

Lady Cilento Children's Hospital Review

Operational and building commissioning

Final Report

28th July 2015

Review Panel

Adjunct Professor Deborah Picone AM

Mr Mark Tucker-Evans

Mr David Roberts

Executive Summary

The establishment of the Lady Cilento Children's Hospital (LCCH) is a significant milestone in the delivery of world class paediatric health services in Queensland. The planning, development, construction and opening of the LCCH was undisputedly one of the more complex undertakings in the Australian hospital infrastructure setting and operationally a very challenging program of work to bring to a safe and satisfactory conclusion.

The presence of this 'state of the art' hospital, coupled with a leading academic and research facility and the high calibre staff, provides a platform for the LCCH to continue to develop as a national and international leader in paediatric health care, education and research.

The Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP, commissioned this Review, on the 30th April 2015, to make recommendations to support future building and operational commissioning processes for public health infrastructure projects, by identifying opportunities for improvement and assessing concerns that have been raised regarding the operational and building commissioning of the LCCH.

The Review Panel has highlighted the numerous challenges faced during the project and articulates the lessons learnt, from both favourable and unfavourable processes and outcomes, and has made subsequent recommendations which will inform future infrastructure projects for Queensland Health. The Review has assessed the concerns raised by patients, clinicians, staff and the community regarding the building and operational commissioning of the LCCH. This Review, concurs with the findings of the LCCH Clinical Review, led by Professor Les White AM, New South Wales Chief Paediatrician, and takes a comprehensive approach to the analysis of commissioning processes of the LCCH project including key stakeholder interviews, public call for submissions, LCCH staff survey, extensive project document analysis and site visits.

Despite repeated, revised forecast Practical Completion dates by the Managing Contractor from the 10th January 2014 until the achievement of Practical Completion of the LCCH nine months later on the 26th September 2014, the CHQ HHS Board took the decision to strive towards the planned opening date of 29th November as discussed at the May Board meeting.

This resulted in significantly compressed schedules and timeframes for building and operational commissioning processes. This in turn led to a best endeavours and minimum safe approach to operational readiness rather than fully executing the original commissioning plans.

Such significant activity required an extraordinary effort from the commissioning teams in order to achieve the agreed minimum set of criteria and to enable the safe opening of the LCCH. The Panel saw evidence in support of the Clinical Review's finding that "it was evident that staff extended themselves in the lead up to and after the opening of the new hospital. Many staff expressed and displayed a level of stress built up from the sustained continuing level of challenges and frustrations experienced."

Limited time and availability of sufficient resources saw the ICT program, consumer engagement, staff training and orientation and management of furniture, fixtures and equipment significantly curtailed. Components of the vital works program and some training and orientation programs were subsequently rescheduled for the months following the opening.

The commitment and devotion of the clinical and leadership teams, hospital staff, Lady Cilento Children's Hospital Program (LCCHP), Children's Health Queensland Hospital and Health Service (CHQ HHS) Board and Executive, Mater Health Services (MHS) Board and Executive, Health Infrastructure Branch (HIB) and other stakeholders in achieving the opening of the LCCH on November 29th 2014 is to be commended. However, the Review Panel found evidence of

Executive Summary

multiple examples where the building and operational commissioning processes exposed the project to risk and capacity challenges.

The Review Panel contends that sufficient evidence existed in the June/July 2014 period and still in late October 2014, which should have raised sufficient corporate concern over November 29th 2014 being a realistic opening date. The Review Panel found across multiple sources and from numerous stakeholders, evidence to support the notion that the building, systems and staff of LCCH were not fully operationally ready on the 29th November 2014.

The LCCH commissioning team are a competent group of senior managers and clinicians selected for their extensive experience in paediatric clinical care and service provision. The Review Panel proffer a view that insufficient experience of the complex interdependencies that exist in operationally commissioning a multi-site tertiary hospital existed within the commissioning team. This was compounded by a myriad of organisational and structural challenges LCCH faced from its unique circumstances and tertiary status. The result was that the CHQ HHS Board and Executive team was challenged by a portfolio of operational, logistical and cultural risks in the crucial lead up period prior to opening. The multitude of issues and the level of overall cumulative risk with which the Board and the Executive attempted to mitigate, became increasingly insuperable.

The Board and clinical teams went to extraordinary lengths, especially in the final month before opening, to provide an environment which would support the provision of safe, high quality care for the patients. The Review Panel supports the findings of the 'Clinical Review' that "no serious adverse events causing long term harm occurred on the day of move or during the first two weeks of operation." In fact, move day was widely acknowledged to be a safe, precise, well managed

and successful exercise. The Panel concurs with the 'Clinical Review' in their finding that the 'consequential stress, fatigue and lowered morale requires priority in the continuing development of the new facility.'

The Panel would like to recognise the effort and sincerity of all key stakeholders who provided critical insight into the LCCH project and have enabled the further development of key recommendations for future health infrastructure projects in Queensland.

Recommendations:

Building on the lessons learnt throughout the project, the Review Panel have developed a list of recommendations to inform future health infrastructure projects.

These recommendations are not a direct comment on the performance, of individuals or groups involved in the commissioning of the LCCH, nor should any be inferred.

Project Timeframes

1. *Establish an experienced health infrastructure commissioning group upon which future projects can draw upon for independent insight, commercial advice and strategic partnering*
2. *Establish and agree in advance good practice guidelines for building and operational commissioning and make sure that progress assessments are undertaken against these guidelines, including an appropriate 'Go/No Go' assessment*
3. *Clearly articulate and adhere to minimum mandatory operational commissioning timeframes and activities*

Executive Summary

Governance

4. *Enable lead clinicians and critical staff members to directly engage and discuss patient safety and quality risks with the Hospital and Health Service Executive leadership and Board members to appropriately inform critical milestones of the project*
5. *Implement a robust, effective and easily understood governance framework*
6. *Schedule regular assessments of the efficacy of the governance framework including its ability to connect the objectives and timeframes of both the project and the operational components of the business*
7. *Provide control, accountability and authority to the Hospital and Health Service as early as possible in the operational commissioning process*
8. *Continually assess the safest and most appropriate approach for the determination of the transition to the hospital opening (eg hard opening versus staged approach)*

Information and Communications Technology

9. *Utilise an integrated risk approach to ICT delivery in which the total weight of combined risk, operations and interdependencies is appropriately assessed and managed*
10. *Adhere to adequate commissioning timeframes, especially post practical completion, to enable the comprehensive integration of ICT systems and staff training and familiarisation with equipment, systems and processes*

Our People

11. *Establish the workforce well in advance of the hospital opening date to enable comprehensive workforce and service integration processes in order to embed models of care, 'ways of working' and team cohesiveness*

12. *At the commencement of the project, engage relevant expertise to facilitate cultural and behavioural integration*

Furniture, fittings and equipment

13. *Utilise a team with comprehensive expertise in the management and procurement of FF&E to appropriately manage risks and deliverables associated with project timeframes and operational commissioning*
14. *Develop service plans that detail the FF&E requirements for the effective delivery and testing that are cognisant of comprehensive clinical review processes, integration requirements and vendor support processes*

Contract Management

15. *Engage appropriately skilled personnel in contract development, negotiation, and management to leverage robust productive and accountable agreements*
16. *Utilise 'competitive dialogue' approaches in contract negotiations to provide an accurate assessment of the capacity and performance of preferred tenders*
17. *Finalise contract negotiation processes well in advance of the hospital opening date to minimise the risks*

Operational Commissioning

18. *Clearly articulate and adhere to realistic and comprehensive building and operational commissioning objectives and timeframes which provide staff with the confidence to effectively undertake their roles and responsibilities*
19. *Establish and adhere to agreed good practice guidelines which identify minimum standards for orientation and training, worksite familiarisation and operational readiness*

Executive Summary

Food Services

20. *Appropriate and accessible retail food services must be available for families and staff at the time of opening of the hospital*
21. *Utilise appropriate planning processes in the design of retail spaces so that tender specifications are well defined, to enable the timely and appropriate selection and management of suitable vendors*

Engagement and Communication

22. *Maintain genuine and meaningful engagement throughout the project lifecycle with patients, families, carers, staff and the broader community*
23. *Provide early and transparent communication regarding anticipated project challenges and issues with specific service profiles*

Contents

Section	Description	Page
1	Introduction – Purpose, scope and approach	7
2	Context	11
3	High level Timeline	13
4	Key case studies and lessons learnt	15
	<i>Project Timeframes</i>	16
	<i>Governance</i>	20
	<i>Information and Communications Technology</i>	23
	<i>Our People</i>	26
	<i>Furniture, fittings and equipment</i>	30
	<i>Contract Management</i>	32
	<i>Operational Commissioning</i>	34
	<i>Food Retail Services</i>	38
	<i>Engagement and Communication</i>	40
5	Recommendations	42
6	Appendices	45
	<i>A – LCCH Program Governance Chart</i>	
7	Glossary of terms	47

Section 1

Introduction: Purpose, scope and approach

Introduction

Purpose, scope and approach

The opening of the Lady Cilento Children's Hospital (LCCH) is a significant milestone in the delivery of world class health services for Queenslanders, with the amalgamation of two well established and high performing organisations into a stand-alone Children's Hospital and health precinct. The LCCH will serve as the hub of a state-wide network of paediatric services and will provide specialist tertiary and quaternary health care services for children, adolescents and their families.

