Western Australian Auditor General’s Report

Non-Clinical Services at Fiona Stanley Hospital
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NON-CLINICAL SERVICES AT FIONA STANLEY HOSPITAL

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

Performance audits are an integral part of the overall audit program. They seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

This audit assessed how effectively South Metropolitan Health Service (SMHS) is managing the non-clinical services contract at Fiona Stanley Hospital.

I wish to acknowledge the staff at SMHS and Serco Australia Pty Ltd involved in this audit.

COLIN MURPHY
AUDITOR GENERAL
16 August 2017
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Auditor General’s overview

Fiona Stanley Hospital was the first large new public hospital constructed in many years, providing opportunities for new approaches to facilities and their management. There has been ongoing public, media and parliamentary interest in the hospital, some focused on the delivery of non-clinical services under a facilities management contract. Non-clinical services are key to safe and efficient patient care and the successful operation of the hospital, and the contract represents a significant commitment by the State that could last for 20 years and will cost billions of dollars.

My report is not about the decision to use a facilities manager, or the process to select one. It is about whether the services the hospital needs are being delivered, what they are costing, and whether the contract is being managed effectively. I have looked at these issues after less than three years of operation because it is important to make sure that lessons are learned early, improvements identified, and that the State is positioned to get best value for money from the contract.

A key message from my report is for South Metropolitan Health Service (SMHS) to take a long term view. Having up to date estimates of total contract costs, and using the extensive data and reporting provided under the contract to identify service improvements and efficiencies, would be key parts of that. SMHS and the facilities manager working together to reduce the reporting burden, and finding ways to resolve contract disputes more quickly and efficiently, would also provide benefits across the term of the contract.

Fiona Stanley Hospital has seen patient numbers increase much faster than forecast since it opened, putting pressure on both clinical and non-clinical services. Both SMHS and the facilities manager have learned a lot about how the hospital operates and about how best to deliver services. My recommendations seek to help them to keep identifying improvements and efficiencies while supporting safe and efficient patient care.
Executive summary

Introduction

Fiona Stanley Hospital (FSH) is the largest hospital in WA, offering health care services to southern Perth suburbs and regional communities across the State. The hospital opened in October 2014. For the first time in WA, government decided to contract a private facilities management company to deliver all non-clinical services.

In November 2015, the Education and Health Standing Committee wrote to the Auditor General asking that he consider an audit of the company’s self-reporting of its performance against its contractual obligations and the level of scrutiny given to that reporting by WA Health.

Our audit has assessed whether delivery of the required non-clinical services was at the cost expected and if the contract is effectively monitored and enforced by the South Metropolitan Health Service (SMHS). The audit’s timing provides an early assessment of the contract and the non-clinical service provision so that lessons can be learned in what may be a 20 year, multi-billion dollar contract.

Background

FSH is a 783 bed public hospital. It includes a 140 bed State Rehabilitation Service, a 30 bed purpose built mental health unit and the State Burns Service.

The Government decided in 2009 to contract-out non-clinical services for FSH to a facilities manager (FM). While outsourcing of services occurs in other WA hospitals, the outsourcing of non-clinical services has not been done on this scale before.

The Minister for Health and Serco Australia Pty Ltd, the FM, signed the non-clinical services contract in July 2011. At approval the contract included 27 ongoing operational services, of which 2 did not proceed and were removed from the contract. A further service was taken off the FM and replaced with a support service resulting in 25 services being delivered by the FM. Elements of the 3 services that were removed from scope are now being delivered by SMHS (Figure 1). Appendix 1 describes each service.
Figure 1: Non-clinical services delivered by the facilities manager and South Metropolitan Health Service

SMHS is responsible for managing the contract, including monitoring the self-reporting by the FM against about 1,000 reporting obligations, including more than 480 key performance indicators (KPIs). If the FM does not meet required performance levels, failure points accrue. Financial deductions (in the form of payment abatements) are imposed as the number of failure points accumulate.

The initial contract term is 10 years, with two 5-year extension options. In July 2011, the approved contract had an estimated contract value of $4.3 billion over 20 years. This included:

- $3.7 billion to the FM for planning and delivering non-clinical services at FSH
- $577 million for hospital equipment provided through a finance lease arrangement.

From August 2011 to 30 June 2017, SMHS spent about $630 million on FM non-clinical services (see Appendix 2) and $212 million on finance lease payments for hospital equipment. Total payments for hospital equipment are now expected to be about $467 million.

In December 2013, the Government delayed the hospital’s opening date from April 2014 to October 2014. The contract was amended to ‘delay and phase’ the opening of the hospital – replacing a transitional period where the FM would take over the site and plan for the hospital to be ready. Delivery of key non-clinical services commenced from practical completion of FSH in December 2013 and full delivery of all non-clinical services was in place from hospital opening on 4 October 2014. SMHS paid $52 million less than the original contract forecast of $192 million, because the delay in opening the hospital reduced the period of full non-clinical services. A timeline of contract events is shown at Appendix 3.
Audit conclusion

Overall, non-clinical service delivery at FSH has met contractual requirements, and SMHS has the resources and processes in place to manage the contract. However, SMHS is not tracking overall cost performance effectively. SMHS is not tracking overall cost against the original base estimate, and needs to monitor against an agreed baseline as FM services are costing more than originally estimated. Actual costs over the last 2 years were $24.6 million higher than base estimates when the contract was approved in 2011, and patient numbers have grown faster than planned, increasing service demand and costs.

Current contract disputes are estimated at between $6 and $7 million and differences of interpretation could add significant costs to the contract. Resolving these disputes is proving to be a lengthy process. Although service delivery has not yet been affected, the longer the disputes are, the greater the risk to service continuity. While adhering to the contract, SMHS and the FM need to find more efficient ways to resolve the disputes.

The extensive reporting under the contract is absorbing a lot of SMHS and FM resources, but has not always reliably captured performance. SMHS effort has mainly sought to ensure compliance with reporting requirements and contract specifications, but this balance of effort needs to shift to using the information to identify service improvements and efficiencies. As part of this, SMHS and the FM should look to reduce the reporting overhead on services which are relatively low cost, predictable and which have less direct impact on the delivery of patient care.

Key findings

The costs of contracted non-clinical services are higher than estimates at approval

After 2 years of full operations (2015-16 and 2016-17) non-clinical services cost $331 million, about $24.6 million more than initial base estimates approved in 2011. This was mainly because initial estimates did not include final prices for 4 services, separate one-off payments for estates and ICT, contract variations, and payments for services delivered in earlier years. Several variable service payments were also higher due to underestimated volumes. Annual forecasts made at the start of each of the 2 financial years have been more accurate with actual costs being $1.6 million above the annual service plan estimates.

Estimates of patient numbers suggest that service volumes will be higher than anticipated

The number of patients coming into the hospital directly influences the cost of some services (for example patient catering and linen) provided under the contract. Original estimates of the contract price made assumptions, such as patient separations (number of patients admitted and discharged). Patient separations were forecast to rise steadily to peak at 66,949 in year 10 of the contract (2020-21). After the end of 2015-16, they were already 22% higher than this forecast and projected to grow in 2016-17 and 2017-18. This will possibly increase the costs of the contract because more of the contract term will have high patient numbers.

SMHS is not tracking total cost performance and does not have a current estimate of what the contract is likely to cost overall

Initial estimates of the full cost of the contract had significant gaps as elements of the contract were not costed and the services included have changed considerably. SMHS has not revised the total contract cost estimate since non-clinical services started, nor is it tracking performance in a way that informs how it may need to adjust services to manage total costs. After 2 years of full operations it has much better information on how the hospital is being used, and how FM services are working which could be used to comprehensively revise the initial estimate.
SMHS track actual costs against the annual service plan. The plan includes fixed costs, and variable costs based on unit prices for services and expected service volumes. SMHS monitors individual unit costs for services to see if they vary against the contract. This annual pricing and monitoring mechanism does not enable SMHS to track long-term cost performance. It could also mask the impact of apparently small annual cost increases.

