of the established Taskforce monitoring our progress and risk management of the FSH Commissioning and reconfiguration of the major hospitals on behalf of Cabinet, clearly showed they appreciate the strengthened governance processes we now have in place and the required staging arrangements for commissioning. I think with their deeper understanding of the issues confronting the project and the manner in which it is now being managed by yourself and Ms Feely, attention and interest from a group of this calibre can only add value to its outcome.

With the benefit of hindsight the draft report you produced after six weeks in the Commissioning role reads as very alarmist. There is no question that much work has to be done but it reads as if nothing can be done to get the project back on track and to meet the as yet unspecified commissioning schedule. Clearly that is not the case.

I am pleased that this report has led to a more pragmatic approach to the design of the ICT for FSH and a range of options for clinical applications so while they may not be the fully digitalised versions that you were assessing for readiness, they will be foundational and steady progress towards digital systems, concurrent with the rest of Health.

Finally, I have asked Ms Angela Kelly, in her role as Executive Support to the FSH Taskforce, to prepare a progress report that I can submit to the Minister for Health when government is formed after 9 March 2013. This report will capture the update we provided to the Taskforce (including governance and ICT) and will be signed off before being submitted to Cabinet through the Minister. This is the process established to ensure government understands the risks inherent in the reconfiguration of hospital services in the South Metropolitan Health Service and of course the Commissioning of FSH and the actions taken to address those risks.



Kim Snowball
DIRECTOR GENERAL

5 March 2013



Mr Kim Snowball
Director General
WA Health
189 Royal Street
East Perth WA 6009

Dear Kim

FIONA STANLEY HOSPITAL (FSH) COMMISSIONING

Thank you for your memo dated 5 March 2013 in response to my "*FSH Commissioning Baseline Schedule Report*" dated 8 December 2012.

I concur with you that, since the change in governance to the FSH Project in mid November 2012, there has been progress and a better understanding of the tasks that have to be completed. As you state, one of these has been agreement to phase the commissioning of the hospital and we now have a macro level phasing schedule from an initial opening date.

In addition there has been progress on ICT following the audit done late last year of all applications required for FSH. However, I must emphasise that, whilst this sets out the requirements for commissioning, the volume of work is huge and timelines very tight. Furthermore, the change to the more realistic and pragmatic approach to ICT will lead to some Facilities Management (FM) interface challenges which are only now being uncovered. Major risks still remain within the ICT stream, particularly the PACS/RIS, LIS and the FM interface. In my view, these issues alone render the April 2014 target likely unachievable.

Workforce and Clinical Commissioning also remain risks to the project due to the magnitude of requirements for commissioning yet to be done or only partially done – each day the team is finding issues that should have been completed or signed off in 2011 or 2012. Since this report three further PMO reports have been produced showing good progress but no change to my appraisal of the challenges of timeframes and delivery dates. Indeed, one of the streams – Workforce – has now a higher risk rating than before, simply because we know more now than we did at 8 December 2012 and are aware of the considerable tasks ahead to address this stream.

Whilst I appreciate the feedback outlined in your memo of 5 March 2013, I do not agree that my report of 8 December 2012 was alarmist and, now 3 months further on, am more convinced that this was an accurate appraisal of how I found the project and the tasks required to get it on track.

Chief Executive Office
Fiona Stanley Hospital Commissioning
Fiona Stanley Hospital
102-118 Murdoch Drive, Murdoch WA 6150
PO Box 404 Bullcreek WA 6149
Telephone (08) 9237 8358
www.fionastanley.health.wa.gov.au

Delivering a Healthy WA



As discussed with you on the phone yesterday, I confirmed that I had produced an Incoming Government Brief (IGB) as requested on 27 February 2013. Although I was advised on 1 March 2013 that the IGB was no longer required, it had already been completed and a copy is attached.

In addition from your memo of 5 March 2013, I understand Angela Kelly is providing a FSH progress report for the Minister for Health (MFH) following 9 March 2013. It is my view that the IGB I have prepared should form the basis of that report to the Minister, and as discussed with you yesterday I will forward a copy to Angela.

Yours sincerely

Dr D J Russell-Weisz
Chief Executive Fiona Stanley Hospital Commissioning

8 March 2013