The development and opening of the LCCH has been under continual review throughout the lifecycle of the project.

The LCCH Program (LCCHP), Children's Health Queensland Hospital and Health Service (CHQ HHS) Board, Executive and staff, Mater Health Services (MHS) Board, Executive and staff, Health Infrastructure Branch (HIB) along with a range of partners and key stakeholders undertook significant effort with great devotion and personal fortitude to open the LCCH on November 29th 2014.

The LCCH is now positioned as a centre of excellence and at the forefront of paediatric care both nationally and internationally. The presence of a 'State of the Art' hospital building, coupled with a leading academic and research facility and the high calibre staff, provides a platform for the LCCH to achieve a position within the top echelon of health service providers.

It is an imperative of good practice that upon the completion of significant infrastructure projects, an objective and analytical lens is applied to ascertain key learnings and recommendations. The purpose of this Review is to make recommendations to support future building and operational commissioning processes for public health infrastructure projects, by identifying opportunities for improvement and assessing concerns that have been raised regarding the commissioning processes carried out for the LCCH project.

The Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP, has appointed a Review Panel on the 30th April 2015, with the following persons as Reviewers for the purposes described within the Terms of Reference:

Adjunct Professor Debora Picone AM

Chief Executive Officer, Australian Commission on Safety and Quality in Health Care

Mr Mark Tucker-Evans

Chair, Health Consumers Queensland and Chief Executive COTA Queensland

Mr David Roberts

Asia-Pacific Health Sector Leader, Ernst and Young

Introduction

Purpose, scope and approach

Terms of Reference

In accordance with the Terms of Reference, the Review will:

1. Assess the governance of, and processes surrounding, the commissioning of the LCCH, by the CHQ HHS Board, Department of Health and other government agencies;
2. Consider system planning, decision-making, resourcing and other related activities that impact on patient safety during the commissioning process;
3. Assess and benchmark the processes and timeframes for building commissioning (required to achieve practical completion) and operational commissioning (required to properly operate) of the facility, taking into account facilities of a similar size and complexity;
4. Consider the appropriateness of the governance practices, management and oversight role employed by the Department of Health and the Board of CHQ HHS in relation to the commissioning of the LCCH and in particular, undertake the following:
 - a. Develop a sequence of key events and significant decision-making points relevant to the commissioning of the LCCH (including with respect to the practices surrounding the funding of the capital works program);
 - b. Assess the governance documentation (including the LCCH project governance chart, plans, policies and procedures in place for the commissioning of the LCCH);
 - c. Identify any limitations in decision-making processes in the commissioning of the LCCH and assess whether any deficiencies may have contributed to the concerns outlined in the background section (above); and

- d. Consider the outcome of the CHQ initiated clinical review into the quality of patient care at the LCCH (during the two weeks of operations from 29 November 2014) and determine whether it identifies any deficiencies in the commissioning process. The current review is intended to build on the clinical review and complement the assessment already undertaken.
5. As necessary, make recommendations for future actions to strengthen management and governance of future large scale public health infrastructure projects.

The scope of the review shall not be limited to the involvement of CHQ HHS and Queensland Health and may extend to Mater Health Services, in accordance with their obligations under the overarching Memorandum of Understanding dated 8th December 2008, in relation to the delivery of the LCCH.

The review is systemic in nature and will not address specific concerns of individuals regarding their treatment in the health system, whether as patients or employees. Specific issues raised about individual patient treatment may be considered and addressed to the extent that they indicate how well the systems are working, both as a whole and individually, or how they may be improved.

Powers of the Reviewers

Reviewers may ask CHQ HHS and Queensland Health employees to participate in informing the Review. However, participation by employees is not legislatively mandated.

Introduction

Purpose, scope and approach

This review has taken a comprehensive approach to the analysis of building and operational commissioning processes of the establishment of the LCCH.

The Review panel drew on their direct and extensive experience in the commissioning of numerous multi-site, tertiary hospital facilities both nationally and internationally as a frame of reference. The Review Panel also received counsel and advice from a number of colleagues with similarly complex, extensive, tertiary hospital commissioning experience, specifically in relation to appropriate project timeframes, governance and operational commissioning practices.

An extensive review of the available literature was undertaken, including as assessment of recent relevant Australian and international hospital case studies, to inform the assessment and to provide a point of reference for comparison. The Review Panel has also referred to guidelines pertaining to building and operational commissioning for healthcare facilities, including the Australasian Health Facility Guidelines as detailed by the Australian Health Infrastructure Alliance (AHIA). The Panel is confident that based on experience, evidence and the outlined consultation process, the observations, lessons learnt and subsequent recommendations represent a robust and thoroughly systemic assessment.

The Review has included detailed consideration of the proportion, extent and the impact of the activities which were actually carried out prior to opening the LCCH as compared to those outlined in the LCCHP and CHQ HHS original commissioning group plans and timeframes.

The Review Panel undertook 40 key stakeholder interviews with members from:

- Health Infrastructure Branch
- Children's Health Queensland Hospital and Health Service
- Mater Health Services
- Lady Cilento Children's Hospital Program
- Other key stakeholder groups

The Public Call for submissions process provided an invitation for the public to provide a response regarding their insights and experience with the operational and building commissioning process of the LCCH. The invitation was listed in the Courier Mail on the 23rd May and the 30th May 2015 and on the Queensland Health Facebook page. The call for submissions was open from the 23rd May to the 4th June 2015.

The Review Panel also deployed a LCCH staff survey which was circulated to the CHQ HHS email distribution list. The survey collection period was from the 25th May 2015 to the 4th June 2015.

The Review Panel undertook a comprehensive document collection and analysis of key LCCH project related material, which stretched to well over 300 documents, including all commissioning planning documents, risk registers, Gateway Reviews and Minutes and Papers from Board meetings, Commissioning Groups and internal and external briefings and communications.

The Review Panel also carried out multiple LCCH precinct site visits, to garner key insights and experience first hand the way finding and access to the LCCH site and the services.

The CHQ HHS Board and Executive were provided with a seven day 'natural justice' process to review components of the report.

Additionally, the CHQ HHS Executive and Board, Department of Health (DoH), Health Infrastructure Branch (HIB) and Mater Health Services (MHS) Executive and Board, were provided with the opportunity to 'fact check' the draft report prior to the submission of the Final Report.

Section 2
Context

Context

The announcement of the LCCH project followed recommendations detailed in a series of reviews, including:

- **The South East Hospital Services Planning Project** (1992/1993) which identified the consolidation of the two paediatric hospitals, Royal Children's Hospital (RCH) and the Mater Children's Hospital (MCH), into one single tertiary hospital as its preferred option
- **The Forster Review** (2005) which recommended the rationalisation of the RCH and the MCH to improve service sustainability and optimise resources including significant on-call requirements
- **The Mellis Review** (March 2006) which recommended the construction of a single, integrated, purpose built, new Queensland Children's Hospital in metropolitan Brisbane to reduce the disaggregation of tertiary paediatric services. Recommendations included:
 - Building adjacent to an adult teaching hospital
 - Building in close proximity to an obstetrics unit
 - When commissioned, the existing children's hospitals would be decommissioned as all services would be amalgamated within the new purpose built single site precinct
 - The Queensland Children's Hospital functioning as the hub of a state-wide network of paediatric tertiary services
- **The Taskforce on Paediatric Cardiac Services** (August 2006) endorsed the main recommendation of the Mellis Review that a single new tertiary level children's hospital be constructed and commissioned to optimise paediatric health care within Queensland

The establishment of the LCCH was announced as an election commitment in August 2006 by the Labor Government with a proposed capital budget of \$700 million and was to be completed by late 2014. The final budget for the LCCH project was \$1.5 billion, with the LCCH opened for patients and families on 29th November 2014.

The establishment of the LCCH required the RCH and MCH workforces and clinical services to be integrated within the newly developed single purpose hospital site. This demanded the delivery of a large scale project that needed to be well planned and executed within budget and scheduled timeframes. It simultaneously required the successful convergence and realignment of two well established hospital services and workforce cultures.