**Overall, the standard of non-clinical service delivery is acceptable and the contract is adequately managed**

The FM is generally delivering non-clinical services to the required standard with 91% of the 500,000 FM reported KPI events passed in 2016-17. There has been little disruption to non-clinical services.

SMHS has adequate contract management resources and processes to oversee compliance with reporting requirements, and identify most performance issues. SMHS has applied the characteristics of good contract management identified in the Auditor General’s report on WA Health ICT procurement in 2016. Contract management staff do monthly compliance checks, review contract reporting and data, inspect and audit service delivery. Progress made by the FM to complete corrective actions from audits are monitored.

Contract managers have identified concerns about planning, resourcing and contract reporting for 3 services (management and integration, managed equipment and estates). We looked at management and integration, and estates in the audit. These 2 services have had improvement plans monitored by SMHS since early 2016. The FM has completed most improvement actions although some are taking longer than expected.

SMHS responded to higher than expected final prices by removing some services from the contract. The original contract included health records and clinical coding, and scheduling and billing services. SMHS rejected the final prices offered by the FM and now provides similar services in-house. It is not possible to compare the price that would have been paid to the FM with in-house costs because full in-house costs are not captured and the specification for in-house delivery is different.

SMHS responded effectively to performance issues in the sterilisation service. SMHS removed this service from the contract in May 2015 and now runs it in-house. Again, comparing costs and performance is not possible because the service now delivered by SMHS does not match the specification contemplated under the original contract. Both parties are still in negotiations about recovering their costs from removing the sterilisation service.

**Reporting has not always reliably captured performance**

The FM is required to report against KPIs and other measures across all the service lines in the contract. Reliable and accurate reporting is key to SMHS using contractual provisions effectively. SMHS has identified issues, and we also identified issues regarding the reliability of FM self-reporting across some services. Since mid-2015, contract managers have found instances where:

- contractual reports on KPI failures have not matched the raw performance data
- KPI failure points have been incorrectly calculated.
We also found gaps in reporting:

- poor performance in the sterilisation service was not identified through KPI reports, and its subsequent removal from the contract was triggered by clinician complaints
- data entry error rates of 26% for cleaning services
- only 5% of ‘cleans’ being entered into the KPI reporting database.

Both SMHS and the FM are working to improve reporting compliance and reliability. The FM has reviewed and documented how KPIs are measured, recorded and reported, and examined data integrity and data controls in their performance reporting systems. SMHS does not consider all reporting issues to be resolved, and is planning to audit the FM’s data control system in early 2018.

SMHS does not have complete assurance that all appropriate financial deductions have been applied when KPIs have not been met. This is because it is difficult to track KPI failures under the extensive and complex performance regime, and because SMHS has not yet verified and reconciled all KPI failure points (and therefore payment abatements). A SMHS audit of FM systems used for reporting KPI failures and invoicing is currently underway.

**Reporting is not yet actively driving service improvement and efficiencies**

The contract requires the FM to report monthly against almost 1,000 reporting obligations across 25 services. A full monthly report on all of these obligations is over 12,000 pages long. Both the FM and SMHS use considerable resources to ensure reporting complies with the contract. However, reporting has mainly focused on compliance and SMHS should look to shift that effort to service improvement:

- The size of the reporting framework results in a significant compliance workload. Contract reporting is one part of the management and integration service line which cost nearly $19 million in 2016-17. The FM has 3 staff and SMHS has 1 senior contract manager supported by 2 contract managers allocated to this work.
- Our analysis of cleaning services data showed the benefits of focusing on performance and cost rather than just compliance. We found inconsistent clinical practices for isolation cleans had contributed to costs being $1.1 million higher than expected in 2015-16. SMHS was aware of issues with isolation cleans, and had been trying to resolve them. During the audit, SMHS issued additional guidance on isolation cleans, reducing their frequency and cost in 2016-17.
- Some service areas have more impact on cost and hospital operations than others. However, SMHS has not yet reviewed the reporting framework to prioritise those areas, or reduce the monitoring frequency of others or removed non-essential elements. This would identify ways to reduce the compliance workload and cost.

**Lengthy contract disputes are likely to increase costs and pose a risk to service continuity**

There are a number of contractual disputes and differences in interpretation between the FM and SMHS, which are likely to increase costs both retrospectively and over the remainder of the contract. These disputes are taking a long time to resolve (4 have been unresolved for 21 months) and although there has not been an impact on service delivery, the longer disputes run, the greater the risk of service disruption.

There are 7 contract disputes; 2 in cleaning and 1 each in helpdesk, management and integration, linen, ICT and internal logistics. In June 2017 the potential retrospective cost impact of these disputes was estimated at between $6 and $7 million. For instance, resolving the dispute over whether the absence of an Identity and Access Management (IAM) System...
has affected the FM’s ability to meet KPIs on answering helpdesk calls may allow the FM to recover nearly $580,000 in deductions.

Disputes could also affect future costs. For instance, there is a dispute over whether the contract covers cleaning emergency department bays between patients. If these cleaning activities are not within the scope of the contract, as the FM believes, this could add about $1 million per year to SMHS costs.

Contract interpretation issues may also have significant cost implications. There are over $10 million in financial claims that are not resolved. SMHS has rejected $8 million of these claims but the FM does not agree, and may escalate the claims to dispute resolution.

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**Recommendations**

**SMHS should by July 2018:**

1. **Drive cost effectiveness of the contract**
   a. update the initial contract cost estimate and monitor contract costs against the revised estimates
   b. update cost estimates by service type and set budget targets for service types
   c. resolve outstanding contract disputes and potential disputes in a more timely manner
   d. complete the audit of KPI failure points and associated payment abatements to ensure they have been correctly applied.

2. **Improve reliability and value of reporting, and identify opportunities to drive service improvements**
   a. continue the program of work to improve reliability of reported information, ensuring that the importance of following procedures for clinical staff is addressed
   b. review reporting obligations and the KPI framework including an assessment of the value of KPIs and the data that is monitored, in order to reduce the reporting burden
   c. undertake more in-depth analysis of KPIs to identify areas which could drive service improvements.
Responses

South Metropolitan Health Service

The South Metropolitan Health Service (SMHS) welcomes the acknowledgement from the OAG of the high levels of accountability, reporting and complexity of the contract, which has more than 480 Key Performance Indicators (KPIs) across 25 services. The services delivered by Serco support the high volumes of patients which are treated at FSH, which includes the treatment of more than 102,000 patients through the Emergency Department, approximately 51,000 admitted inpatients (including emergency and elective surgery), performing more than 34,000 operations and more than 540,000 outpatient appointments.

The contract is achieving positive results in a number of areas and the FM is delivering many of the services to a high standard. Serco staff on the ground have developed and maintained strong working relationships with WA Health staff, site visitors and our patients. This effectively supports a patient-focused and integrated approach to ensure the delivery of high quality care.

SMHS is undertaking substantial work in consultation with Serco to resolve outstanding contract disputes, and to develop processes to ensure any future disputes are dealt with in a timely manner. SMHS is confident that it is already effectively using the reporting and data provided by Serco to monitor and drive performance. SMHS is committed to identifying further opportunities for improvement and ensuring highly reliable, accurate and appropriate reporting under this contract.

The SMHS Board and Executive are pleased with the OAG’s findings regarding the appropriateness and quality of contract management within SMHS, and note that this is particularly positive given the complexity of the contract and its reporting requirements. SMHS is confident that it is delivering robust and diligent contract management across a range of high value and high risk contracts within the south metropolitan area and will continue to ensure Serco is accountable, meet their obligations under the contract and support excellent patient care.

SMHS accepts the recommendations identified by the OAG and will take action to address them by July 2018. SMHS recognises and welcomes the opportunity for further improvement and will work closely with Serco to address the audit findings and recommendations.

