



Western Australian Auditor General's Report

Fiona Stanley Hospital Project

Report 5 – June 2010





**THE PRESIDENT
LEGISLATIVE COUNCIL**

**THE SPEAKER
LEGISLATIVE ASSEMBLY**

PERFORMANCE EXAMINATION – FIONA STANLEY HOSPITAL PROJECT

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance examinations are an integral part of the overall performance auditing program and seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities thereby identifying opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance parliamentary decision-making to the benefit of all Western Australians.

A handwritten signature in black ink, appearing to read 'C. Murphy'.

COLIN MURPHY
AUDITOR GENERAL
23 June 2010

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Auditor General's Overview

The Fiona Stanley Hospital is one of the biggest capital works projects ever undertaken by government in Western Australia. Once commissioned, it will be a state of the art tertiary hospital that will influence the delivery and costs of healthcare into the future. This report provides a health check on progress so far, and reviews the key risks to the hospital being ready to treat patients when it opens its doors in 2014.

Many of the lessons in this report for capital works projects echo those in previous reports. Like other projects, initial unrealistic timelines and budgets were based on a limited understanding of what the project would involve. Despite the risks and complexity in such a major project, attempts were made to fast track it. This proved both inefficient and ineffective. Mitigating the resulting risks took months of additional effort by all the agencies involved in project governance.

As a capital works project, the risks on the Fiona Stanley Hospital are now reducing. Suitable governance and project management arrangements are in place, although the Steering Committee needs to make sure its oversight of Fiona Stanley Hospital is not diluted by the new responsibilities it has taken on recently for other health capital projects. The expected award of the stage two design and construction contract should provide greater certainty on construction costs and risk allocation.

Turning the building into a working hospital requires facilities management services, key information systems and workforce needs to be carefully planned and closely coordinated with the hospital's construction. The latter two requirements in particular are emerging as serious challenges for WA Health, which if not addressed will cause delays to when the community has a fully operational hospital.

Executive Summary

Introduction

At an estimated capital cost of \$1.76 billion, the Fiona Stanley Hospital (FSH) is Western Australian Government's largest ever building project. Government announced it would build a new tertiary hospital for the southern metropolitan area in 2004 in response to the Reid Report on Health Reform. FSH is intended to meet the report's objective of delivering health care services closer to where people live. The FSH forward works began in July 2008 and construction started in March 2009 for a planned opening in May 2014. The building site is in Murdoch, adjacent to the St John of God private hospital.

WA Health will own and operate FSH, and is responsible for the overall project management and budget. Since early 2009, the Department of Treasury and Finance-Strategic Projects (DTF-SP) on behalf of the Minister for Works, has been overseeing the building of FSH for WA Health. The construction contract is managed by an integrated project team comprising public servants from WA Health, DTF-SP and consultants.

A two stage contracting model is being used to build FSH. In March 2009, Brookfield Multiplex was appointed the Managing Contractor for stage one design and construction. The stage two contract is scheduled to be awarded in August 2010, with a planned practical completion date for construction in December 2013.

In addition to the \$1.76 billion capital works project, WA Health is tendering for a Facilities Manager to provide the majority of the FSH non-clinical services. These services are expected to include facilities administration, cleaning, catering and building maintenance, as well as supplying furnishings and selected medical equipment. With an estimated value of \$2.5 billion over 20 years, this contract is also scheduled to be awarded in August 2010. The Facilities Manager and the stage two Managing Contractor will need to work together to make sure the hospital is built and ready for commissioning by December 2013 and opening by May 2014.

We examined the planning and management of the FSH project between March 2004 and April 2010. We focused on three main lines of inquiry:

- What is the current status of the FSH against original scope, cost and time estimates?
- Has the FSH project been effectively planned and managed?
- Have significant project risks been identified and are there arrangements in place to manage them?

Audit Conclusion

The estimated capital costs of the FSH stand at \$1.76 billion compared with an original estimate of \$420 million, and the opening date is between three and a half and four years later than originally planned. In common with other capital projects, the original estimates were unrealistic and were not based on a good understanding of what this major project would involve. Better definition of the requirements of the hospital has resulted in scope changes which have increased forecast costs, and delayed the opening.

The planning phase for FSH was neither efficient nor effective. Attempts to fast track project planning to meet unrealistic deadlines caused delays and risks. The project business case and other key planning documents had significant gaps which required additional time and resources to fix. Oversight was hampered by a lack of full and timely information. This delayed final project approval, and the start of subsequent phases. The additional scrutiny did, however, have the benefit of producing a more realistic scope, budget and timeline for the project which have so far proved robust. Project management and governance frameworks are defined and agreed, and the awarding of the stage two construction contract will transfer the responsibility for finalising the design and construction to the contractor and provide more certainty about project costs.

Significant risks remain on the project. While these risks have been identified, the strategies to manage them are not all well advanced. Particular attention needs to be paid to transition and workforce planning, and the delivery of key information and communication technology (ICT) systems. Without effective management of these risks FSH may be further delayed, cost more and may not deliver all the planned services to patients when it opens.

Key Findings

- Between 2004 and 2007, the capital budget for FSH grew from \$420 million to \$1.76 billion as project definition improved:
 - the capital budget for FSH has increased in stages
 - the original cost estimate for FSH was unrealistic because it was based on a minimal understanding of what services the hospital would deliver
 - significant scope and design changes have increased the size and estimated cost of the hospital.
- The \$1.76 billion capital budget covers the cost of construction and some fit-out, but not everything needed to open a working hospital.
- The \$1.76 billion capital budget has not changed since December 2007; it will be reviewed in late 2010 after the stage two construction price and the scope of the facilities management contract are known.
- The opening date for the hospital is between three and a half and four years later than originally planned. Inadequacies in planning the project delayed the start of construction, and the increases in scope extended the construction timeframes.

- WA Health's parallel planning process did not achieve its objective of fast tracking approvals:
 - WA Health's original business case was behind schedule and had information gaps; it took eight months to fix it.
 - FSH Steering Committee oversight was hampered by a lack of timely and accurate information; and this delayed approvals.
- The project has relied heavily on external project planning and management expertise but the costs of consultancy contracts have not been well managed.
- The FSH project has lacked robust financial and project management systems since it started, but these are now being put in place.
- Project governance and management arrangements are now clearly defined ahead of awarding the major construction contract.
- Further scope and design changes if approved could result in the building costing more than the 'guaranteed maximum price'.
- Failing to effectively coordinate the facilities management and the construction contracts could delay the hospital being ready on time and increase whole life costs; the State is responsible for managing this risk.
- Transition, workforce planning and ICT are major risks that have not yet been adequately addressed:
 - A transition plan for making the hospital operational is not yet in place; FSH is waiting for South Metropolitan Area Health Service (SMAHS) and WA Health to complete their plans.
 - FSH workforce planning is behind schedule, despite the need to have over 2 000 trained staff recruited and in place when the hospital opens.
 - New technology including patient administration systems (PAS) may not be ready and tested in time for the hospital opening, adversely affecting patient services.