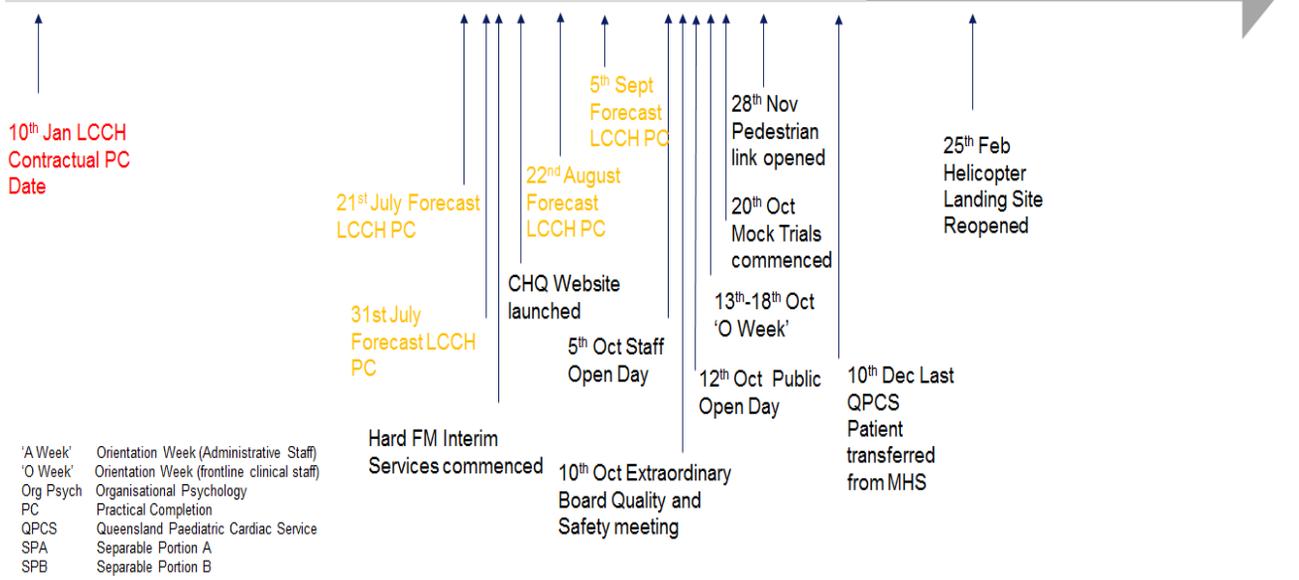
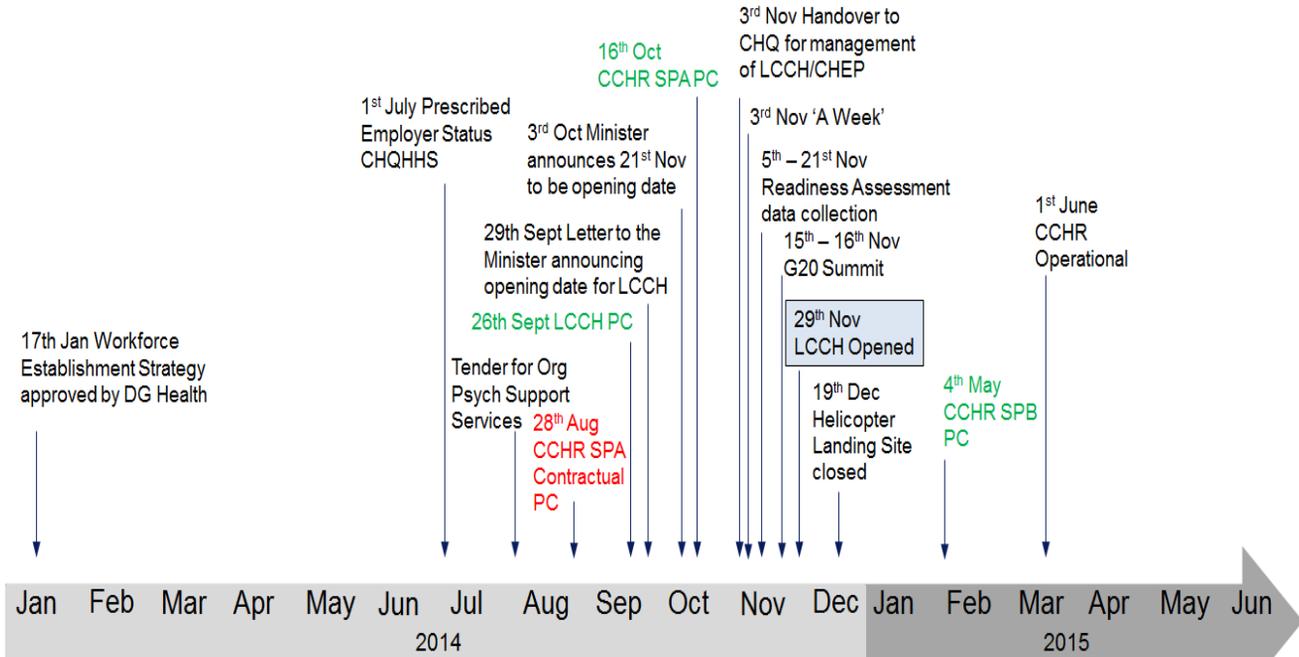
The newly established LCCH hospital provides:

- 359 public beds (overnight and same day) - 71 more beds than the RCH and MCH combined
- Models of care that support access to day procedures and ambulatory care
- Sleeping accommodation options for parents or carers within single patient rooms
- Ongoing delivery or expansion of services previously provided at both the RCH and MCH
- An expanded range of services to patients up to 16 years for new patients and 18 years for existing patients

In response to suggestions that clinical care had been compromised in the first two weeks of operation, the CHQ HHS Board took the initiative to bring forward a planned independent panel Clinical Review, led by Professor Les White AM – New South Wales Chief Paediatrician. The Clinical Review made an assessment of the quality of care delivered to patients on the day of the move and in the two weeks of clinical operations following the opening of the LCCH. This assessment, which occurred during a period of reduced patient load, found that 'although a combination of factors generated an unparalleled level of complexity and risk, no serious adverse events causing long term harm occurred on the day of the move or during the first two weeks of operation of the LCCH.' This report was then publically released in March 2015.

Section 3
High Level Timeline

High level timeline of LCCH milestones and key events for the period January 2014 to June 2015



'A Week' Orientation Week (Administrative Staff)
 'O Week' Orientation Week (frontline clinical staff)
 Org Psych Organisational Psychology
 PC Practical Completion
 QPCS Queensland Paediatric Cardiac Service
 SPA Separable Portion A
 SPB Separable Portion B

Section 4

Key case studies and lessons learnt

Project Timeframes

The LCCH was opened for patients and families on the 29th November 2014 with the subsequent decommissioning of both the RCH and MCH sites after this milestone. The revision of forecast practical completion dates by the Managing Contractor significantly compressed operational commissioning processes leading up to the opening date.

At the CHQ HHS Board Meeting on the 29th May 2014, 'the Board sought clarity from the CHQ HHS Executives present over the proposed opening date for the new facility.' It was determined that the 'Health Service Chief Executive (HSCE) had a high level of confidence' that the anticipated opening date of the LCCH would be the 29th November 2014, 'pending any major uncontrolled events, natural disasters or significant events at either the G20 or B20 summits.' The period from June 2014 to September 2014 was a critical time for the project and a period of significant opportunity to reflect and reconsider progress of the project and the level of clinical and corporate risk.

The confirmation and request for the announcement of the LCCH opening date was officially communicated in a letter by the CHQ HHS Board Chair to the Minister for Health on the 29th September 2014. This letter detailed to the Minister for Health that the Board could provide confidence that the risk mitigation strategies that had been implemented would enable a safe transition of services to the LCCH. The Minister for Health publicly announced the LCCH opening date on the 3rd October 2014. The Review Panel would contend that sufficient evidence existed in the June/July 2014 period and still in late October 2014, which should have raised sufficient corporate concern over 29th November 2014 being a realistic opening timeline.

Practical completion of the LCCH main building and Children's Health Energy Plant (CHEP) was achieved on the 26th September 2014, three days prior to the CHQ HHS Board confirmation of the opening date to the Minister for Health.

The proposed forecast date for practical completion of the LCCH/CHEP was repeatedly revised from the original proposed date of 10th January 2014. Revised forecast practical completion dates included the 21st July, 31st July, 22nd August, 5th September and 12th September 2014. The achievement of practical completion on the 26th September 2014, included the establishment of a 'New Separable Portion 10' which encompassed multiple Building Certifier exclusions as stated in the Certificate of Substantial Completion. As agreed at the November 2014 CHQ HHS Board meeting, the repeated delays in achieving Practical Completion resulted in the CHQ HHS HSCE formally providing feedback to both the Minister for Health and directly to the Managing Contractor, regarding the Board's perception of sub-standard performance of the Managing Contractor.