Serco

SMHS is receiving outstanding value from the Facilities Management Services Contract at Fiona Stanley Hospital. Like for like costs are in line with the initial estimate despite patient numbers being approximately 22% greater than anticipated and, as pointed out within the Summary of Findings, the distraction of the significant unresolved disputes relating to the contract.

The Summary of Findings in the report states that actual costs for the delivery of FM’s Services over the past two years were $24.6 million higher than estimated when the contract was approved in 2011. The analysis used by the Auditor General in comparing the estimated and actual costs is not consistent with the methodology applied to the initial estimate. Serco has provided its analysis to the Auditor General which shows actual costs were $2.1m higher than the initial estimate on a like for like basis. This excludes variances for the four services which did not have final prices included in the initial estimate.

The report states that that the actual cost of services over the past two years are $1.6m above the Annual Service Plan estimate. Serco does not agree with this. The analysis that Serco provided to the Auditor General confirms that the cost of services was $10.6m lower.
than the Annual Service Plan forecast provided to the Auditor General and Department of Health over the same period.

Over the last two years, Serco has consistently increased performance and established effective systems and processes to drive efficiencies and continuous improvement in provision of the services. However, Serco believes there is opportunity to work collaboratively with SMHS to further improve outcomes for both parties. Both parties have a mutual common interest in ensuring that:

- the Contract services are provided in an efficient and cost effective manner, which prioritises optimal health outcomes;
- disputes are resolved in a timely and mutually agreeable manner, without recourse to litigation; and
- priority is given to identifying and initiating performance improvements.

From commencement of the Contract, Serco has been supporting SMHS in the running of Fiona Stanley Hospital without impact to clinical services. In some instances delivering services in good faith has meant that Serco was not compensated for that work and put patient outcomes ahead of valid financial claims. Resolutions of the outstanding disputes and contractual issues are essential to ensuring this good will and flexibility in service delivery endures.

The KPI regime in the Contract is complex, driven by penalties which at times do not reflect any actual costs related to the KPI failures and is administered in a way that does not effectively promote or encourage genuine process improvement and efficiencies. Serco fully supports undertaking a strategic review of the KPI regime in order to properly support the Contract services, drive performance improvement and reduce the wastage of resources associated with onerous and inefficient administration of the KPI regime.

Serco also fully supports undertaking a strategic review of the onerous reporting obligations under the Contract and the processes for addressing disputes, which have to date failed to finally resolve any formal dispute between the parties. To be effective, such strategic reviews of the Contract must entail all stakeholders, including the Contract parties, engaging openly and in good faith and with agreement on the scope of the review and desired outcomes. Serco will commit all appropriate time and resources to such reviews in an effort to achieve mutually agreeable improvements to this critical priority and long term Contract.
Audit focus and scope

We assessed how effectively SMHS is managing the non-clinical services contract at FSH. We focused on 2 lines of inquiry:

1. Is the contract delivering the services needed at the cost expected?
2. Is SMHS effectively monitoring and enforcing the provisions of the contract?

We focused on the management of the non-clinical services contract by SMHS, and examined service line processes, procedures and performance management systems used by the FM to deliver non-clinical services. Clinician meetings were also held to discuss FM services. We looked in greater detail at 4 of the service lines where there were high levels of disputes and interpretation issues. These were cleaning, management and integration, estates and ICT.

For each service, we developed test plans and audit criteria, and conducted exercises to observe and collect data on the FM’s activity. For the cleaning service, a second phase involved recalculating and re-performing the monthly data procedures by the FM to check it was reliable and reproducible.

The audit did not assess the initial decision to contract out non-clinical services to a private contractor, the process used to appoint the facilities manager or the delivery of clinical services at FSH.

During the audit, we reviewed documents produced by the Fiona Stanley Hospital Commissioning and Major Hospitals Transition Taskforce. Health redacted some of the material in the documents on the grounds of legal professional privilege, and cabinet confidentiality. We conducted additional fieldwork, where necessary, to ensure sufficient and appropriate evidence to support our conclusion and findings.

This was a broad scope performance audit, conducted under section 18 of the Auditor General Act 2006 and in accordance with Australian Auditing and Assurance Standards. Performance audits primarily focus on the effective management and operation of agency programs and activities. The approximate cost of tabling this report was $649,000.
Audit findings

Indications are that non-clinical services under the contract will cost more than expected

The costs of contracted non-clinical services are higher than estimates at approval

Actual costs of non-clinical services after the first 2 full years of operations have been higher than approved estimates in 2011 (see Appendix 4):

- Service costs in 2015-16 were around $170 million, about $20 million more than the initial base estimate in 2011, and about $5.2 million more than the 2015-16 annual service plan estimate which sets a budget for the year ahead based on hospital data and previous year operations.

- Service costs in 2016-17 were nearly $161 million, about $4.6 million more than the initial base estimate in 2011. However, this was $3.6 million less than the 2016-17 annual service plan estimated.

The key reasons it cost more for non-clinical services compared to initial base estimates are:

- 4 services were not fully costed when the contract was approved in 2011. Electronic records management had a fixed management fee but delivery costs relied on future decisions regarding ICT initiatives. Future delivery costs were not included for linen, pest control and grounds maintenance because the FM and Health would subcontract these services through a competitive process. Government was advised about possible costs for these extra ‘pass through’ costs at time of approval. Pass through costs for these 4 services were $17.3 million over 2015-16 and 2016-17.

- Additional works and other services in estates and ICT requiring separate payment which the contract contemplated.

- One-off and delayed payments (i.e. back payments for services from a previous year such as sterilisation services).

- Underestimated service volumes, for example, in external transport and human resource management.

- No estimates were made for isolation cleans.

- Contract variations for additional services outside the scope of the contract. An example is shown below of an ICT contract variation.

Contract variations in ICT

ICT services accounted for most of the $11.5 million in variation payments between 2014-15 and 2016-17. One example was the replacement of ‘thin’ client personal computers (running directly from a remote server) with conventional desktop personal computers (with a hard disk drive). This was done because ‘thin’ computers did not provide adequate functionality to run Health legacy applications. Since 2014-15 the replacement program has cost $6.9 million. SMHS advised this fee will be reviewed in 2017.
Although the total cost of services was higher than 2011 estimates, fixed costs have been lower. In 2016-17 fixed payments represented 74% of actual costs. Fixed costs give SMHS price certainty and allows for risk transfer to the FM. An example of a fixed payment is routine cleaning. Fixed payments are based on price indexation (i.e. labour and materials indexation) so any movement in these indices impacts the value of payments. Because price indexation has been lower than expected, there has been a reduction in fixed payments.

**Estimates of patient numbers suggest that service volumes will be higher than anticipated**

The number of patients coming into the hospital directly influences costs for some services, such as linen and catering. The initial estimate of the contract price made assumptions about patient numbers. For example, 2 measures of patient numbers, patient separations (number of people admitted and discharged) and bed days (length of stay), were forecast to rise steadily to peak in 2020-21 and 2021-22 respectively.

One variable cost in the contract is patient catering where the contract specifies a unit cost per meal, rather than a total fixed cost. A large increase in the number of patients means that SMHS pays more. Keeping the variable cost component low allows SMHS to better control its budget.

Patient numbers, a key driver of some FM service costs, have grown faster than predicted. In 2015-16, assumptions for patient separations were underestimated by 24% and patient bed days by 2%. Additionally, peak patient separations expected in year 10 (2020-21) of the contract were exceeded by 22%. Both patient separations and bed days are forecast to be substantially exceeded over 2016-17 and 2017-18. This is likely to push up the costs because more of the contract term will be at high patient volume. SMHS has not revisited these estimates to quantify the likely increase in total contract price, however it does undertake an annual forecasting exercise to determine estimates of demand and costs.

**SMHS is not tracking total cost performance and does not have a current estimate of what the contract is likely to cost overall**

SMHS is not tracking performance against a total cost estimate to identify where they may need to adjust services to manage total costs over the life of the contract. It tracks actual costs against the annual service plan which sets out the services required for the year, and estimates the cost. SMHS also reviews where costs are higher and lower in the annual service plan to identify areas they can improve. However, this approach to managing costs does not provide for tracking of long-term performance, or support exploring opportunities to contain future costs.