Recommendations

- WA Health should ensure that all future health infrastructure projects conform to the Strategic Asset Management framework so that projects:
 - are supported by a robust business case that incorporates identified health needs and whole of life costs
 - have budgets and timelines that are based on sound planning and a clearly defined scope
 - are planned in a structured and orderly way to minimise risk to the State.
- The Department of Treasury and Finance should reinforce the Strategic Asset Management framework with more rigorous staged project approval processes, and only recommend funding for those projects that demonstrate realistic budgets and timelines supported by sound planning.
- WA Health and the Department of Treasury and Finance should ensure robust financial and project management systems are implemented on the FSH project and are in place for all government capital projects.
- WA Health and the Department of Treasury and Finance, once the stage two contract has been awarded, should :
 - ensure the time, construction and through life cost impact of any changes to the design or project brief are fully assessed before being approved
 - actively manage the coordination of the Facilities Manager and the stage two Managing Contractor contracts to minimise potential completion or commissioning delays.
- WA Health should progress its mitigation strategies for the remaining risks to ensure the hospital is fully operational on opening, specifically it should:
 - finalise a comprehensive transition plan and allocate a budget for this
 - complete whole of health and SMAHS workforce planning, and finalise FSH workforce planning
 - implement planned whole of health recruitment strategies
 - ensure that the PAS and other ICT systems are tested and in place before opening.

Response from the Department of Health

WA Health accepts and supports the key findings of the performance examination and is pleased to have been given the opportunity to work collaboratively with the Office of the Auditor General in the completion of this important review.

As Acting Director General of Health, I am confident that the key issues raised in this report have already been identified by the Fiona Stanley Hospital project team and that plans are in place to address each of the areas identified for attention or improvement.

The use of the 2004/05 amount of cost and time as a starting budget is flawed in my view. The announcements in 2004/05 were simply statements of intent. The time and cost information approved by the Expenditure Review Committee in September 2005 is the first approved budget and timeline for this project.

During the course of the development of the Fiona Stanley Hospital project, the project has had to manage significant environmental and political events, including the impact of the early calling of a State election in 2008 and the resultant 'caretaker' mode period, and the decision to retain Royal Perth Hospital as an operating hospital.

Response from the Department of Treasury and Finance

Overall, the findings and recommendations detailed in the Auditor General's report are fully supported by this department which as you have identified, was responsible for raising many concerns during the planning and development phase for the Fiona Stanley Hospital project.

As I have noted in respect of a recent similar performance examination, since the implementation of Works Reform in early 2009, substantial progress has been made towards addressing the concerns raised in your examination. Indeed, these very concerns were a significant driver in the development of Works Reform principles and initiatives. In light of this, I consider the change and timing in management responsibilities related to the transfer of the 'Works' function to the Department of Treasury and Finance in early 2009 under Works Reform to be fundamental to the examination.

I look forward to receiving the Auditor General's report.

The Fiona Stanley Hospital is central to delivering future health care services

FSH is more than a major building project

At an estimated capital cost of \$1.76 billion, the Fiona Stanley Hospital (FSH) project is one of the biggest building projects undertaken by the Western Australian Government. When completed, the hospital complex will cover an area equivalent to two city blocks and its main thoroughfare will be as long and wide as the Hay Street mall.

The FSH's project objectives are to:

- deliver patient-centred care
- provide clinical support to general hospitals and community based services in the health service area
- maximise the value for money of health care services by delivering sustainable, appropriate and localised health care.

The FSH project objectives reflect the recommendations of the Health Reform Committee's final report, *A Healthy Future for Western Australians, 2004* (the Reid Report). The report recommended that hospitals and health services should be reconfigured to deliver a wider range of inpatient and outpatient services closer to peoples' homes. FSH is an essential part of this hospital reconfiguration.

When completed, FSH will combine with other hospitals in the South Metropolitan Area Health Service (SMAHS) to provide a network of health care services to people living in communities south of Perth and across Western Australia. The 643 bed tertiary hospital will include: a 24-hour emergency department, the State burns centre, a cancer centre, a secure mental health unit, and medical research facilities. It will deliver a wide range of specialised medical and surgical services.

In addition to buildings that have been designed to provide efficient health care, a working hospital also requires doctors, nurses and a wide range of non-medical staff to run it. Staff require the right medical and technical equipment to treat patients, ICT that supports patient administration and medical systems, and cleaning, linen and catering services to support patient care. The building and all these elements must be in place before FSH can be opened for service.

WA Health will own and operate FSH; DTF-SP is overseeing its construction

The Director General of WA Health and the Under Treasurer are both accountable for ensuring that FSH opens on time and on budget. The Department of Treasury and Finance-Strategic Projects (DTF-SP) is in charge of FSH's construction and WA Health will own and run it.

WA Health is responsible for service delivery and is the hospital owner. It is responsible for making sure that FSH's project brief correctly reflects its service delivery requirements, and that the hospital is ready for providing services when its doors open. DTF-SP, on behalf of the Minister for Works, is responsible for delivering buildings that meet WA Health's service delivery requirements.

Since early 2009 DTF-SP has been responsible for asset delivery. Prior to that, the then Department of Housing and Works (DHW) was responsible for asset delivery, but did not play a significant role in managing this project.

Between late 2006 and early 2010, a multi-agency FSH Steering Committee provided oversight of the project, including endorsing recommendations to the former Expenditure Review Committee, now the Economic and Expenditure Reform Committee (Figure 1). In April 2009, the FSH Steering Committee became the Major Health Infrastructure Project Steering Committee, taking on oversight of a number of other major health capital projects. In March 2010, a Project Control Group (PCG) was established to deal with operational matters. The PCG is chaired by the CEO, SMAHS and includes the Executive Director DTF-SP, and the Executive Directors FSH Project and Procurement.