At the point of Practical Completion of the LCCH and CHEP, there were 1900 Builder Certifier Defects and 26 identified exclusion zones. There were 20 remaining exclusion zones as at 7th Nov 2014 with six exclusion zones identified as critical to opening. Some 500 defects were still outstanding as at 18th November 2014 with 44 defects considered 'must do' before opening. At Practical Completion, the LCCH building and CHEP was handed over from the Managing Contractor, to the LCCHP. The management of LCCH/CHEP was transferred from the LCCHP to CHQ HHS on the 3rd November 2014. At this point, full control and management of the LCCH was now within the remit of CHQ HHS leading up to the opening date.

The academic and research facility, Centre for Children's Health Research (CCHR,) was separated into two portions, SPA and SPB. Practical completion of CCHR SPA (Pathology, link tunnel and Level 1 Store) was achieved on the 16th October 2014, some three months later than the originally proposed date. It was recognised that to enable the effective management of patients, it was essential that Pathology services were operational at the time of opening of the LCCH. An agreement was reached to commence commissioning

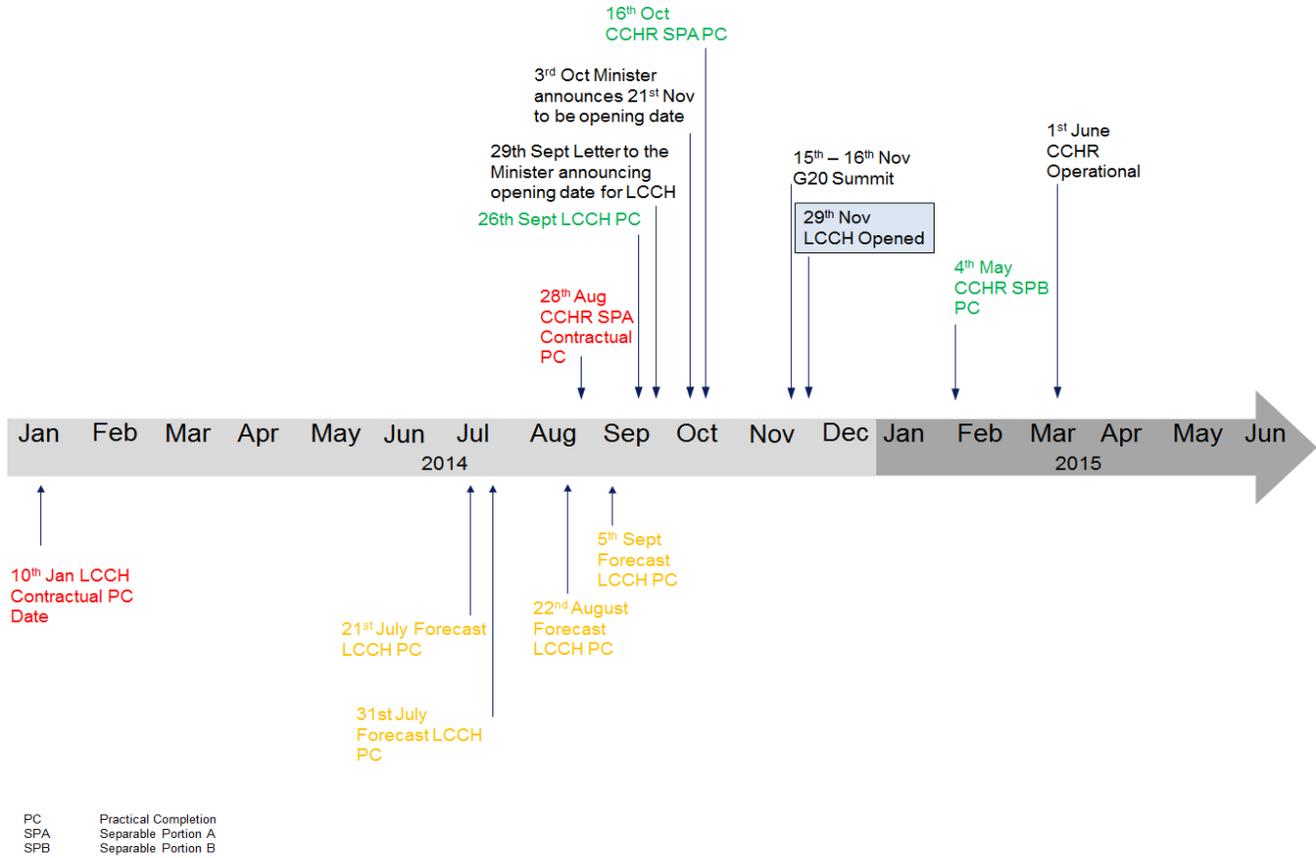
Project Timeframes

activities prior to the achievement of practical completion so that Pathology services would not impact on the opening of the LCCH.

Practical completion of CCHR SPB was achieved on the 4th May 2015. The original proposed date for practical completion was October 2014. The CCHR building was operational as of the 1st June 2015.

The repeated non-achievement and revision of practical completion dates by the Managing Contractor, significantly compressed operational commissioning processes prior to the opening date of 29th November 2014. Despite assertions from the CHQ HHS Board and Executive that commissioning processes commenced from the 11th November 2013 and client commissioning

processes commenced from 21st July 2014, the LCCH was and continued to be a 'building site' up to and after the achievement of Practical Completion on the 26th September 2014. As the LCCH building was the responsibility of the Managing Contractor until the achievement of Practical Completion, there was a requirement that personal protective equipment (PPE) was worn when accessing the building and visits scheduled and supervised with the Managing Contractor. Clearly, the presence of ongoing building works affects the ability, extent and capability to undertake comprehensive commissioning processes. In the Review Panel's view, it is not advisable, nor effective, to partially commission within a building site, particularly when it involves larger hospital complex infrastructure builds.



Project Timeframes

The achievement of practical completion with significant caveats including exclusion zones and identified defects, meant that numerous commissioning processes, including orientation and simulations had to be revised, re-scoped and be undertaken in less than optimal conditions. This included commissioning activities occurring within ongoing building works and revised or scaled back to enable some basic testing and trials to be undertaken.

The project timeframes were further challenged by the zone restrictions enforced as part of the G20 summit on the 15th and 16th November 2014, which took place only two weeks prior to the opening of the LCCH.

The CHQ HHS Executive and Board took a considered decision to continue to aim to strive towards the 29th November 2014 opening date. This included maintaining the forecast opening date decision subject to continual information regarding the risks and required mitigation strategies, de-scoping of commissioning activities, adoption of minimum standards and agreements on extensive post works schedules. The CHQ HHS Board Chair, HSCE, Executive Director of Medical Services (EDMS) and Executive Director of Nursing Services (EDNS) presented to the Minister for Health on the 20th November 2014 to detail the strategies that were to be put in place to enable a safe 'Move Day' transition to the LCCH on the 29th November 2014.

In order to meet the less than originally planned commissioning time frames, commissioning group leaders needed to identify the minimum safe operational criteria and abbreviate their commissioning plans accordingly in order to achieve the opening date. Such significant activity required an extraordinary effort from the commissioning teams in order to achieve the agreed minimum set of criteria and to enable the safe opening of the LCCH.

The significant work by the CHQ HHS Executive to resolve issues to facilitate the readiness of the

LCCH was acknowledged by the CHQ HHS HSCE at the 27th November Board Meeting. At this Board meeting, the CHQ HHS HSCE also indicated that the CHQ HHS Executive and Board had made a decision to delay the the transfer of cardiac services to the LCCH until the 10th December 2014. The CHQ HHS HSCE detailed that this was due to issues associated with an unexpected surge in neonatal deliveries requiring cardiac intervention and the readiness of the ICU space. This decision was communicated to the Minister for Health. Additionally, mock trials for cardiac services were conducted in the week after the opening of the LCCH, from the 1st December 2014, due to issues with staff availability and increased clinical service requirements.

The great devotion and effort of all staff involved in delivering the project is evident. The Review Panel would contend that the commissioning teams had insufficient previous experience of the complex interdependencies in operationally commissioning a hospital. The CHQ HHS Commissioners were selected according to their clinical expertise and senior management experience.

Whilst being highly competent service managers, and clinicians, numerous commissioning group leaders reported that they were leading significant components of such a project for the first time, with little exposure to similar comparators as a guide. It appears there was limited practical experience and ability to innately assess progress against accepted benchmarks and risk profiles with building and operational commissioning processes.

Solving problems and mitigating known risks further exacerbated by an inadequate commissioning timeframe, placed unreasonable strain on the commissioning groups. Sub-optimal and often last minute work-arounds created excessive workloads for numerous operational commissioning groups. This approach to operational commissioning should be avoided in future health infrastructure projects as it unnecessarily increased the project risk and challenged the comprehensiveness of the commissioning processes.