SMHS has not revised the total contract cost estimate since non-clinical services contract started. This cost information was also not available for the November 2015 Education and Health Standing Committee report which noted that:

*The contract upon signing was estimated to be worth $4.3 billion over 20 years. Given the change in the number of services and other contract variations, the Committee sought an update on the current value of the contract and estimated savings. In response, the Department reported that a full revision of the estimated contract value cannot be accurately completed at this point of time.*

SMHS now has a better understanding of how the hospital is being used and how the FM is performing. These factors, plus changes to services, contract variations and amendments will affect the overall cost of the FM contract and should be analysed to develop long term estimates.
The current approach to benchmarking has not driven service price improvements

One way SMHS seeks to manage costs is through benchmarking. However, this is proving difficult. Under the contract, the FM is required to conduct benchmarking every 5 years to provide SMHS with information as to whether service prices remain competitive. If the benchmarking process finds service prices are not competitive, SMHS can negotiate contract amendments such as a reduction in service price.

The benchmarking process was due to be completed and a report provided by early November 2016 but the report has been delayed. A consultant was engaged by the FM and, after completing planning and scoping work, the FM advised SMHS about challenges with the process such as a lack of comparable hospitals, difficulty obtaining service metrics and accuracy of comparable data. SMHS may therefore find itself unable to determine if the contract is competitive in the current market. This approach to managing cost does not adequately drive cost efficiencies, as it is infrequent and unreliable. The overall value of each service and the best model or mix of activities is not routinely considered.

Overall, the standard of non-clinical service delivery is acceptable and the FM contract is adequately managed

The FM is meeting most of the service performance standards in the contract

The majority of FM services have met most of the performance standards under the contract. About 91% of 500,000 reports against KPIs passed in 2016-17.

There is general satisfaction with the FM’s performance. Between June 2015 and May 2017 service compliments (from consumers and health employees) outnumbered complaints 1,029 to 766. Regular meetings between SMHS, the FM and clinicians about governance and operational issues help the FM respond to service issues ‘on the ground’, particularly when issues could impact on clinical services. This has meant that the FM has delivered consistent service levels across the majority of service lines with minimal disruption.

However, clinicians did perceive the contract as rigid, creating another layer of process to resolve service issues in a timely way, for example, logging work orders for portering and cleaning services through the helpdesk rather than asking someone on the ward, and the time taken to fix maintenance issues. This perception may be because clinicians were used to processes at other hospitals, and were still adjusting to different processes at FSH.

Source: SMHS
SMHS has adequate contract management processes and procedures in place to monitor FM services

SMHS has adequate processes to monitor the FM contract and service delivery. It created a contract management directorate in February 2015, 5 months after the hospital opened. Prior to this, the Chief Executive of FSH Commissioning was responsible for contract management. SMHS revised the original contract management plan in June 2015. In October 2015, it developed a framework and procedures for managing the contract. SMHS later reviewed its contract management framework to ensure it applied characteristics of good contract management identified in the Auditor General's report on WA Health ICT procurement in 2016. The contract management plan and procedures which support staff managing the contract were approved in the middle of 2016.

Six senior contract managers from 2 teams, SMHS Contract Management and FSH Operations, actively manage and monitor the FM contract by completing:

- annual activities, including forecasts and reviews of the FM's annual service plan, reviews and approval of facilities management plans, and reviews of FM financial capacity and contract risks
- reviews of performance reporting, including manual checks of KPIs
- a range of service monitoring activities including audits, site inspections and desktop analysis. SMHS performed 107 formal audits and inspections across 18 services between January 2016 and June 2017. Progress made by the FM to complete corrective actions from audits are also monitored.

SMHS monitoring activities have picked up FM performance issues. Contract managers have identified concerns about planning, resourcing and contract reporting for 3 services (management and integration, managed equipment and estates). We looked at management and integration and estates in the audit. We found SMHS had raised concerns about resource management, quality of facilities management plans and inconsistent reporting in the management and integration service. They also raised issues about planning, site management, additional works and inconsistent reporting in estates.

SMHS and the FM recognise management and integration, and estates services as 2 of the largest and most complex services to manage. Since early 2016, both services have had improvement plans in place with key deliverables and completion dates, which SMHS monitors.

The FM has completed most of the original actions from these 2 improvement plans but new actions have been added and we are concerned that some actions are taking a long time to address. This is partly because the parties are yet to agree on how to resolve some issues.

SMHS has changed the scope of services under the contract because of price and performance issues

The FM currently provides 25 services rather than the 27 ongoing operational services under the original contract approved in 2011 (see Table 1). Of these 27 services, 2 did not proceed and were removed from the contract. One service was taken off the FM and replaced with a support service resulting in 25 services being delivered by the FM. These changes occurred during commissioning and initial operation of the hospital, reducing the estimated cost of the 20 year contract by $167 million. Elements of the 3 services that were removed from scope are now being delivered by SMHS.
In 2014, health records management and clinical coding, and scheduling and billing were removed for cost reasons. When the contract was approved in 2011, these services were not fully scoped or costed. Only a FM fee was included for their development and management. SMHS now delivers a reduced version of these 2 services. It is not possible to compare the FM’s price with in-house costs because full in-house costs are not captured and the services delivered are substantially different to the service specified and priced under the original contract.

In May 2015, SMHS took over the sterilisation service because of poor performance. Again, comparing in-house costs and performance with the FM is not possible because the in-house service delivery is substantially different to the service specified and priced under the original contract.

1 Fleet management was not included in the approved contract but is now part of the vehicle and traffic management service.
SMHS introduced a sterilisation support service into the contract, now run by the FM. This includes moving sterilised instruments around the hospital, maintaining an instrument tracking system, and organising repairs and maintenance.

Contract changes to supplies and sterilisation support are yet to be finalised. Changes were made to functions in early 2015, but specifications and revised costs are still not agreed. SMHS removed the procurement function from the supplies service provided by the FM in early 2015, in response to over and under ordering of medical and other supplies. It is anticipated that when these specifications are finalised there will be an adjustment to monthly payments increasing sterilisation support costs, but reducing supplies costs. Both parties are still in negotiation in regard to these matters, and the recovery of SMHS and FM costs following the removal of the sterilisation service.

**Reporting has not always reliably captured performance**

The FM is required to report against KPIs and other information across all services in the contract. Reliable and accurate reporting is key to SMHS imposing financial deductions known as payment abatements and other sanctions when the FM fails to deliver services to the required standard. Since opening the hospital, reporting by the FM has not always reliably reflected actual performance.

**Poor performance in the sterilisation service was not reflected in the data**

The reported KPI data on the sterilisation service did not adequately highlight areas of poor performance. Concerns about performance were escalated mainly through complaints from theatre staff rather than KPI reporting which showed acceptable service levels. Self-reporting was immature immediately after the hospital opened. The performance regime agreed under the contract meant sterilisation problems attracted low levels of KPI failure points. This understated the risks and impact of issues in the sterilisation service.

**Sterilisation – An example of data reliability issues**

**What are sterilisation services?**

As part of the initial non-clinical services contract for FSH, the FM was required to clean, disinfect and sterilise all medical devices used in the hospital in the performance of the health functions.

**What went wrong?**

Incidents included wet instrument trays being delivered to operating theatres, instrument packs with missing or incorrect tools and labels, and in one instance a bone fragment was found on an instrument.

**What was the response?**

On 21 May 2015, after 6 months delivering the sterilisation service, a formal notice was issued to the FM and the responsibility for sterilisation was transferred back to SMHS. SMHS removed the service due to 2 breach notices being issued which were not remedied by the FM to SMHS satisfaction.