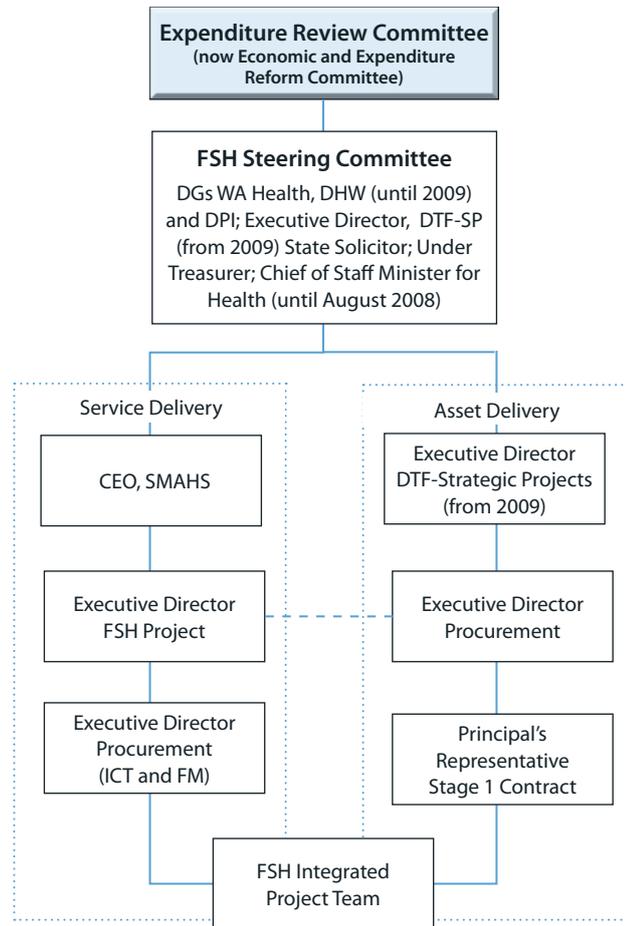


Figure 1: FSH project governance structure between late 2006 to March 2010

The FSH project's governance structure reflects the different roles of WA Health and DTF in delivering a working hospital. Since late 2006, it has been overseen by a multi-agency steering committee. Day to day, the project is managed by an integrated project team comprising public servants from WA Health and DTF-SP, as well as contracted staff.

FSH is being built using a two stage contracting strategy

The FSH project is using a two stage contracting strategy. Stage one covers early contractor involvement in developing the design and planning the hospital construction. Stage two covers finalising the detailed design and constructing the hospital. This is the first time this contracting model has been used for building construction in WA, though similar models have been used in other jurisdictions.

The stage one contract was awarded in February 2009 to Brookfield Multiplex FSH Contractor Pty Limited (the Managing Contractor). During stage one, the Managing Contractor has provided input into the hospital design, prepared project management plans, developed a construction schedule, and carried out early site works. The Managing Contractor has progressively called for subcontracts as the design has been developed. Eighty per cent of the subcontracts have been tendered and prices agreed.

At the end of stage one in June 2010, the Managing Contractor will present the State with a detailed design based on the project brief, and a 'guaranteed maximum price' for stage two. The stage two Managing Contractor will assume full responsibility for completing the hospital's design and construction to meet the detailed design, management plans, construction program and other elements of the accepted stage two offer. The stage two contract is expected to be awarded in August 2010. Government will either accept the stage one Managing Contractor's bid or return to the market to tender for stage two. This would affect project scheduling and cause delays.

The FSH facilities management contract is currently being tendered

In November 2009 the government called for expressions of interest from the private sector to provide facilities management and support services for FSH. WA Health will not know for certain the final scope of services to be provided until August 2010, when it plans to award a contract to the successful bidder.

It is planned that the Facilities Manager will be responsible for the overall operation and maintenance of FSH facilities and support services. The Facilities Manager will be responsible for providing services, such as catering, cleaning, administrative support, and the equipment to support these services. The initial term of the contract will be 10 years, with an option to extend this by two additional terms of five years. Government announced that this contract is expected to cost \$2.5 billion.

The Facilities Manager and the stage two Managing Contractor are expected to work together to make sure the hospital is built and ready for use by December 2013, so that doctors, nurses and other staff can begin preparing for its opening in May 2014.

Agencies involved in the examination

This examination involved two agencies:

- WA Health
- the Department of Treasury and Finance (DTF).

Examination focus and scope

We examined the planning and management of the FSH project including planning, development of the business case and the procurement strategy, and project management between March 2004 and April 2010. We focused on three main lines of inquiry:

- What is the current status of the FSH project against original scope, cost and time estimates?
- Has the FSH project been effectively planned and managed?
- Have significant project risks been identified and are there arrangements in place to manage them?

The Australian Government has provided \$255.7 million in funding for a 140 bed State rehabilitation service which will be located within the FSH site. The construction of the rehabilitation centre is outside the scope of this examination.

We conducted the examination in accordance with the Australian Auditing Standards.

The estimated capital cost of the Fiona Stanley Hospital is \$1.34 billion higher and the opening date is between three and a half and four years later than originally approved

Findings

- Between 2004 and 2007, the capital budget for FSH grew from \$420 million to \$1.76 billion as project costs and scope were better defined:
 - the capital budget for FSH has increased in stages
 - the original cost estimate for FSH was unrealistic because it was based on a minimal understanding of what services the hospital would deliver
 - significant scope changes have increased the area of the hospital and the estimated cost.
- The \$1.76 billion budget covers the capital cost of construction and some fit-out, but not everything needed to open a working hospital.
- The opening date for the hospital is between three and half and four years later than originally planned.

Between 2004 and 2007, the capital budget for FSH grew from \$420 million to \$1.76 billion as project costs and scope were better defined

The capital budget for FSH has increased in stages

In March 2004, the government announced plans to build a new tertiary hospital in the southern metropolitan area for \$420 million. The current FSH project capital budget approved in December 2007 is \$1.76 billion, four times the original estimate (Figure 2). This was primarily due to better definition of the project scope leading to an increase in the hospital's total area and construction costs. The capital budget has not changed since December 2007.

Government Approved Budget	Original Budget 2004-05	First Revised Budget – September 2005	Second Revised Budget – November 2006	Third Revised Budget – December 2007	Current Business Case Budget – June 2008
	(\$m)	(\$m)	(\$m)	(\$m)	(\$m)
Construction and building works	420	300	486	755	755
General site works		24	61	69	69
Car decks		9	25	50	50
Contingency		22	87	110	110
Escalation		232	211	431	431
Professional fees		55	114	186	186
Furniture, fixtures and equipment		96	107	146	146
Art		4	1	1	1
Allowances		–	–	13	13
		420	742	1 092	1 761

Figure 2: Fiona Stanley Hospital budget history from 2004 to 2007

There has been a fourfold increase to the budget between 2004 and 2007.

Source: FSH Project

The capital budget has increased in stages, as the scope and costs of the project have been better defined. The budget was revised by \$322 million in 2005 to \$742 million, by \$350 million in 2006 to \$1.092 billion, and most recently in 2007 by \$669 million to \$1.76 billion. The final project approval in June 2008 maintained the \$1.76 billion budget.

The main cost components, accounting for 90 per cent of the budget increase since 2005, are:

- estimated construction costs (increased by \$455 million)
- increased provision for escalation (increased by \$199 million)
- higher professional fees (increased by \$131 million)
- increases in the project contingency (increased by \$88 million)
- additional provision for furniture, fixtures and equipment (increased by \$50 million).

As building costs have increased, escalation, contingency and professional fees have increased proportionally. This indicates that the change in scope, as reflected in the size of the hospital, has been the main driver of increases to the FSH project budget. Each component's proportion of the total costs has remained relatively stable. Construction and building works, followed by provision for escalation have remained the major cost components for the 2006 and 2007 revised budgets.