Project Timeframes

The three month period post operational 'Go Live' is often as challenging as the actual commissioning period. It is traditionally an exhaustive time for staff who must provide high quality care, while learning new systems, processes and team dynamics. Even now over six months post opening of the LCCH, interviewees frequently commented on the levels of fatigue and diminishing resilience amongst them and their colleagues.

The continual revision of the project milestones, and the acceptance of multiple certifier caveats and compromised and compressed commissioning processes, suggests that the project was repeatedly challenged by the governance, commissioning and operational handover experience in operational commissioning and the project wide risk based decision-making of the teams involved.

Lessons Learnt

- Utilise a dedicated and experienced commissioning team, and commissioning leader that have been involved with multiple infrastructure projects of similar magnitude. The commissioning leader must carry the appropriate project wide authority and be the ultimately responsible for the risk profiling of the project
- Implement and adhere to defined and absolute criteria for the achievement of readiness for 'Go Live' that is universally understood by all stakeholders
- Significantly compressing planned commissioning timeframes places the project at unnecessary risk
- Maintain effective interactions with the Managing Contractor to control risk, scheduling of project works and adherence to project timeframes

- Undertake regular and effective assessments of readiness across the project and all commissioning groups to achieve project milestones, including practical completion
- Avoid undertaking primary client commissioning activities in the presence of ongoing building works, particularly scenario testing and orientation training as it significantly diminishes the impact of the program
- Appropriately manage project timeframes, interdependencies and deliverables to avoid the need for excessive workloads
- Agree on minimum scope of trial and scenario testing schedules and obtain approval when original plans are amended or diluted
- Identify and escalate project risks as early as possible to enable the detailed development and timely deployment of effective contingency plans

Recommendations

1. ***Establish an experienced health infrastructure commissioning group upon which future projects can draw upon for independent insight, commercial advice and strategic partnering***
2. ***Establish and agree in advance good practice guidelines for building and operational commissioning and make sure that progress assessments are undertaken against these guidelines, including an appropriate 'Go/No Go' assessment***
3. ***Clearly articulate and adhere to minimum mandatory operational commissioning timeframes and activities***

Governance

The governance structures as articulated in the LCCH Program Governance Chart (Appendix A), covering the construction and commissioning of the LCCH, are well supported by clearly enunciated and sound governance principles. This framework is further detailed in the LCCH Project Governance December 2013 document. Despite this, numerous members of the CHQ HHS Executive and clinical leadership team reported that the governance structures, processes and procedures were often not well understood and routinely not always well enacted. Interfaces with the numerous stakeholders, including the DoH, changed during the course of the project, as did a number of key roles and individuals. Based on uniform feedback from those interviewed and surveyed, attendance and engagement at the various governance forums also varied significantly throughout the duration of the LCCH project. The Panel heard multiple reports of a level of disconnect between the CHQ HHS Board Executive and their stakeholders, clinicians, staff, unions and community,

The governance structure, despite being clearly articulated, was inherently convoluted with multiple sub-committees and numerous interfaces including the:

- Department of Health
- Health Infrastructure Branch
- Mater Health Services
- Royal Children's Hospital
- Children's Health Queensland Hospital and Health Service
- Lady Cilento Children's Hospital Program
- Multiple vendors
- Multiple contractors

The governance structure resulted in shared responsibilities and multiple handovers throughout the project lifecycle. Handover from the LCCHP to CHQ HHS commissioning leads was stated but it is very difficult to ascertain what was actually happening. At Practical Completion, the LCCH building and CHEP was handed over from the Managing Contractor, to the LCCHP. The management of LCCH/CHEP was transferred from the LCCHP to CHQ HHS on the 3rd Nov 2014.

Responsibility for taking ownership of the building and opening it, seems to have evolved over 2014, from the Managing Contractor to LCCHP to CHQ HHS, and as a result, clear accountability was not evident in decision making responsibilities until middle to late 2014.

The numerous interfaces and sheer volume of interactions in the governance of this complex project further highlighted the differences in organisational cultures, behaviours, practices and attitudes between the different bureaucracies, public and private hospital organisations and the newly formed HHS. The perspective of numerous CHQ HHS Executives and lead clinicians who were interviewed supported this view as well as expressing a sense of the lack of transparency of key decision making processes and poor and/or delayed communication of decisions once made. Lead clinicians did report the value in fora to be able to adequately present and discuss evidence regarding clinical risk direct to the CHQ HHS Executive and Board team (for example the Extraordinary Board Quality and Safety meeting held on the 10th October 2014).

As a result of the growing view that the overarching governance structure wasn't functioning well or perhaps was not 'fit for purpose', action was taken by LCCHP and CHQ HHS to address these issues. This included the appointments of both the Chief Information Officer, to improve the delivery of the ICT program and transition to business as usual, and the Executive Director Development and Commissioning, to provide a single point of contact and executive level coordination between the LCCHP and CHQ HHS. This late bolstering of capability within the CHQ HHS Executive team, should have occurred well in advance of mid 2014.

The governance structure appears to have struggled to bond the relevant parties together. There were numerous comments from key stakeholders that the underlying organisational cultures and historical relationships may have undermined or eroded the impact of the technically sound governance structures.

Governance

There has been repeated inference from key stakeholders of an inconsistent and non-uniform view of who the 'client' was throughout the duration of the LCCH project. There were also numerous comments from the LCCHP, CHQ HHS, MHS and clinical staff that despite funded off-line time for staff involved in commissioning activities, demands of 'business as usual' requirements at both the RCH and MCH hospitals significantly compromised the availability of key staff to engage appropriately in commissioning activities.

Despite the articulation of the program governance structure, the management of multiple project components proved both challenging and the framework insufficiently agile particularly when the pace and workload of the LCCH project escalated.

There are numerous instances where the CHQ HHS Board and Executive circumvented the governance structure to escalate project concerns and expedite decision making. The CHQ HHS Board and Executive actively aimed to mitigate short comings of the governance arrangements by directly engaging with contractors, HIB, DoH and the Minister for Health.

Challenges associated with the governance structure were further highlighted in May 2014, when the CHQ HHS Board discussed that the utilisation of a 'No Go/Go' gateway assessment detailing critical points in the achievement of practical completion and transition was unhelpful.

Within the governance structure, senior staff from both the CHQ HHS and MCH were assigned as Commissioners and appointed against criteria which included 'subject matter expertise.' The previous hospital commissioning experience of a number of individuals assigned to these roles appears to be limited. Within this structure the nominated commissioners were responsible for providing advice to CHQ HHS and LCCHP regarding the operational readiness and comprehensiveness of commissioning processes for the assigned division. With limited relevant tangible experience and previous familiarity in

building and operational hospital commissioning processes, commissioners reported that this phase was tremendously challenging to gauge genuine risk.

Lessons Learnt

- Schedule regular opportunities for lead clinicians and critical staff to directly engage and discuss patient safety and quality risks with the Hospital and Health Service Executive Leadership and Board members to appropriately inform critical milestones of the project
- Enable the early identification and appointment of key Executive positions to support and manage critical project processes
- Limit the complexity of governance frameworks and promote universal awareness and acceptance of the structure
- Governance structures must be supported by the experience of the stakeholders responsible for leading and being accountable for components within the framework
- Enable and encourage ongoing feedback and the ability to review the efficacy of the governance framework, throughout the project lifecycle
- Implement governance structures which enable the rapid escalation of project risks and limit the need to circumvent or bolster formal processes
- Effectively communicate decision making and progress to all stakeholders with reference to the governance framework and project objectives
- Thoroughly and regularly assess the complexity and impacts on decision making and timeframes which different behaviours, practices and cultures from multiple organisations and stakeholder groups can bring to a project

Governance

Recommendations

4. Enable lead clinicians and critical staff members to directly engage and discuss patient safety and quality risks with the Hospital and Health Service Executive Leadership and Board members to appropriately inform critical milestones of the project

5. Implement a robust, effective and easily understood governance framework

6. Schedule regular assessments of the efficacy of the governance framework including its ability to connect the objectives and timeframes of both the project and the operational components of the business

7. Provide control, accountability and authority to the Hospital and Health Service as early as possible in the operational commissioning process

8. Continually assess the safest and most appropriate approach for the determination of the transition to the hospital opening (eg hard opening versus staged approach)

Information and Communications Technology

The LCCH precinct was a 'brownfield' site requiring the implementation of a major large scale Information and Communications Technology (ICT) program. This included extensive integration and configuration requirements of equipment, systems, enterprise and local applications including new technology to Queensland Health and previously untested system interactions across multiple vendors and providers. The ICT budget allocated to the LCCH project was originally \$40 million (2008/2009) The budget was subsequently revised to \$54 million (2010/2011) and then to \$93 million (2012/2013) to accommodate private contractor spend and project scale.