**Why did the reporting system not pick up all KPI failures?**

The performance regime did not adequately highlight areas of poor performance. Given the severity of these issues, we expected to see more failed KPIs in the monthly reporting and the imposition of large financial deductions. This was not the case as self-reporting was immature immediately after the hospital opened and under the contract failure points attached to certain sterilisation service KPIs were very low (i.e. worth only 1 failure point).
From December 2014 to June 2015, the FM accrued 5,076 KPI failure points for the sterilisation service which resulted in a financial deduction of about $4,600.

Complaints about the service were made by clinicians, including 23 serious incidents reported by theatre staff in a separate clinical incident management system.

What have SMHS and the FM done to address concerns?

The service was transferred from the FM to SMHS in May 2015. Subsequent reviews of performance failures for the sterilisation service completed by SMHS and the FM estimated financial deductions should have been significantly more. The total figure to be paid by the FM will be determined when the sterilisation support service specification is finalised.

Data recorded for cleaning services did not always match actual activity

We conducted a data verification process for the cleaning service to assess data reliability. This was completed in 2 stages (Figure 3). Stage 1 tested the accuracy of cleaning data going into the KPI reporting system using an observational exercise. In the second stage we used July 2016 cleaning data to test the validity of self-reporting by the FM, to confirm whether processes for reporting on the number and types of cleans in monthly reports was robust and reproducible.

![Figure 3: OAG testing of cleaning service reporting](image)

To test the accuracy of data being entered into FM systems we observed cleaning activity in 2 medical wards over 2 days. Observations were then compared with data contained in 2 systems, OnBase (electronic records management) and Agility (KPI reporting system) to check if they matched. We looked at:

- cleaning type
- start and finish times for each clean
- location
- number of cleans
- cleaner names and staff number
- health employee identification numbers of staff that requested the isolation clean.
The cleaning data was not as accurate as expected. In our sample of 54 cleans:

- 5 cleans were not recorded in either OnBase or Agility
- 14 electronic records had at least 1 data entry error. This represents an error rate of 26%. For example, 1 clean had the wrong location, 1 had a wrong finish time and 12 had a different number of cleaners recorded
- 11 records had a different cleaner’s name listed in the system, though we did not count these as errors.

While most of the errors would not affect billing or KPI reporting, they suggest problems with data in FM systems which would therefore affect overall self-reporting. Capturing all cleaning activity is important for understanding demand and resourcing needs. Also, inaccurate times could impact on whether the service meets the KPI and associated financial deductions. Recording the wrong type of clean can also have a cost implication for SMHS, for example, if a standard clean is recorded as a more expensive isolation clean. We found no evidence that this had occurred in the July 2016 cleaning data.

FM reporting processes for cleaning are well documented. The cleaning service activity entered into FM systems forms the basis of its monthly self-reporting to SMHS. Three systems (OnBase, Agility and TopCat – audit software) are used to store data related to cleaning. We tested FM processes to see if reporting the number and types of cleans was robust. We looked at 51,170 records (isolation cleans, standard cleans and linen changes) from July 2016, and replicated its monthly report to a high degree of accuracy.
The KPI data collection system does not record all service activity

Agility, the main system used to report KPIs and associated failure points, may not capture all of the service activity it should. In our data testing of the cleaning service we found less than 5% of cleaning activity was captured in the system in July 2016. This was due to cleaning data being recorded using the TopCat audit tool and the OnBase record management system, and the high number of ad hoc, ‘tap on the shoulder’ cleaning requests not entered by hospital or FM staff.

The records management system (OnBase) did record much of this ad hoc cleaning data, however it is not used in KPI reporting. This creates a risk that the FM is not deducted as much as it should be, and that SMHS is paying for services that are not to the required standard, due to under-reporting of cleaning KPIs. However, feedback from clinicians about cleaning services is generally positive and suggests that the service is adequately supporting hospital functions.

Resources are being directed to improve reporting reliability

Monthly reports show some issues with the reliability of reporting in the services we reviewed (management and integration, cleaning, estates and ICT). Since the middle of 2015 SMHS contract managers have identified instances of:

- raw data on KPI failures that doesn’t match what is in reports
- incorrect calculation of KPI failure points
- some KPI audits have not been completed in the agreed time.

Robust reporting provides assurance to SMHS that services are being delivered and measured appropriately. It also reduces the administrative burden involved in verifying the accuracy of monthly reports.

SMHS does not have complete assurance that all appropriate financial deductions have been applied when KPIs have not been met by the FM. This is because it is difficult to track KPI failures under the extensive and complex performance regime in which failure points are often disputed, adjusted and reclassified using manual and automatic reporting processes. SMHS are currently doing an audit to verify and reconcile all KPI failure points (and therefore payment abatements) by checking FM systems used for reporting failures and invoicing.

The FM has worked with SMHS to make changes to reporting and review performance systems and data. This includes:

- changes to the structure and format of reporting, modifying data extraction processes, and clarification of how the FM is meeting reporting obligations. By early 2016 SMHS believed compliance rates for reporting had increased to around 90%. There continue to be different interpretations of some reporting obligations, for example, reporting on assets contained in the asset management system
- in early 2016, the FM reviewed and documented the performance regime for all KPIs. SMHS deemed the FM’s performance monitoring plan did not comply with the contract because it did not detail processes for recording, measuring and reporting for all KPIs (i.e. automatically calculated by Agility, and other KPIs verified only by FM audit processes). The FM and SMHS are yet to agree on 447 KPI interpretations across all services
- the FM audited data integrity and controls, and found similar weaknesses to our testing of cleaning data. They are now mapping access controls and reviewing the data control system to ensure compliance with Information Systems Audit and Control Association Standards.
Feedback on reporting issues is raised at relevant Specialist Service Group meetings between SMHS and the FM. At the time of finalising this report, all reporting issues are not resolved and SMHS plans to audit the FM's data control system in early 2018.

**Reporting is not yet actively driving service improvement and efficiencies**

FM contract reporting is complex, with multiple manual and automated systems producing performance information and data. Every month the FM reports its performance against almost 1,000 reporting obligations across 25 services. If the entire monthly report was printed it would be more than 12,000 pages long. Reporting ranges from performance of services against more than 480 KPIs to compliance with contract provisions like having documentation in place. Failure points and possible financial deductions attach to non-compliance with the content and format of each monthly reporting obligation.

One consequence of the size of the reporting framework is that during the first years of operation, just ensuring that each reporting obligation had been met and reports were in the right format took up a lot of time and resources for the FM and SMHS. Contract reporting is part of the management and integration service, which includes other deliverables such as management plans, and asset and inventory management systems, in addition to reporting. This service cost nearly $19 million in 2016-17. The FM has 3 staff and SMHS has 1 senior contract manager supported by 2 contract managers allocated to contract reporting work.

The intended benefit of this extensive data collection and reporting is to inform performance analysis, service improvements and cost management. However, the data has not been fully leveraged and there is scope to use it in a more planned and systematic way to drive performance improvement and accountability across all services. The isolation clean case example below shows how data has been used to improve performance of the contract.

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**Isolation cleans – using data to improve performance**

*What are isolation cleans?*

Isolation cleans are a higher level of cleaning used for rooms where a patient is known or suspected to have a highly transmissible pathogen. These are paid for by SMHS on a cost-per-clean basis, rather than as a fixed cost in the contract. Currently, SMHS pays nearly $100 for each isolation clean. In 2015-16, isolation cleans cost $2.1 million, $1.1 million more than estimated in the annual service plan.

*What concerns did we notice in the data?*

In our audit of cleaning practices, we found that 27% of the 1,740 isolation cleans performed in July 2016 were in 1 ward, which was a very high proportion. We also noted 7 instances of rooms receiving an isolation clean despite being unoccupied since a previous isolation clean.

*Why was this happening?*

In June 2015, the FM was directed by FSH clinicians to perform all discharge and scheduled daily cleans in this ward as isolation cleans. Clinicians often requested isolation cleans as a preventative clean rather than due to the previous patient having a suspected pathogen.
How was this remedied?