Between 1 July 2006 and the end of April 2010, \$277 million had been spent on the project. Of this, \$193 million was for construction works and site establishment costs and \$84 million for project planning and administration. The budgeted amount for this period was \$260 million. The \$17 million variance is due to construction works being brought forward ahead of schedule, and there is no impact on the overall budget figures.

The \$193 million in construction works and site establishment costs covered:

- core hospital construction costs of \$106 million
- construction costs of \$44 million for other buildings including plant, administration, mental health, pathology and education
- precinct and site establishment costs of \$43 million.

The \$84 million in project planning and administration costs comprises:

- staffing, office running costs, travel and accommodation costs of \$14 million
- consultants fees of \$70 million.

The expenditure on consultants includes services provided by architects, designers, electrical and mechanical engineers, and quantity surveyors. Consultants also provided financial, project management and project direction services. We requested a breakdown of the \$70 million into specific consultancy activities. The current financial reporting system was not able to provide the details for \$15.5 million of these activities.

The original cost estimate for FSH was unrealistic because it was based on a minimal understanding of what services the hospital would deliver

The original budget of \$420 million set in 2004 proved unrealistic. At that stage, no analysis had been done to determine what clinical services would be delivered in the hospital and the infrastructure needed to deliver these services. The whole of WA Health clinical services analysis required to define the FSH scope and functions was not completed until September 2005, 18 months after the original budget approval. Completion of that analysis resulted in the FSH capital budget being increased by \$322 million (77 per cent) to \$742 million.

In September 2005, WA Health completed the Clinical Services Framework (CSF) and the Metropolitan Infrastructure Development Plan (MIDP). These documents set out the State's future clinical service needs and health infrastructure requirements. They also formed the basis for SMAHS clinical service planning and the development of the FSH business cases. These defined the scope and clinical service requirements for the new tertiary hospital.

Significant scope changes have increased the area of the hospital and the estimated cost

From 2005 to 2007, changes to the scope of FSH facilities and services increased the building area which in turn increased the budget. The changes covered both the clinical services to be delivered at FSH and a doubling of the number of single bed rooms. The initial area of 100 000 square metres for the hospital has increased by 44 per cent to a total area of 144 000 square metres. The hospital area has not changed since December 2007 (Figure 3).

The estimated capital cost of the Fiona Stanley Hospital is \$1.34 billion higher and the opening date is between three and a half and four years later than originally approved

Budget Dates	Scope of hospital facilities and clinical services	Budget (\$)
2004-05	<ul style="list-style-type: none"> Total area for hospital not yet determined 	420 million
September 2005	<ul style="list-style-type: none"> Total hospital area 100 000 m² Services and facilities identified: <ul style="list-style-type: none"> general acute, rehabilitation, and acute mental health inpatient facilities emergency department neonatal nursery, renal dialysis operating theatre and procedure suite facilities medical imaging, radiotherapy, pathology ambulatory, therapy and day rehabilitation facilities furniture, fixtures and equipment non clinical support facilities (kitchens, administration areas) education and research facilities 	742 million
November 2006	<ul style="list-style-type: none"> Increase in hospital total area to 116 000 m² Amended and additional services and facilities: <ul style="list-style-type: none"> increased areas for pathology, theatres, bio-medical engineering and cell tissue manufacture advanced medical imaging 	1.092 billion
December 2007	<ul style="list-style-type: none"> Increase in hospital total area to 144 000 m² Amended and additional services and facilities: <ul style="list-style-type: none"> single bed room increase from 40% to 83% of total hospital beds ecological sustainability development to improve building quality, efficiencies and energy consumption design changes to promote staff well-being in working environment extra furniture, fixtures and equipment due to increase in clinical services 	1.76 billion
April 2009	<ul style="list-style-type: none"> No increase in total hospital area Royal Perth Hospital remains open Amended and additional services and facilities: <ul style="list-style-type: none"> neonatal, obstetrics, maternal mental health unit 	1.76 billion

Figure 3: Changes to the scope of hospital facilities and clinical services between 2004 and 2009

There have been changes to the scope of hospital facilities and clinical services since the original 2004 budget. More detailed clinical service and health infrastructure planning clarified the services to be delivered and the facilities needed to deliver them. This translated to an increase in total area and a corresponding increase in budget.

Source: FSH Project and Office of the Auditor General

Changes in the mix of clinical services and related facilities between April 2007 and December 2007 have accounted for the greatest increase in hospital area (28 000 square metres). The most significant of these changes included:

- ambulatory care including allied health (12 145 square metres)
- interventional and surgery (6 670 square metres)
- inpatient units including single beds (9 760 square metres).

The number of single bed rooms was increased from 257 to 534 in 2007. This added just over 3 300 square metres to the area of the hospital and \$44.5 million in capital construction costs. The potential impact on other capital costs, such as ICT, was not addressed in the revised budget.

The decision for increasing single bed rooms followed a 2007 ministerial study trip to the United States (US), and a subsequent business case. The business case assessed the benefits in terms of meeting patient expectations and controlling hospital acquired infections. It concluded that single bed rooms would be more comfortable for patients and, based on research in the US and the United Kingdom, could help reduce infection rates. WA Health estimated that the increase in single rooms with adjoining bathrooms would mean a \$1 million a year increase in hospital running costs for additional cleaning, utilities and maintenance. It considered the impact on staff efficiency to be minimal.

The \$1.76 billion budget covers the cost of construction and some fit-out, but not everything needed to open a working hospital

The current capital budget of \$1.76 billion covers the construction of the hospital and a proportion of the furniture, fittings and equipment (FF&E). It does not cover all the costs of delivering an operational hospital. Some capital costs are outside the current project budget, specifically ICT and FF&E. Costs associated with transition to the new hospital, facilities management, workforce planning, staff recruitment and training will be part of WA Health's annual recurrent budgets, and not the FSH capital budget.

Procurement of key components of the ICT systems required for FSH are being paid from WA Health's capital budget for ICT. These include:

- administrative systems and applications i.e. Patient Administration System (PAS)
- data and networking equipment
- medical/patient use/entertainment systems
- voice communications (including handsets) for staff.

The FSH capital budget contains provision of \$146 million for FF&E. This level of funding was based on the assumption that Royal Perth Hospital would close and FF&E worth around \$27 million would be transferred from Royal Perth Hospital. The project budget includes \$350 000 for moving FF&E from Royal Perth Hospital to FSH.

The estimated capital cost of the Fiona Stanley Hospital is \$1.34 billion higher and the opening date is between three and a half and four years later than originally approved

Government has stated that it intends to keep Royal Perth Hospital open. This changes the assumption that the \$27 million worth of FF&E will be available, but the actual impact on the FF&E provision for FSH is not yet clear. It is not yet known whether a shortfall will be made up through additional capital funding or be added to the facilities management contract and funded through recurrent expenditure.