There were numerous dependencies associated with the effective and successful implementation of the ICT program including:

- Procurement processes and delivery and installation timeframes
- CHQ HHS business decisions
- Detailed workforce profiles
- Orientation and training requirements
- Vendor reliability and availability
- Service level agreements
- Management of change requests
- Completion of building works

The achievement of Practical Completion on the 26th September 2014 and the opening date of the 29th November 2014, provided a significantly challenging environment for the commissioning of the ICT program. These challenges included managing the interdependent operational commissioning requirements, ongoing building works, exclusion zones, vendor contractual obligations, receipt of detailed business and service configuration requirements and compressed commissioning timeframes.

Commissioning of the ICT program included:

- Configuration of communication systems
- Establishment of system interfaces
- Testing and re-testing of ICT componentry
- Resolution of identified defects
- User acceptance

The delivery and commissioning of the ICT program by the LCCHP saw ICT staff undertaking excessive workloads to meet an agreed set of minimum requirements. The constraints associated with the capacity of the Health Services Information Agency (HSIA) to provide adequate resources, required the engagement of external contractors to assist with the completion of the ICT works, which affected the total spend.

As previously outlined, the continual delays and repeated revision of achieving forecast Practical Completion dates, resulted in the ICT testing and integration work needing to be administered within a significantly reduced timeframe. As detailed in the September 2014 CHQ HHS Board Papers, 'although everything possible is being done to work alongside the builder's activities, much of the ICT testing and integration work will be delayed until Practical Completion is achieved.' Furthermore it is also detailed within these Board papers that due to the 'compressed timescale for site access and integrated ICT testing, the window between Practical Completion and mock trials/opening continues to shorten, with no contingency for any unprecedented event.'

A significant event that arose during the commissioning process was the need to replace 2850 nurse call buttons (3543 including staff asset buttons). The Managing Contractor engaged another vendor to provide an alternative nurse call solution due to changes with the vendor going into receivership. A further decision was made by the CHQ HHS Executive to reduce the scope of the integrated nurse call services by uncoupling the system from the paging and messaging system for all hospital areas except for Emergency, Intensive Care, Cardiac and Operating Theatres for the LCCH opening day. Stakeholders interviewed reported that the 'nurse call button' event triggered a broader review of any risks to operational readiness which may be posed by a number of other core processes and systems.

Information and Communications Technology

Furthermore, the successful delivery of the ICT program required the appropriate access to, and availability of, LCCH staff to provide all levels of training and familiarisation with ICT componentry and systems. Significant delays in workforce recruitment, delays to the completion of building works and delays to the delivery and installation of equipment compounded the ICT commissioning requirements. The ICT program was repeatedly challenged by limited access to areas for ICT works to enable testing, integration, training and user acceptance processes to be undertaken. On the day of opening of the LCCH, there were numerous staff, especially MCH staff, who were unfamiliar with a number of key Queensland Health applications and even more who were self reportedly less than proficient in their use. Again CHQ HHS compromised on their original plan and prioritised training on clinical applications rather than provide comprehensive training on all applications.

As of September 2014, there was also acknowledgement that a significant ICT works program would need to continue post opening of the LCCH, upon meeting an agreed minimum ICT scope for Day One operational requirements

A significant component of the LCCH project was the extensive data integration, convergence and information sharing requirements between the RCH and MCH. This included the management of privacy, indemnity and intellectual property matters. A data sharing agreement was executed between MHS and CHQ HHS on the 19th September 2014. Final MCH data uploads were planned to be completed by the 28th November 2014 with reconciliation processes to be completed by the 12th December 2014. The data was progressively uploaded, however there was an emphasis on utilising up-to-date patient data, balanced with the need to minimise a large data extraction process. The scanning of paper based Mater Health Records into the LCCH Integrated Electronic Medical Record (iEMR) system commenced from the 22nd September 2014. The Data Extract Work Package was signed on the 16th March 2015,

however the upload of the information commenced from the 25th September 2014. The late finalisation of the data uploads and need for reconciliation processes placed unnecessary risk of inaccurate and incomplete information on the operational effectiveness of the LCCH. Furthermore, the Health Records Sharing Work Package was not signed until 20th April 2015.

The configuration requirements of the ICT program were significant and dependant on user data and workforce profile information from both the MCH and RCH. LCCHP stakeholders reported that the decision was taken to generically configure numerous ICT interfaces, due to the lack of provision of timely, key service requirements and business information. Examples of the impact of these requirements included:

- Staff logins were created in instances with minimal information, including the utilisation of generic logins as required
- Significant additional support and effort was brought into the project to reconfigure and tailor ICT interfaces leading up to, during and post the move into the new facility
- Underestimated and inaccurate assessments of the demand on a newly established switchboard on Day one due to user unfamiliarity with the communication systems and incorrect staff profile configurations throughout the precinct (As a result, CHQ HHS established a Telecommunications Taskforce on the 2nd December 2014 to manage previously unidentified communications issues)
- As close as three days prior to opening, 100 Emergency Department Wi-Fi handset related telephone numbers had not been provided which had a significant potential impact on internal hospital communication capabilities and with the Queensland Ambulance Service. This issue was to be resolved prior to opening day, but should not have been a risk so late in the commissioning process

Information and Communications Technology

Lessons Learnt

- ICT program of work is a significant project in itself, and must be appropriately governed, risk profiled, budgeted, resourced and managed
- ICT program is reliant on multiple interdependencies that can result in delays and/or the reduction in scope of trial, testing and user acceptance processes
- Changes to the ICT scope must be closely monitored along with milestones, risk and implications for health service operations
- Clinical engagement and leadership in the ICT development, specification, design and implementation is key to enable ICT systems to meet the clinical needs of the hospital. It will also support the roll-out and future adoption of practices of key staff
- Facilitating the timely input of detailed business requirements and information into the ICT configuration process is crucial and a core role for both the Project team and operational managers
- Management of multiple vendors and contractors requires strong governance, effective performance monitoring capabilities and a consistent approach
- Appropriate time and resourcing must be allocated to staff to undertake orientation and training activities, particularly when new systems, integration processes and technology modalities are utilised
- Assessments of staff capability and competence of core clinical ICT systems and application should be undertaken
- Minimum mandatory training should be undertaken on critical clinical ICT systems prior to use in a live clinical setting
- Bolster ICT support services in the months following the opening of the service

Recommendations

9. Utilise an integrated risk approach to ICT delivery in which the total weight of the combined risk, operations and interdependencies is appropriately assessed and managed

10. Adhere to adequate commissioning timeframes, especially post practical completion, to enable the comprehensive integration of ICT systems and staff training and familiarisation with equipment, systems and processes

Our People

The establishment of an integrated and cohesive LCCH workforce which is able to manage the complexities of tertiary and quaternary level paediatric care is integral to the effective delivery of safe and high quality services.

The Workforce Commissioning Group was faced with the challenging task of effectively combining two well established paediatric workforces with the capability and skills to deliver on the operational plan. This included retaining current skills, knowledge and experience, integral to the effective functioning of the LCCH.

The establishment of a single cohesive workforce delivering agreed models of care at the LCCH was further challenged by having to synthesise well established routines, behaviours, processes and organisational cultures from two equally unique organisations. Both the RCH and MCH were characterised by intrinsically ingrained values and ways of working to enable the effective delivery of a complex array of interrelated paediatric services. Merging and optimising the RCH and MCH processes, systems and cultures into the newly founded LCCH required effective planning, development, support processes and most significantly, time.

The significant clinical risks associated with the imperative for behavioural, process, operational and cultural integration was clearly outlined by the CHQ HHS Executive and lead clinicians in numerous commissioning plans and planning documentation.

Cognisant of these challenges numerous documents and CHQ HHS Executive team interviews indicated the critical need to establish the LCCH workforce as early as possible to enable the integration of the two previously separate workforces. An effective clinical leadership team needed to be established early and made accountable for the planning and integration processes prior to the move.

Clinical leadership positions needed to be established early in order to support staff

through processes of significant change and disruption and to promote cohesion and positive staff morale. These processes required time and agile management and were critical for the effective functioning of a complex workforce. Furthermore, it was essential that clinical leaders embedded the models of care and service integration prior to the opening of the LCCH.

In 2010, CHQ HHS implemented the Clinical Services Integration (CSI) Project. The purpose of the CSI project was to enable integration processes between both the RCH and MCH. There were 32 clinical services involved in the CSI project, with each service providing a doctor, nurse, allied health professional and administrative officer from each hospital to provide leadership to the integration process and further develop models of care. It is reported that these groups transitioned into the establishment of the Commission Governance Groups and Subgroups.

A key component of empowering the workforce is to enable staff to be cognisant of roles and responsibilities, systems and processes and interdependencies. This level of integration extends across disciplines, specialties and to community services. A comprehensive program of specialty and departmental specific orientation and training and familiarisation with both workspaces and relative peers needed to be delivered with precision. Significant delays to the recruitment of the workforce compounded the extent to which these processes were able to be achieved.