In September 2016, FSH Infection Prevention and Management requested isolation cleans to only be performed as clinicians requested them in line with hospital policy. Isolation cleans in the ward fell to 6% of the overall number the following month.

A new FSH Environmental Cleaning Policy was implemented in May 2017 to provide a simpler framework and criteria for clinicians and FM staff to follow regarding isolation cleans. To increase the rigour around isolation clean requests, FSH employees must now log all isolation cleans via Agility by either a call or email to the helpdesk, or via the self-service online portal.

In 2016-17 isolation cleans cost $1.74 million, nearly $140,000 less than the annual service plan forecast. Analysis of cost and performance data could be conducted at a future date to measure the impact of changes to policy.

SMHS has not yet reviewed the utility and value of all items in the reporting framework to identify ways of reducing the compliance workload and cost, but there is an opportunity to do so. Given the volume of information and data, it is not possible to review all reported information and every aspect of each KPI with available SMHS contract management resources. Additionally, not all services and therefore reporting obligations and KPIs require the same level of monitoring.

There are a number of services which are relatively low cost, predictable and which have less direct impact on the delivery of patient care. For example, pest control, vehicle and traffic management, fleet and property management services cost $935,000 in 2016-17 yet there are 40 contractual reporting obligations and 58 KPIs to report against every month. Some of these may be necessary for purposes other than monitoring contractual performance, but even so the frequency of reporting and monitoring could be reviewed. SMHS has not reviewed the required reporting outputs and frequency of reporting for services to ensure resources are prioritised towards evaluating reporting that has an impact on the delivery of patient care and the management of hospital assets.

SMHS now have 2 years of data on operations and a better understanding of what reported information and KPI data is most important for managing the contract and service risks. Prioritising and removing some non-essential elements and reducing reporting and monitoring frequency for certain areas would help SMHS to use limited resources to focus more on performance and cost management rather than compliance.

Lengthy contract disputes are likely to increase costs and pose a risk to service continuity

Contract disputes are taking a long time to resolve through existing processes and have significant cost implications. Four formal disputes have been unresolved since October 2015, in cleaning, helpdesk, management and integration, and linen services. More recent disputes in ICT and internal logistics are from August and October 2016. A second dispute in the cleaning service was also raised in February 2017. In June 2017, if all disputes were decided in the FMs favour, SMHS estimated dispute costs could be $6 million, while the FM estimated dispute costs could be over $7 million. The contract disputes are about:

- Which cleans are included in the contract price and which cleans are not. In August 2015 the FM issued a variation for additional cleaning services worth about $2 million per year which SMHS did not accept. One aspect of this dispute is over whether the contract covers cleaning bays between patients in the emergency department which has a possible cost implication of around $1 million per year. The FM estimate for the cleaning dispute is $4.6 million.
• Whether the absence of an Identity and Access Management (IAM) System has affected the FM’s ability to meet helpdesk KPIs. If this dispute is resolved in their favour, the FM estimates it may be able to recover payment abatements worth about $580,000.

• Whether the asset management system is an integrated site-wide system, that stores estate and medical equipment asset data, maintenance records and integrates with other systems to enable whole of life asset planning. If resolved in their favour, the FM estimates it may be able to recover about $570,000 in payment abatements.

• Whether costs of laundering FM uniform items should be covered by the FM or SMHS. The FM’s approximate costs of these items is $150,000.

• Whether the FM is entitled to payment for resources required to undertake manual processes required to enable hospital employees’ access to certain ICT applications, due to the absence of an IAM system. The FM’s approximate cost of this work is $460,000.

• Whether the FM is entitled to payment for additional resources required to manage helpdesk calls and for porter moves of patient specimens and medications around the hospital as a result of defects in and incorrect usage by hospital users of the Pneumatic Tube System, and whether the FM took all reasonable steps to mitigate the requirement to have additional resources appointed. The FM claims it has incurred additional costs of nearly $550,000.

• Whether the FM is entitled to payment for all isolation cleans claimed by the FM. SMHS has withheld payments to the value of around $250,000 and the FM does not accept the rejection of these invoices.

SMHS advised they have requested additional information from the FM to substantiate their position on the ICT and internal logistics disputes. This has not yet been received. While disputes are being reviewed, the FM has continued delivering services as required in the contract, including reporting KPI failures. SMHS has advised that where contractual obligations are not complied with, failure points and abatements will be applied.

There are also areas within the contract that may become disputes if they cannot be resolved informally. Most of these involve ambiguities where the contract does not clearly outline what is required and has led to different interpretations. Examples of contract interpretation issues in estates are below.

### Contract interpretation in the estates service

#### Upgrade Works Schedule

SMHS and the FM have differing views about items subject to upgrade works and how payments should operate. Under the contract an Upgrade Works Schedule was to be set up to fund the replacement, refurbishment or upgrade of Building and Site Service Assets (BSSA), including electrical, mechanical, hydraulic, fire, security, medical gases and pneumatic tubes.

SMHS has not approved the FM’s Upgrade Works Schedule. They claim it does not identify individual BSSAs, the type of work to be performed, timing of this work, estimated costs for each BSSA and the level of financial responsibility divided between SMHS and the FM. However, the FM does not agree with assertions made by SMHS. In 2016 the FM estimated upgrade works would cost $36 million over the remaining 5 years of the initial term of the contract.
**Water bellows**

The FM carried out work following 2 significant hot water rubber bellows failures in April and July 2015. Bellows are flexible joints made from heat resistant materials installed in industrial piping systems to absorb movements due to changes in flow and external disturbance. The 2 leakages, in different parts of the hospital, caused major disruption to the running of the hospital and damage to hospital equipment. The FM is claiming $670,000 for works it carried out. This was adjusted from $740,000 following negotiations between SMHS and the FM. SMHS asserts this claim still contains labour charges which the FM is not entitled to, as the contract price already covers these.

The FM and SMHS are awaiting the outcome of testing of the bellows to determine whether the bellows failure can be classed as a defect. Processing of the claim is held up until this final determination is provided by the insurer’s experts.

Contract interpretation issues may have cost implications of about $10.4 million, excluding upgrade works schedule costs. These include items and services (mainly in ICT and estates) purchased and performed by the FM between 2011 and June 2017, which it believes are outside the scope of the contract. For example, the FM did work to integrate clinical equipment into ICT infrastructure in the lead-up to commissioning the hospital. The FM is claiming about $2.6 million for work they believe is not in its scope under the contract. SMHS asserts this was covered under pre-operational, managed equipment and ICT services, and a procurement and installation fee.

There is a process to review and assess ongoing financial claims through meeting regularly and reporting monthly to the Facilities Management Advisory Group. SMHS has rejected nearly $8 million in claims and $2.4 million in claims are still unresolved. If the FM does not agree with SMHS decisions, it can lodge these matters as disputes. As long as the issues remain unresolved, there is uncertainty about extra contract costs.