The FSH capital budget will be reviewed in late 2010 and will take into account the stage two construction price and the scope of the facilities management contract

The current capital budget (\$1.76 billion) has not changed since December 2007. During late 2010 a number of remaining cost uncertainties will be resolved. Specifically, the stage two Managing Contractor contract will be priced and awarded, and the Facilities Management contract will also be let. This will give greater certainty on the likely cost of the project. A review of the budget is planned to take these developments into account. The review will also take into account any financial impact on FSH of Royal Perth Hospital remaining open, and should identify any need to revise the current FSH budget.

The opening date for the hospital is between three and a half and four years later than originally planned

The opening of FSH has been delayed by between three and a half and four years from the original date of 2010 to the current planned opening in May 2014. The delays to the opening date reflect the delays in the construction start dates caused by:

- poor planning that held up project approval
- extended construction timeframes reflecting increased scope.

In 2004 WA Health announced FSH would open in 2010, but did not record when in 2010. WA Health's intention to plan and build a 610 bed tertiary hospital in around six years was unrealistic and was not based on a good understanding of what the project would involve.

WA Health took over a year to do the clinical and infrastructure planning needed to define the scope of services for FSH. This was completed in September 2005. As a result of the time required for this planning, WA Health extended the hospital completion date by over a year from 2010 to December 2011.

In December 2006, following further planning, WA Health deferred the completion date again by 12 months to December 2012. Achieving this new date depended, in part, on delivering an acceptable business case by December 2006 to start construction by September 2008. The final business case was not submitted until December 2007, 12 months late, and was not approved until June 2008. The delay in project planning pushed back the start of construction to March 2009.

The approved business case included changes in the scope of services to be delivered in FSH and this increased the hospital area. As a result, the estimated time to construct the hospital was increased by six months. The delays in planning and the extended construction timelines led to a revised completion date of December 2013 and the current planned opening date of May 2014 (Figure 4).

The estimated capital cost of the Fiona Stanley Hospital is \$1.34 billion higher and the opening date is between three and a half and four years later than originally approved

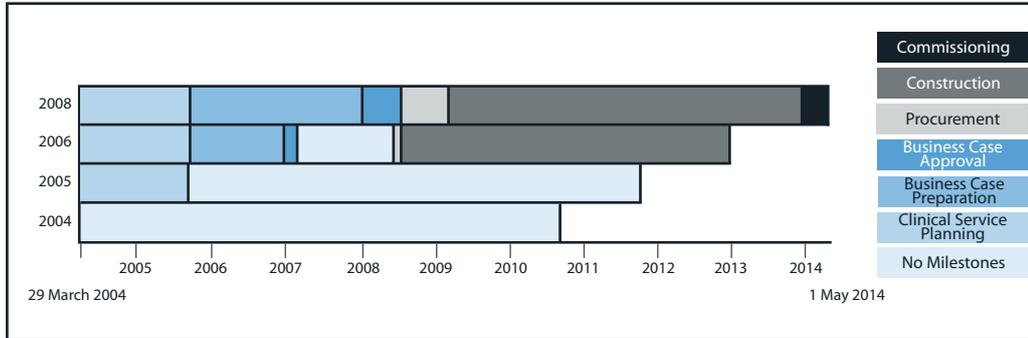


Figure 4: Original, revised and current proposed construction completion dates for FSH

The FSH project timelines were repeatedly extended during the planning stages of the project. The current proposed construction completion date has not changed since December 2007.

Source: FSH Project and Office of the Auditor General

Current WA Health reporting to the Steering Committee advises that the project is on track.

Inefficient and ineffective planning delayed project approval; inadequate financial systems do not effectively support project management

Findings

- WA Health's parallel planning process did not achieve its objective of fast-tracking approvals:
 - WA Health's original business case was behind schedule and lacked essential information; it took eight months to fix it.
 - FSH Steering Committee oversight was hampered by a lack of timely and accurate information and this delayed approvals.
- The project has relied heavily on external project planning and management expertise but the costs of consultancy contracts have not been well managed.
- The FSH project has lacked robust financial and project management systems since it started, but these are now being put in place.
- Project governance and management arrangements are now clearly defined ahead of awarding the major construction contract.

WA Health's parallel planning process did not achieve its objective of fast tracking approvals

WA Health tried to fast track normal project planning steps so that FSH construction could start in September 2008. To do so, the business case, the project definition plan and the procurement strategy were developed in parallel rather than sequentially as recommended in government's Strategic Asset Management (SAM) framework (Figure 5). Parallel planning was a high risk approach that initially produced inaccurate budgets and timelines due to an under-developed scope. This did not speed up the process as intended.

An acceptable business case which was expected in December 2006 was not completed until the end of December 2007, and was not approved by government until June 2008. The procurement strategy was separately approved in late 2007, ahead of the business case approval. Normally, this would not occur until after the business case has been approved. Earth works commenced in mid 2008 under a forward works contract, and early construction did not start until March 2009.