Opening day at the LCCH, should not have marked the moment that a number of clinical teams actively functioned together for the first time. The successful integration of Oncology Services at the RCH in 2010 and Cardiac Services in 2011, demonstrated that combining workforces and models of care could have been achieved across specialties and teams, even if this required a split of services across two sites. The critical nature of specialist and tertiary hospitals clearly indicates the need for an emphasis on teamwork, aligned response mechanisms, cultural integration and

Our People

articulated objectives and performance frameworks.

CHQ HHS implemented the 'Collaborative Work Agreement' in an attempt to support staff to develop greater knowledge, understanding and familiarity with their respective peers at the alternate children's hospital. This was a worthy initiative, however there was a requirement for a written formal request and acceptance by Executive staff at both RCH and MCH for the release of the staff on each occasion. This process was cumbersome, and often staff would only be released for short periods of time. Team work, integration and the development of routines takes time and sustained engagement. Processes which facilitate this are favourable.

The Workforce Establishment Strategy developed by CHQ HHS was approved by the Director General of Health on the 17th January 2014, and was formally communicated and discussed at the LCCH Union Consultative Forum on the 23rd January 2014.

Appointing the workforce establishment in the months leading up to the opening of the LCCH hampered integration opportunities which may have occurred had recruitment been carried out 12-18 months in advance. The delayed finalisation of the LCCH workforce also resulted in reduced opportunities to orientate and train the LCCH workforce. It is evident from the commissioning plans, that the intent was to integrate the workforces, however the extent of recruitment and cultural integration requirements for the two large and well established organisations appears to have been a very significant challenge. Staff uncertainty associated with recruitment timeframes, in some cases letters of appointment provided in the weeks and days approaching the opening of the hospital, hindered the full implementation of the Workforce Establishment Strategy.

The distribution of appointment confirmation letters is detailed in the proceeding table:

	Forwarded from	Finalised by
Medical	19 th Sept 14	10 th Nov 14
Nursing	20 th June 14 (CHQ) 24 th June 14 (CHQ)	25 th Nov 14
Allied Health	26 th June 14	27 th Nov 14
Administration	14 th Oct 14 (CHQ) 15 th Oct 14 (MCH)	28 th Nov 14

The late formal written notification to staff confirming their role at LCCH compromised the time staff had to prepare for the significant workforce integration and service model change requirements, as well as providing certainty of their working future. The Review Panel were advised that there were verbal offers made from April to staff, earlier than the provision of documented formal correspondence. In the Review Panel's opinion this is still too late for sufficient team and cultural integration processes to occur. Furthermore, the provision of a verbal offer is not as reassuring as a formal letter of offer, particularly when the staff were dealing with other challenges and stresses associated with preparing for the transition to the LCCH on top of managing 'business as usual' processes. This included the uncertainty resulting from resigning from an existing position based on a verbal offer.

Identified issues associated with the amalgamation of the RCH and MCH workforces included:

- Disparities in staff classification levels
- Transfer of leave entitlements/liabilities
- Funding for operational staff redundancies
- Mandatory Super providers
- Staff disengagement and resignations placing 'business-as-usual' at risk to the continuation of services at both the RCH and MCH

Additional factors affecting and complicating workforce commissioning processes included:

- CHQ HHS achieving prescribed employer status from 1st July 2014 (Board recommendation on 27th February 2014)

Our People

- Introduction of senior medical contracts by the Government at the time, which needed to be finalised by 4th August 2014
- Availability of staff, particularly MCH staff, to participate in orientation and training activities due to staff shortages which was further complicated by delays in the appointment process and associated concerns regarding job security

The structure and recruitment of administrative staff was the last major area to be finalised by the 28th November 2014. The late appointments resulted in subsequent challenges including:

- Significantly limited training opportunities compared to the plan
- Development of an appropriate and effective organisational understanding of the newly established LCCH structure
- Review of administrative staff structure post opening was required to facilitate an appropriate skill-match, and an efficient distribution of administrative resources across the LCCH precinct

The readiness of the administrative staff recruited from MHS was further compounded by the limited access to these staff members prior to the transition to the LCCH. The MHS administrative staff were largely unfamiliar with many Queensland Health systems including HBCIS, Practix and the iEMR. An extensive post-opening training and support program was required.

The appointment of an external contractor to provide hard and soft facilities management services, as a result of processes associated with the 'contestability agenda' of the Government at the time, further compounded the workforce and culture integration requirements associated with the LCCH project. Support staff are integral team members within hospital organisations and the subsequent appointment of an external facilities

management workforce had significant ramifications for RCH and MCH team morale, workforce capability, performance management and the complexity of cultural integration requirements.

The CHQ HHS Board and Executive has stated that in the months leading up to the opening of the LCCH, the attrition rate of staff at both the RCH and MCH, posed a very high risk to the ability to effectively deliver services in line with 'business as usual' processes. Paediatric Intensive Care and Retrieval services in particular were deemed as being adversely impacted. Maintaining agreed elective surgery throughput in accordance with the National Elective Surgery Targets was also compromised by staff shortages. Contingency plans were also required from January 2015 to manage an anticipated surge in acute surgery demand (30%) and required the scheduling of additional acute theatre sessions.

In the Review Panel's view, the appointment and commencement of organisational psychology services by CHQ HHS to support the integration of the RCH and MCH workforces was not in effect until September 2014. It was also identified that the majority of the program content would be provided post move. This is a significant underestimation of the complexity of the cultural integration requirements for the LCCH project, already complicated by the late establishment of the workforce. Organisational psychology services would have benefited from greater time prior to the opening of the LCCH, to allow sufficient time for all staff to effectively evaluate and develop strategies for managing and optimising opportunities provided by the transition to the LCCH.

CHQ HHS also engaged the Cognitive Institute from May 2014 to provide transition management strategies, to a restricted number of middle management and senior leadership staff and was commenced later in the project.

Our People

The management of significant change and the assimilation of all relevant personnel to their new and refreshed roles, should have taken greater prominence and greater emphasis in workforce establishment, realignment and development processes. These processes should have occurred well in advance of the opening of the LCCH and provided a stable platform for teams to integrate and align.

Lessons Learnt

- Cultural integration, synthesis of values and behaviours and alignment of objectives is critical and should commence up to two years prior to opening date
- Integrating large workforces takes significant time and requires supportive and agile management
- Consider streamlining approaches to employment screening, credentialing, visa approval and notification
- Allow sufficient time for complexities associated with clinician employment including contracts, accreditation and rostering requirements
- Embedding models of care and ways of working is as important as appointing the workforce establishment
- Matching skill requirements to anticipated organisational demand is complex and requires comprehensive planning processes
- Engage with the numerous government agencies (e.g. DoH, Department of Premiers and Cabinet) early in the process to fast track approval for recruitment, strategies, exemptions and funding
- Organisational psychology services need to be established early and considered as an integral component to projects requiring change and alignment of organisational cultures and should feed directly into service planning processes and reach all staff

Recommendations

11. Establish the workforce well in advance of the hospital opening date to enable comprehensive workforce and service integration processes in order to embed models of care, 'ways of working' and team cohesiveness

12. At the commencement of the project, engage relevant expertise to facilitate cultural and behavioural integration

Furniture, Fittings and Equipment

The management of furniture, fittings and equipment (FF&E) requirements for the LCCH project included the procurement, installation, testing and commissioning of a significant proportion of new equipment as well as managing the inventories of legacy equipment, to be transferred from the RCH and MCH.

Comprehensive FF&E commissioning processes enable the availability of equipment for trials and scenario testing to promote familiarity with equipment, technology systems and processes as well as the identification of defects, issues and gaps. Delays in defining equipment specification and delayed equipment delivery, late procurement and delivery estimates based on warranty management processes, impeded systems integration and training opportunities.

The Review Panel found evidence that some commissioning teams were still defining equipment requirements and specifications as late as June 2014, with ordering taking place of critical equipment in the months leading up to opening day. To support the programming, tracking and reporting of FF&E, it was determined at this time that a consultant should be engaged by LCCHP to manage this process and be the key conduit to provide updates on the program status. Once it was determined that not all FF&E would be able to be procured and delivered in time for day one of operation, a prioritisation exercise was undertaken, in August 2014, with the senior clinical staff to determine equipment critical and non-critical for opening day.

The management of legacy equipment required the accurate identification of equipment, including the timing to transition the equipment to the LCCH without impacting on 'business as usual' processes at the RCH and MCH. Changes to the list and rectification of inaccuracies of equipment to be transferred across to the LCCH continued to occur in the final months of operational commissioning. FF&E lists are crucial pieces of information for clinical and non-clinical teams. The lists ought to be provided well in advance to end users in a format

that is both meaningful and facilitates feedback. A significant challenge associated with the accurate provision of FF&E lists was that the clinical and hospital staff who were involved in culminating the lists did not have the appropriate level of FF&E management knowledge or experience to respond accordingly. In fact, the lists were provided multiple times and in multiple formats.