Currently, there is no impact to clinical services as the FM continues to support SMHS in the running of FSH. In some instances, this may mean the FM delivers services for which, at the time, they do not get paid. Over time this could reduce goodwill or lead to less flexibility in service delivery.
## Appendix 1: FM non-clinical services

<table>
<thead>
<tr>
<th>Non-clinical services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Audio visual</td>
<td>Manage the operation and security of audio visual equipment and all telehealth (health consultation via phone or video) requirements</td>
</tr>
<tr>
<td>2. Cleaning</td>
<td>Cleaning all clinical and non-clinical areas in the hospital</td>
</tr>
<tr>
<td>3. Electronic records management</td>
<td>Manage the mail room, scanning, filing, storage, security and management for all non-patient records</td>
</tr>
<tr>
<td>4. Energy and utilities</td>
<td>Manage the central plant operation and maintenance, mechanical, electrical and hydraulic services</td>
</tr>
<tr>
<td>5. Estates</td>
<td>Manage and maintain fire systems, lifts, security systems, nurse call systems and pneumatic tube systems. Also a first response team attends to immediate faults, repairs and minor works</td>
</tr>
<tr>
<td>6. External transport</td>
<td>Provide transport for eligible patients and equipment between hospitals and to the community</td>
</tr>
<tr>
<td>7. Fleet management</td>
<td>Manage fleet vehicles for use by authorised hospital employees</td>
</tr>
<tr>
<td>8. Grounds maintenance</td>
<td>Maintain the hospital’s 5 hectares of natural bushland, parks, gardens and courtyards</td>
</tr>
<tr>
<td>9. Help desk and communications</td>
<td>Provides a single point of contact for access to all facilities management services and includes coordination of all service requests and switchboard functions, including coordination of all patient enquiries</td>
</tr>
<tr>
<td>10. Human resource management</td>
<td>Provide selected human resource services for FSH employees and volunteers, including non-clinical training and induction, occupational safety and health, and workers compensation</td>
</tr>
<tr>
<td>11. ICT</td>
<td>Provide technology that will establish the hospital as a digital hospital and support and complement WA health systems</td>
</tr>
<tr>
<td>12. Internal logistics</td>
<td>Provides functions performed in other hospitals by orderlies and patient care assistants, including the movement of patients, specimens, samples and pathology, and furniture</td>
</tr>
<tr>
<td>13. Linen service</td>
<td>Provide an uninterrupted supply of linen to support patient care at the hospital</td>
</tr>
<tr>
<td>14. Managed equipment</td>
<td>Procurement, installation and maintenance of all medical equipment, including supply and accessories, upgrades, enhancements and training</td>
</tr>
<tr>
<td>15. Management and integration</td>
<td>Provide services in a manner that ensures all of the elements of each service is fully integrated, with transparent performance reporting</td>
</tr>
<tr>
<td>16. Patient catering</td>
<td>Procure, manage and deliver a high-quality and nutritious catering service to patients</td>
</tr>
<tr>
<td>17. Patient entertainment</td>
<td>Provide patient entertainment services which gives patients access to meal ordering, television, internet, movies, Skype and telephone at their bedside</td>
</tr>
<tr>
<td>18. Pest control</td>
<td>Provide pest control for the 64 hectare hospital site</td>
</tr>
<tr>
<td>19. Property management</td>
<td>Management service for all leasable spaces in the hospital including retail catering</td>
</tr>
<tr>
<td>20. Reception</td>
<td>Information service points at main hospital building, rehabilitation building and education building</td>
</tr>
<tr>
<td>Non-clinical services</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21. Safety and incident management</td>
<td>Maintain and promote the safety and security of all individuals, equipment and the hospital site</td>
</tr>
<tr>
<td>22. Sterilisation support</td>
<td>Managing the movement of sterilisation instruments around the hospital, maintaining an instrument tracking system, and organising repairs and maintenance</td>
</tr>
<tr>
<td>23. Supplies management</td>
<td>Management and delivery of supplies across the hospital site</td>
</tr>
<tr>
<td>24. Vehicle and traffic management</td>
<td>Manage traffic flows, incidents, parking on site, staff permits, infringements and fines</td>
</tr>
<tr>
<td>25. Waste management</td>
<td>Manage waste segregation, storage and disposal of hospital waste</td>
</tr>
</tbody>
</table>
Appendix 2: FM service payments

Notes:
The contract was originally structured into 3 stages:

- **Pre-operations** – planned from August 2011 to December 2013. This stage included equipment procurement and installation, and non-clinical service development.

- **Transitional** – planned from December 2013 to April 2014. The stage where the FM took over management of the hospital site and provided partial and full operational services. This stage was fully replaced by the delay and phased stage where the FM maintained the hospital site, tested equipment and systems and delivered partial non-clinical services from October 2014 as part of a phased hospital opening.

- **Full operations** – planned for April 2014. The point when the hospital was originally intended to become fully operational.
## Appendix 3: Contract timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>December: Expression of interest for Facilities Management Services Contract</td>
</tr>
<tr>
<td></td>
<td>February: Release of request for submission (RFS)</td>
</tr>
<tr>
<td></td>
<td>May: Closing date for responses to RFS</td>
</tr>
<tr>
<td></td>
<td>June: Evaluation process and pre-selection proposal and negotiations process</td>
</tr>
<tr>
<td>2010</td>
<td>July: Facilities Management Services Contract (FM Contract) with Serco Australia Pty Ltd signed</td>
</tr>
<tr>
<td></td>
<td>August: Pre-operations stage starts. Planned to run to December 2013</td>
</tr>
<tr>
<td>2011</td>
<td>September: Pre-operations stage</td>
</tr>
<tr>
<td>2012</td>
<td>December: FM take over management of hospital site from builder</td>
</tr>
<tr>
<td></td>
<td>Delay and phase stage to March 2015. Replaced part of pre-operational service and all of the transitional service.</td>
</tr>
<tr>
<td>2013</td>
<td>April: Original proposed hospital opening</td>
</tr>
<tr>
<td></td>
<td>May: Health decide to operate 2 services in house (health records management and clinical coding, and scheduling and billing service)</td>
</tr>
<tr>
<td></td>
<td>October: Phased hospital opening commences</td>
</tr>
<tr>
<td>2014</td>
<td>April: Full hospital operations commence</td>
</tr>
<tr>
<td></td>
<td>May: SMHS takeover sterilisation services and the FM commences a support service</td>
</tr>
<tr>
<td>2015</td>
<td>June: Completion of first full financial year of operations (2015-16)</td>
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<tr>
<td></td>
<td>October: Benchmarking FM non-clinical services commences</td>
</tr>
<tr>
<td>2021</td>
<td>August: Expiry of initial 10 year term</td>
</tr>
<tr>
<td>2026</td>
<td>August: Expiry of first 5 year extended term</td>
</tr>
<tr>
<td>2031</td>
<td>August: Expiry of second 5 year extended term</td>
</tr>
</tbody>
</table>
## Appendix 4: FM service estimates and actual costs

### FM service payments 2015-16

<table>
<thead>
<tr>
<th>FM services</th>
<th>2011 initial estimate</th>
<th>ASP estimate</th>
<th>Actual costs</th>
<th>Cost difference (2011 estimate vs actual)</th>
<th>Cost difference (ASP vs actual)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hard FM services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy and utilities</td>
<td>25,839,441</td>
<td>31,201,642</td>
<td>31,845,459</td>
<td>(6,006,018)</td>
<td>(643,817)</td>
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<tr>
<td>Estate</td>
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<tr>
<td>External transport</td>
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</tr>
<tr>
<td>Vehicle and traffic management (includes fleet management)</td>
<td>68,189,224</td>
<td>68,038,648</td>
<td>72,981,067</td>
<td>(4,791,843)</td>
<td>(4,942,419)</td>
</tr>
<tr>
<td>Grounds maintenance</td>
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<tr>
<td>Pest control</td>
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<tr>
<td>Safety and incident management</td>
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<tr>
<td><strong>Soft FM services</strong></td>
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</tr>
<tr>
<td>Cleaning</td>
<td>68,189,224</td>
<td>68,038,648</td>
<td>72,981,067</td>
<td>(4,791,843)</td>
<td>(4,942,419)</td>
</tr>
<tr>
<td>Helpdesk and communications</td>
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<tr>
<td>Human resource management</td>
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<tr>
<td>Internal logistics</td>
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<tr>
<td>Linen</td>
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</tr>
<tr>
<td>Patient catering</td>
<td>68,189,224</td>
<td>68,038,648</td>
<td>72,981,067</td>
<td>(4,791,843)</td>
<td>(4,942,419)</td>
</tr>
<tr>
<td>Property management</td>
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<tr>
<td>Reception</td>
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<tr>
<td>Sterilisation support</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Supplies management</td>
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<tr>
<td>Waste management</td>
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</tr>
<tr>
<td><strong>Management, procurement and integration services</strong></td>
<td>36,244,905</td>
<td>35,481,347</td>
<td>35,253,448</td>
<td>991,457</td>
<td>227,899</td>
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<tr>
<td>Managed equipment</td>
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<tr>
<td>Management and integration</td>
<td></td>
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</tr>
<tr>
<td><strong>Information communication and technology services</strong></td>
<td>19,617,656</td>
<td>29,887,662</td>
<td>26,770,878</td>
<td>(7,153,222)</td>
<td>3,116,784</td>
</tr>
<tr>
<td>Audio visual</td>
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<tr>
<td>Electronic records management</td>
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<tr>
<td>ICT</td>
<td></td>
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</tr>
<tr>
<td>Patient entertainment</td>
<td>19,617,656</td>
<td>29,887,662</td>
<td>26,770,878</td>
<td>(7,153,222)</td>
<td>3,116,784</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>149,891,226</strong></td>
<td><strong>164,609,299</strong></td>
<td><strong>166,850,852</strong></td>
<td><strong>(16,959,626)</strong></td>
<td><strong>(2,241,553)</strong></td>
</tr>
<tr>
<td>Variation payments</td>
<td>169,806</td>
<td>4,472,726</td>
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<td>(4,472,726)</td>
<td>(4,302,920)</td>
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<tr>
<td>Service abatements and adjustments</td>
<td></td>
<td></td>
<td></td>
<td>(1,362,332)</td>
<td>1,362,332</td>
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<tr>
<td><strong>Total service payments</strong></td>
<td><strong>149,891,226</strong></td>
<td><strong>164,779,105</strong></td>
<td><strong>169,961,246</strong></td>
<td><strong>(20,070,020)</strong></td>
<td><strong>(5,182,141)</strong></td>
</tr>
</tbody>
</table>
Notes:

Reasons for the $20 million increase in cost compared to the initial base estimate in 2011 include:

- items not included or fully priced in the 2011 estimate totalling $24.7 million:
  - subcontractor costs for electronic records management, linen, grounds maintenance and pest control – $8.7 million
  - contract variations – $4.5 million
  - ICT contingency\(^2\) – $3.9 million
  - estate additional works and upgrade works – $3.5 million
  - isolation cleans – $2.1 million
  - human resource management service (workers’ compensation and practitioner adjustment payment) – $1.4 million
  - sterilisation support – $1.1 million
  - vehicle and traffic management, property management and patient entertainment – $0.9 million
  - financial deductions (payment abatements) – $1.4 million

- items costing more than the 2011 estimate totalling $3.4 million:
  - external transport service – $2.8 million
  - patient catering – $0.6 million

- items costing less than the 2011 estimate totalling $8.1 million:
  - fixed service payments – $6.1 million
  - waste management and sterilisation – $2 million

Note – Actual costs correlate to the FM monthly invoice which does not necessarily correlate to the activity month due to a time lag in invoicing.

---

\(^2\) The contract allows ICT contingency payments to resolve issues on the ICT compliance document and/or ICT additional risks for which the FM incurs costs in achieving that resolution.
## FM service payments 2016-17

<table>
<thead>
<tr>
<th>FM services</th>
<th>2011 initial estimate</th>
<th>ASP estimate</th>
<th>Actual costs</th>
<th>Cost difference (2011 estimate vs actual)</th>
<th>Cost difference (ASP vs actual)</th>
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<tbody>
<tr>
<td><strong>Hard FM services</strong></td>
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<td>Energy and utilities</td>
<td>26,870,831</td>
<td>34,379,957</td>
<td>31,866,610</td>
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<td>2,513,347</td>
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<tr>
<td>Estate</td>
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<tr>
<td>External transport</td>
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<tr>
<td>Vehicle and traffic management (includes fleet management)</td>
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<tr>
<td>Grounds maintenance</td>
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<td>Pest control</td>
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<td>Safety and incident management</td>
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<td><strong>Soft FM services</strong></td>
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<td>Cleaning</td>
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<tr>
<td>Linen</td>
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<tr>
<td>Patient catering</td>
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<tr>
<td>Property management</td>
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<td>Reception</td>
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<td>Sterilisation support</td>
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<tr>
<td>Supplies management</td>
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<td>Waste management</td>
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<tr>
<td><strong>Management, procurement and integration services</strong></td>
<td>37,584,035</td>
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<tr>
<td>Management and integration</td>
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<tr>
<td><strong>Information communication and technology services</strong></td>
<td>20,346,448</td>
<td>23,831,796</td>
<td>25,154,849</td>
<td>(4,808,401)</td>
<td>(1,323,053)</td>
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<tr>
<td>Audio visual</td>
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<tr>
<td>Electronic records management</td>
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<tr>
<td>ICT</td>
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<tr>
<td>Patient entertainment</td>
<td></td>
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<tr>
<td><strong>Sub total</strong></td>
<td>156,340,221</td>
<td>161,113,221</td>
<td>158,444,741</td>
<td>(2,104,520)</td>
<td>2,668,480</td>
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<tr>
<td>Anticipated changes in superannuation law</td>
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<td>Variation payments</td>
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<td>(3,886,700)</td>
<td>(788,137)</td>
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<tr>
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<td>(1,405,982)</td>
<td>1,405,982</td>
<td>1,405,982</td>
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<tr>
<td><strong>Total service payments</strong></td>
<td>156,340,221</td>
<td>164,511,784</td>
<td>160,925,459</td>
<td>(4,585,238)</td>
<td>3,586,325</td>
</tr>
</tbody>
</table>
Notes:
Reasons for the $4.6 million increase in cost compared to the initial base estimate in 2011 include:

- items not included or fully priced in the 2011 estimate totalling $21.3 million:
  - subcontractor costs for electronic records management, linen, grounds maintenance and pest control – $8.6 million
  - contract variations – $3.9 million
  - estate additional works and upgrade works – $3 million
  - ICT contingency and upgrade work – $1.8 million
  - human resource management service (workers’ compensation and practitioner adjustment payment) – $1.8 million
  - isolation cleans – $1.7 million
  - sterilisation support – $1 million
  - vehicle and traffic management, property management and patient entertainment – $0.9 million
  - financial deductions (payment abatements) – $1.4 million
- items costing more than the 2011 estimate totalling $3 million:
  - external transport service
- items costing less than the 2011 estimate totalling 19.7 million:
  - managed equipment, waste management, patient catering and sterilisation – $10.6 million
  - fixed service payments – $9.1 million

Note – Actual costs correlate to the FM monthly invoice which does not necessarily correlate to the activity month due to a time lag in invoicing.
## Auditor General’s Reports

<table>
<thead>
<tr>
<th>Report number</th>
<th>2017 reports</th>
<th>Date tabled</th>
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<tbody>
<tr>
<td>12</td>
<td>Information Systems Audit Report</td>
<td>29 June 2017</td>
</tr>
<tr>
<td>11</td>
<td>Opinion on Ministerial Notification</td>
<td>29 June 2017</td>
</tr>
<tr>
<td>10</td>
<td>Timely Payment of Suppliers</td>
<td>21 June 2017</td>
</tr>
<tr>
<td>9</td>
<td>Opinion on Ministerial Notification</td>
<td>8 June 2017</td>
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<tr>
<td>8</td>
<td>Management of Medical Equipment</td>
<td>25 May 2017</td>
</tr>
<tr>
<td>7</td>
<td>Audit Results Report – Annual 2016 Financial Audits – Universities and TAFEs – Other audits completed since 1 November 2016</td>
<td>11 May 2017</td>
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<tr>
<td>6</td>
<td>Opinions on Ministerial Notifications</td>
<td>13 April 2017</td>
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<td>5</td>
<td>Accuracy of WA Health’s Activity Based Funding Data</td>
<td>11 April 2017</td>
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<td>4</td>
<td>Controls Over Purchasing Cards</td>
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<td>3</td>
<td>Tender Processes and Contract Extensions</td>
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<td>2</td>
<td>Opinion on Ministerial Notification</td>
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<td>1</td>
<td>Opinion on Ministerial Notification</td>
<td>30 March 2017</td>
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