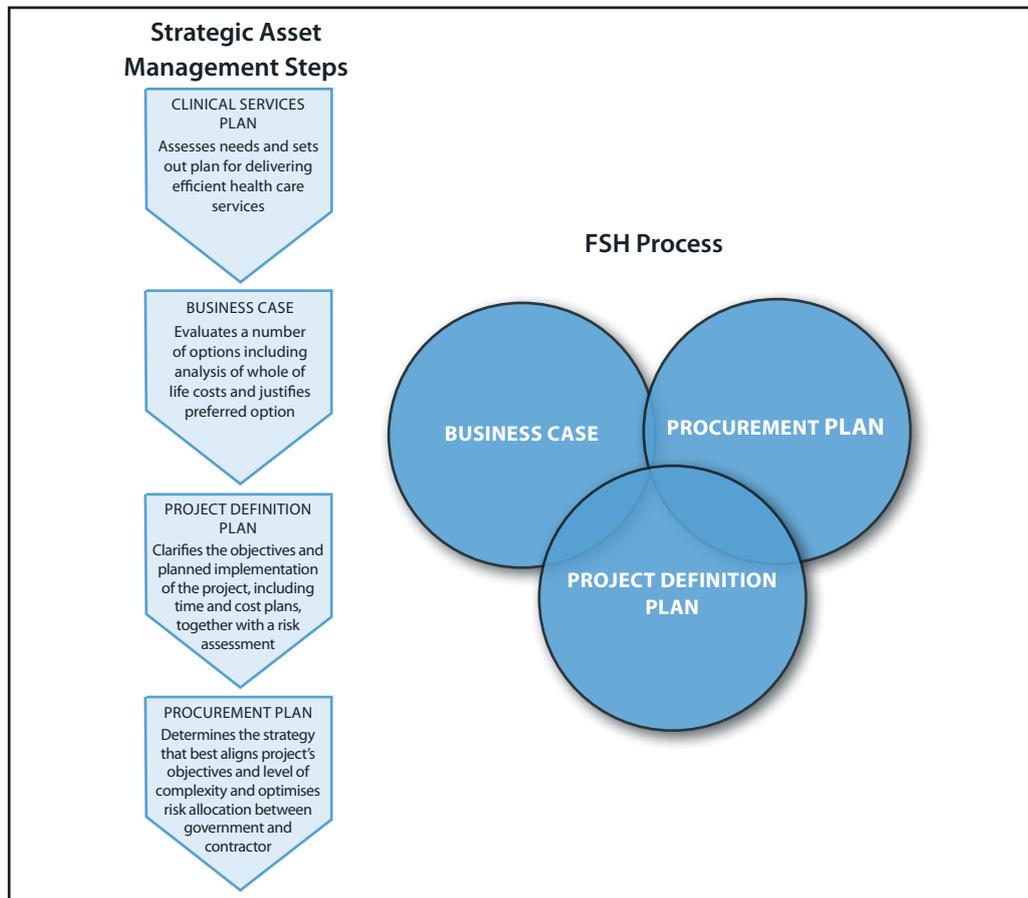


Figure 5: The SAM requirements and the FSH process

WA Health developed the SAM requirements (the business case, project definition plan and procurement plan) all at the same time, not sequentially, in order to meet announced timeframes. This approach did not work as intended.

Source: Office of the Auditor General

SAM is designed to deliver the State value for money, and to minimise risks through careful and orderly project planning. SAM has sequential steps with important check points for external review and approvals. Each step informs the next. The key steps involve development of a:

- needs assessment – to determine whether a service need exists. For WA Health, this assessment required clinical service planning.
- business case – to propose a range of building options, analyse the whole of life costs for each, and justify the preferred option
- project definition plan – to clarify what is being built, its cost and the time it will take to build, and to assess risks
- procurement strategy – given the above, to determine how best to share the construction risk between the State and the building contractor.

WA Health used a parallel planning process rather than SAM's sequential one so that FSH construction could start in 2008 and be completed by December 2012. Although it realised that this approach presented risks, WA Health informed the Minister and DTF that this was the best option for expediting the project to meet agreed dates. WA Health did not highlight the risk that the process could potentially deliver an inaccurate estimate of scope, cost and time. Nor is it clear from the available records that it received formal approval to proceed.

The parallel planning process delivered an unacceptable business case that if approved would have allowed the project to go to market with a substantially underestimated scope and budget. The FSH Steering Committee did not consider the business case to be sufficiently developed to go forward for government approval.

WA Health's original business case was behind schedule and lacked essential information; it took eight months to fix it

WA Health started work on the business case in September 2005 and it was scheduled for completion in December 2006. It was not submitted to the FSH Steering Committee until April 2007. The Steering Committee did not endorse the original business case as there were a number of significant information gaps. It took a further eight months, until December 2007, and concerted effort by WA Health and DTF before an acceptable business case was completed.

At that time, DTF's role in SAM was to review and evaluate business cases and make recommendations to Government about their reasonableness. DTF recommended to the Steering Committee that WA Health needed to do further work on the April 2007 FSH Business Case. This was because:

- the cost estimates were not considered robust and lacked detail
- there was no project risk assessment or mitigation strategies
- the recurrent costs of the hospital and its staffing requirements were not defined.

Using the parallel planning process, WA Health submitted the project definition plan as part of the business case. Under normal process the project definition plan follows the business case and defines the preferred option that has already been approved. The FSH project definition plan assumed the recommended option in the business case would be approved.

The business case and project definition plan was not well developed and presented an underestimated budget of \$1.092 billion. WA Health took a further eight months to resolve the information gaps in the business case, complete detailed planning and present a revised cost estimate of \$1.76 billion. This required significant input from DTF and other agencies, well beyond the normal levels of engagement. The revised business case, including the project definition plan, was submitted to DTF for review on 31 December 2007, and was approved by government in June 2008.

The outcome of the additional time and effort was a more detailed project scope, a revised and significantly increased, but more realistic project budget, and a longer delivery timeframe. This provided government with greater certainty before inviting tenders for early contractor involvement. It also reduced the risk of potential scope changes later in the process, when changes are likely to cost more and lead to unplanned construction delays.

FSH Steering Committee oversight was hampered by a lack of timely and accurate information and this delayed approvals

A lack of timely and accurate information hampered the Steering Committee's capacity to provide effective oversight. The Steering Committee's role is to provide independent oversight and advice to government. Fulfilling this role requires clear and transparent approval processes and the provision of adequate information. Using the parallel planning approach, WA Health requested the committee's endorsement of some approvals before complete information was available for the committee to make decisions. It also submitted documents to the Steering Committee for endorsement without giving sufficient time for review.

In September 2007, the Steering Committee held up the approval of the business case and the procurement process for several months. The Steering Committee expressed concern about the project's approval process over the preceding nine months. It requested better processes, and adequate time to review submissions before endorsing them for government approval. Throughout 2007, WA Health did not provide information to the Steering Committee when requested or by the agreed time. Despite the Steering Committee's concerns, WA Health continued trying to fast track the FSH project.

WA Health proposed saving time by involving the Managing Contractor early in the design process. It asked for Steering Committee endorsement to start a procurement process for appointing a Managing Contractor in September 2007. However, at this stage, WA Health had not yet submitted an acceptable business case or project definition plan, and the accuracy of project cost and time estimates were still in doubt. The Steering Committee halted the approval process for both the business case and the start of the procurement process. Neither were approved for several months.

The project has relied heavily on external project planning and management expertise but the costs of consultancy contracts have not been well managed

The FSH project has relied on consultants to provide much of the required expertise. WA Health have poorly supervised and managed the work of the consultants and consultancy contracts have cost significantly more than agreed.

When the FSH project started, neither WA Health nor the former Department of Housing and Works had the skills or capacity to manage a large and complex building program such as the FSH project. WA Health appointed consultants to produce the business case and provide project direction for the FSH project. The contract for the development of the business case cost three times more than initially budgeted, and the business case that was delivered had significant gaps. WA Health engaged the same consultants to provide project direction services. The maximum value of the project direction contract has already been spent nearly three years into the eight year contract.

In 2005, the SMAHS tendered for consultants to produce a business case and provide associated coordination services. There was one respondent to the tender. The contract was awarded in September 2005 for \$824 645 with a maximum 450 consulting days. The cap on the fee and the number of consulting days was determined by WA Health.

This contract was extended to \$1.65 million in July 2006 with an end date in January 2007. The contract was further extended by \$1 million to \$2.65 million with a new end date of 30 April 2007.

In June 2007, WA Health awarded a contract for the provision of project direction services for the FSH development. The contract was awarded for a maximum of \$13 million and 7 800 working days over an eight year period, the duration of the FSH project. By April 2010, nearly three years into the contract, the maximum \$13 million had been spent. In part, this was due to WA Health requesting the consultants to do additional work outside the scope of the original contract without seeking to vary the contract. The only variation to this contract has extended the consultant services for another six months until a new contract for services can be developed, tendered and awarded. The variation to the contract is expected to run out by June.

Consultants on the contract have been working additional hours without prior approval from the FSH team, and invoicing for their time. As late as December 2009, the process for consultants seeking approval before working additional hours was not being followed. It appears that consultants were paid nevertheless. The FSH team are applying the approval process more rigorously.

The FSH project has lacked robust financial and project management systems since it started, but they are being put in place

Over \$200 million had been spent on the FSH project to the end of April 2010 without robust systems and processes for project accounting including financial forecasting to completion, and reporting. The absence of these systems impacts WA Health's ability to monitor project progress and track expenditure. For example the current system does not enable the FSH Project team to track what has been spent on individual consultancy contracts.

Since early 2008, three reviews have identified the lack of a comprehensive financial project reporting system as a significant risk to the project. No formal project management methodology or software was put in place when the FSH project commenced and is still not fully in place. A proprietary project accounting system is scheduled to be fully implemented by 1 July 2010. The existing system will continue to be used in the interim.

For major projects like FSH, good practice is to use an accounting system that can produce accurate and detailed reconciliation of actual expenditure and commitments against planned expenditure. The existing FSH financial systems do not allow for commitments to be allocated across the cost centres associated with the project's work breakdown structure. So tracking expenditure against activities is problematic. This reduces the FSH Project team's capacity to know if the project is on track or to spot problems as they develop and to provide accurate and timely advice to the Steering Committee. Financial commitments are managed manually in Excel, which is both time consuming and subject to error.

The Managing Contractor must provide detailed cost reporting monthly for costs associated with the construction of the hospital. However, this does not reduce the FSH project team's obligation to ensure that project costs are accurate and systems are in place at a whole of project level. WA Health and DTF-SP are in the process of installing more robust and reliable systems.

Project governance and management arrangements are now clearly defined ahead of awarding the major construction contract

The next significant event on the FSH project will be the awarding of the stage two contract. This will place most of the remaining risk for the construction phase with the Managing Contractor, and provide greater financial certainty through an agreed 'guaranteed maximum price'. The Managing Contractor will be responsible for finalising the design.

Clear arrangements for the project governance framework have recently been established. They include appropriate agency representation and agreed terms of reference. These arrangements are a development of previous governance arrangements reflecting the progress of the project. Under the new arrangements, the Steering Committee's responsibilities have been expanded to include seven other major health capital projects. An FSH Project Control Group (PCG) now reports to the Steering Committee and is responsible for most project decisions. The effectiveness of these changes to the governance arrangements will become clearer as the project progresses.

The FSH Project team have assessed the level of resources in the project structure it will need to manage the stage two contract. There will be an FSH project team member mirroring each of the stage two Managing Contractor's lead staff. This reduces the likelihood that the State's contract management will be under resourced. Many of the FSH team will be public servants, and some contract staff will be needed.

Significant risks remain to the hospital opening on time, budget and being fully operational, but not all mitigation strategies are well advanced

Findings

- Further scope and design changes if approved could result in the building costing more than the 'guaranteed maximum price'.
- The risk of failing to effectively coordinate the Facilities Manager and Managing Contractor rests with the State.
- Transition, workforce planning and ICT are major risks that have not yet been adequately addressed:
 - a transition plan is not yet in place; FSH is waiting for SMAHS and WA Health to complete their plans
 - FSH workforce planning is behind schedule, despite the need to have over 2 000 staff recruited and in place when the hospital opens
 - new technology including patient administration systems may not be ready and tested in time for the hospital opening.

Further scope and design changes if approved could result in the building costing more than the 'guaranteed maximum price'

Any changes to the agreed design of the hospital could result in a variation to the contract and an increase in costs above the 'guaranteed maximum price'. It is realistic to expect that a project of this size and complexity will have further design changes.

To manage this risk, the impact of any proposed design changes on cost, timeframes, whole of life costs and the effective operation of the hospital, need to be evaluated. The FSH Project team used a sound process during stage one to evaluate the impact of design change requests, and this process should continue to be rigorously applied. At March 2010, there were \$7.4 million in approved variations and an additional \$5.8 million awaiting approval. Approved variations and some of the variations awaiting approval will be included in the 'guaranteed maximum price'. Further variations, if subsequently approved, will be an additional cost. The FSH project budget includes provision for variations.

Further design changes are likely to come from two sources: through ongoing consultation with users or input from the Facilities Manager.

Stakeholders were consulted during design development in stage one and consultation will continue throughout stage two. If requested, WA Health will assess the necessity, cost and implications of any suggested design changes. If accepted, these changes become variations to the Managing Contractor contract and will be additional to the 'guaranteed maximum price'.

Other variations to the design may come from the Facilities Manager. The Facilities Manager will be engaged around the same time as the stage two Managing Contractor. The Facilities Manager will be required to provide services within the constraints of the current hospital design. The timing of the decision to contract out facilities management did not allow for the involvement of the Facilities Manager in the stage one design. Had the Facilities Manager been involved in the earlier design stage it may have been possible to incorporate preferred service delivery methods, and allowed for innovation in the hospital design at relatively low cost. This may have delivered cost savings over the life of the Facilities Management contract.

It has yet to be decided exactly how the Facilities Manager's services will be provided, and whether these will be constrained by the hospital's design. The draft Facilities Management contract contains provisions for the Facilities Manager to initiate design changes in order to improve efficiencies. Any design changes arising from the Facilities Manager contractor's requirements will need to be assessed using the existing design variation process, as well as considering the cost impact over the life of the facilities management contract.

The risk of failing to effectively coordinate the Facilities Manager and Managing Contractor rests with the State

The failure to coordinate the Facilities Manager and Managing Contractor contracts could delay the hospital being ready on time and increase whole of life costs. The responsibility for managing this risk rests with the State.

Provisions in both contracts require the contractors to cooperate. The Facilities Manager must align with the Managing Contractor's program. Under the procurement strategy the State is principal to both the construction and facilities management contracts. Therefore, the State retains the risk of making sure the two contractors schedule their work program so the hospital opens on time and runs effectively. This is a key risk that the FSH Project team, PCG and Steering Committee will need to monitor closely.

The Managing Contractor procurement strategy being used for FSH allocates more risk to the contractor than would a traditional construct only contract. Procurement strategies for similar facilities in other jurisdictions have involved contracts with a single entity for both construction and facilities management, often under a Public Private Partnership (PPP). This type of strategy places the coordination risk entirely with the contractor. For FSH, the State has effectively broken a PPP into its component parts and taken on the risk of coordinating these activities. While this should have reduced the risk premium in the contract prices, realising this benefit will rely on the State managing the retained risk effectively.

Transition, workforce planning and ICT are major risks that have not yet been adequately addressed

A transition plan is not yet in place; FSH is waiting for SMAHS and WA Health to complete their plans

WA Health does not yet have a comprehensive transition plan for FSH, or a budget for the cost of transition. A draft transition plan exists, but it does not include all the elements required and needs reviewing and updating.

Transition planning is critical to making the hospital operational. It includes: commissioning the hospital, coordinating the facilities management services with clinical services, and the timely attraction, engagement and training of staff. These are yet to be planned and finalised. A comprehensive FSH transition management plan is needed for this to happen in an efficient and effective manner.

WA Health needs to determine the cost of transitioning services to FSH. These costs should be considered against each item in the transition plan. Work on this has commenced, but WA Health has not yet estimated the cost for transitioning FSH into operation.

To date, only limited transition funding has been identified and budgeted – \$350 000 in the capital budget. This amount was to include moving furniture and equipment from Royal Perth Hospital, a provision that was made on the assumption that Royal Perth Hospital would close. However, the government has announced that Royal Perth Hospital will remain open. WA Health therefore needs to consider how this will impact on the FSH transition, including the budget requirements.

FSH workforce planning is behind schedule, despite the need to have over 2 000 staff recruited and in place when the hospital opens

Workforce planning is a key risk. WA Health have not yet defined the exact number of staff that will be required, but estimate that approximately 2 000 medical, nursing and allied health professionals are needed to staff the hospital from 2014.

Meeting this staffing requirement will be a significant challenge. There is a limited pool of trained health care professionals available in WA. A delay in workforce planning may result in FSH not having sufficient staff in time for opening. Alternatively, it may lead to staff being 'poached' from secondary hospitals creating shortages elsewhere in the health care system.

FSH workforce planning is still in the early stages. As with transition planning, FSH is dependent on SMAHS, which is in turn dependent on WA Health to provide workforce modelling to complete its workforce planning. The workforce modelling was due in December 2009, but is not yet ready. SMAHS have been aware of this risk since 2006.

The risk of not having enough staff at FSH will be affected by government's decision to keep Royal Perth Hospital open. The FSH business case assumed the majority of staff would come from Royal Perth Hospital when it closed. Closing Royal Perth Hospital would have released over 1 700 medical, nursing and allied health professionals. WA Health's latest plans assume that Royal Perth Hospital will stay open with 400 beds.

WA Health considers staff will be attracted to working at FSH because of its:

- proximity to where staff live
- availability of increased training and up-skilling for health care workers
- offer of a new and innovative workplace with unique opportunities.

WA Health has some strategies in place, or being developed, to overcome staffing shortfalls. It has a nursing recruitment office in the United Kingdom, and is exploring the potential for employing Assistants in Nursing who would perform basic nursing tasks under the supervision of a Registered Nurse. This could reduce the total number of nurses needed. WA Health are also working with Curtin University of Technology to open a second School of Medicine in the State. However, even if successful, it will be at least 2016 before the first cohort of graduate doctors is available.

An important part of workforce transitioning requires each department or clinical service in the hospital to have a workforce structure and an operational service plan in place to direct how the service will be delivered before transitioning begins. Traditionally, heads of clinical departments are appointed to develop the operational service plan, resource requirements and to assist with recruitment. SMAHS has postponed appointing department heads and is proposing to use departmental Reference Groups instead for the initial transition planning. Department heads are planned to be appointed in early 2011. SMAHS will need to allow sufficient lead time for recruitment and appointment of department heads, so as to ensure a smooth transition to opening.

New technology including patient administration systems may not be ready and tested in time for the hospital opening

There is a significant risk that the patient administration system (PAS), being delivered by WA Health, will not be ready for the opening of FSH. The PAS holds patients' personal and medical information and makes this information readily accessible to hospital staff. If PAS is not in place then reliable key information may not be available or timely, which could impact on both the efficiency and safety of patient care. WA Health is not on schedule to deliver the PAS or FSH's paperless records system. As late as April 2010, WA Health had not appointed a project team or allocated funding for the FSH project.

The vision for FSH is that it will be a 'paperless' hospital. All clinical and non clinical services will be supported by ICT systems. Forms (including patient admission forms and charts) and patient records will be viewed electronically. All non clinical services will also be automated through ICT systems. For example, patients will order their meals using a touch screen at the bedside.

The FSH business case includes a demarcation document which explains which parts of the hospital's ICT are included in the capital budget and which parts are to be provided and paid for by WA Health. One of the responsibilities of WA Health is to deliver the new PAS, which is currently in the design process. This process is behind schedule, having been planned for rollout and piloting in November 2010. To date only a portion of the licences required for the new software have been purchased. If the delays continue there is a risk of FSH being the first test site for the new system. This could result in the system not being fully operational on opening.

The FSH team has a contingency strategy to use the facilities management contract to procure some of the ICT if WA Health cannot deliver on time. This could result in an overall increase in the cost of ICT for FSH as interim solutions are funded under the FSH facilities management contract, while development of the final systems continues to be funded through WA Health.

Auditor General's Report

REPORT NUMBER	2010 REPORTS	DATE TABLED
4	Audit Results Report: Annual Assurance Audits completed since 2 November 2009, including universities and public colleges; and Compliance Audits: Managing attractive assets; Managing salary payment errors	5 May 2010
3	Public Sector Performance Report 2010 – Opinions on three 'Ministerial Notifications' – ministerial decisions to not provide information to Parliament – Registration of Medical Practitioners	5 May 2010
2	Information Systems Audit Report	24 March 2010
1	The Planning and Management of Perth Arena	10 March 2010

	2009 REPORTS	
13	Audit Results Report: 2008-09 Assurance Audits	11 November 2009
12	Fourth Public Sector Performance Report 2009 – Preliminary Examination of the Royalties for Regions Program – Accountability for Government Grants – Management of Government Purchasing Cards	11 November 2009
11	Third Public Sector Performance Report 2009 – Regulation of Firearms – Follow-up – Managing Staff Attendance in the Public Sector – Evaluation in Government	21 October 2009
10	Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services	14 October 2009
9	Every Day Counts: Managing Student Attendance in Western Australian Public Schools	19 August 2009
8	Opinion on Ministerial Notification: Ministerial Decision to not Provide Information to Parliament – Country Age Pension Fuel Card	19 August 2009
7	Second Public Sector Performance Report – Dangerous Goods Safety – Compliance in Western Australia's Commercial and Recreational Fisheries	25 June 2009
6	Maintaining the State Road Network	17 June 2009
5	Rich and Rare: Conservation of Threatened Species	10 June 2009
4	Coming, Ready or Not: Preparing for Large-scale Emergencies	20 May 2009
3	Audit Results Report – 31 December 2008 Assurance Audits and other audits completed since 3 November 2008	6 May 2009
2	Information Systems Audit Report	8 April 2009
1	Public Sector Performance Report 2009 – Management of Water Resources in Western Australia – Follow-up – Administration of the Metropolitan Region Scheme by the Department for Planning and Infrastructure – Management of Fringe Benefits Tax	1 April 2009

The above reports can be accessed on the Office of the Auditor General's website at www.audit.wa.gov.au

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