Further complexities associated with FF&E processes included:

- Procurement processes, including 'just in time' approaches, were not universally understood by some clinicians and created unnecessary angst
- Changes to purchasing delegation responsibilities occurred during the project resulting in the delays in Departmental sign off of major orders
- Procurement and vendor lead times and delivery timeframes varied significantly, both favourably and unfavourably to those forecast in original plans
- Variable access to support from vendors
- Testing area availability was limited and resulted in a significant proportion of testing being undertaken off site. Small bulk devices that were suitable for transporting were tested off site and then repacked by area and delivered directly to these areas (comprising approximately two thirds of all devices)
- Scheduling of asset and non-asset placement and the interactions and interdependencies with commissioning activities was not well understood
- A significant proportion of medical equipment required testing and installation prior to mock trials

The Review Panel found evidence of equipment not being available for mock testing and orientation, being of the wrong specifications or not arriving until just days prior to opening day. Clinicians reported personally spending time in loading docks looking for crucial ward, theatre and intensive care equipment in the week prior to opening, with the poles used to mount the pumps in PICU being on the risk register as late as Tuesday the 25th November 2014. Linen, flow meters and

Furniture, Fittings and Equipment

clinical consumables were also being sourced for the wards in the final week. These comments were not universal, but of a sufficient frequency to cause concern for critical clinical areas and to raise serious concern over readiness.

LCCHP engaged an external vendor to undertake an audit of existing surgical instruments to determine the number that needed to be replaced. This report was completed in May 2014 and delineated the procurement requirements for replacement surgical instruments. Additionally, CHQ HHS undertook an assessment of new instrument requirements for services at the LCCH that were either expanding or to be newly established. This assessment was provided to LCCHP in September and October to commence the procurement processes. In December 2014, CHQ HHS determined that there were deficiencies in surgical instrumentation and further procurement was required. This process was not completed until February 2015.

Recommendations

13. Utilise a team with comprehensive expertise in the management and procurement of FF&E to appropriately manage risks and deliverables associated with project timeframes and operational commissioning

14. Develop service plans that detail the FF&E requirements for the effective delivery and testing of service requirements that are cognisant of comprehensive clinical review processes, integration requirements and vendor support processes

Lessons Learnt

- Procurement processes for FF&E must be cognisant of delivery lead times and integrated testing requirements and build in sufficient contingency
- The delivery of equipment should be timed to enable fully integrated testing, cognisant of potential impacts on warranty conditions
- Inventory management of legacy equipment must account for parallel 'business as usual' processes during the transition phase
- Sufficient space must be allocated for the testing of equipment to minimise transport and handling requirements
- Management of FF&E lists needs to be standardised and undertaken by staff familiar with these processes

Contract Management

Well executed contract management is a critical aspect of any large scale infrastructure build, particularly when engaging multiple organisations in the building, commissioning and operational delivery components. The integration and management of multiple contractors is challenging and requires effective contract development, negotiation and management strategies and capability to address such issues as:

- Scope and definition of construction, capital and operational contracts
- Service level agreements with third party providers
- Escalation points within the governance framework
- Ongoing performance management of the contractor
- Integration of contractors
- Negotiating 'Whole of Life cycle' contracts rather than just the capital component during procurement processes

The LCCHP as with all Queensland Government building projects at the time, utilised the standard construction contracts as managed by the Department of Housing and Public works. The inclusion of Liquidated Damages in the Managing Contractor agreement was at the time considered to be contrary to the principles of a relationship style contract. It was considered that the application of Liquidated Damages would not be in the interest of speeding up any completion of the project, given the Managing Contractor would be incurring costs of their own caused by any delays. The Principal could still pursue damages, should it choose to, where significant breaches of the contract occurred. The LCCHP reported that they had limited leverage in negotiations, especially with respect to timeframes, with the Managing Contractor as a direct result of the composition of this agreement.

Ongoing running costs associated with LCCHP procured contracts were hard to ascertain and not well transitioned to CHQ HHS, making bottom up budget building processes challenging for CHQ

HHS. Robust management of vendor contracts and performance is also critical to enable effective commissioning processes. Managing a large number of contracts, across multiple vendors is both complex and challenging and was always going to be a success factor in a large infrastructure build, as for the LCCH. For example, the demand for the integration and configuration of theatres was challenged by vendor availability and viability throughout the construction and commissioning process, which then impacted on the ability to undertake sufficient scenario testing and readiness assessments in all theatres. This process was also compounded by the finalisation of minor building works resulting in an extended mock trial period to the 25th November 2014.

The initial management of the performance of the hard and soft facilities management provider elicited challenges. The repeated delays in practical completion provided significant issues and challenges for the hard and soft FM contractor and CHQ HHS including:

- Lack of access to site and specific unit areas to determine and modify the flow of services and procedures
- Limited time to collaboratively work with CHQ HHS staff and to draft and develop policies and procedure manuals that would meet the requirements of managing the LCCH
- Inability of CHQ HHS to assign sufficient resources to review draft manuals with the contractor that had been provided to CHQ HHS in September 2014

These factors impacted on the ability of CHQ HHS to observe and adequately assess the experience, performance, comprehensiveness and ability of the FM contractor to meet operational requirements. When issues and sub-optimal performance of the cleaning, portage and Help Desk services provided by the FM contractor became apparent, following the opening of the LCCH, immediate action was taken by the CHQ HHS Board and Executive and formal correspondence was provided to the contractor from the CHQ HHS

Contract Management

Board in January 2015. A strategy was immediately implemented which enabled regular engagement between the FM contractor and the CHQ HHS Board and Executive, until there was sufficient demonstration of the contractor's ability to meet contractual requirements for maintaining clinical areas.

Another example of challenging contract management processes relates to CHQ HHS having a non-finalised agreement in place with MHS to open and operate the LCCH car park. An understanding was determined that MHS would be able to operate the LCCH car park, presuming a letter of intent would be signed prior to operationalisation. From 29th November 2014, the LCCH car park was operational, however, there was no formal signed agreement at this point. This agreement was eventually signed on the 5th June 2015. Although the car park was fully operational on opening day, the contract management process was prolonged.

There were numerous Service Level Agreements which still had not been signed, as late as 17th November 2014. Agreements with third parties that had not been finalised at this point in time included:

- Ronald McDonald House
- Education Queensland
- Radio Lollipop
- Starlight Foundation

The significant activity and negotiation of contractual arrangements in parallel with compressed and challenging commissioning processes, continued to place the opening of the LCCH under significant pressure and elevated risk.

Lessons Learnt

- Engage contract management expertise in the development, negotiation and ongoing management of service contracts
- Carefully consider the contractual agreements between the Managing Contractor and Project Sponsor to optimise the agility and effectiveness of the relationship
- The organisational purchaser should be the owner of both the initial capital purchase and ongoing running costs associated with negotiated contracts
- Contractual agreements should include appropriate performance management frameworks
- Contract management may benefit from 'competitive dialogue' approaches to ascertain capability, prospective performance of suitable providers and cultural fit in the new organisation

Recommendations

15. Engage appropriately skilled personnel in contract development, negotiation, and management to undertake robust contract management processes to leverage productive and accountable agreements

16. Utilise 'competitive dialogue' approaches to contract negotiations to provide an accurate assessment of the capacity and performance of preferred tenders

17. Finalise contract negotiation processes well in advance of the hospital opening date to minimise the risks

Operational Commissioning

A key challenge in the operational commissioning of the LCCH included consideration for the ongoing delivery of high quality 'business as usual' services at both the RCH and MCH right up until Move Day. The CHQ HHS Executive were required to balance their time in operationally running the RCH and commissioning the LCCH. The availability of RCH and MCH staff to participate in commissioning activities, developing new models of care and training and orientation was significantly impaired.

Integral processes associated with enabling the operational readiness of the LCCH included:

- Integration of models of care across two sites
- Projection of service activity and demand
- Amalgamation of standard operating procedures
- Incorporation of current state into future models
- Outpatient and theatre scheduling
- Scheduling of accommodation
- Delivery of the full suite of paediatric services for day of LCCH opening
- Recruitment of an appropriately skilled workforce
- Integration of two organisations and workforce cultures

The ability to effectively participate in commissioning processes was further complicated by the reported attrition rate of staff at both sites which threatened the capability and integrity of clinical services. The attrition rate was rated as a 'very high risk' in September 2014 by the CHQ Board – September 2014 in the Strategic Risk Report. This was further compounded by the delayed workforce appointments, which further minimised opportunities for specialties and teams to synthesise models of care and ways of working and provide a stable platform for clinical teams to move towards the opening of the LCCH.

The inability to undertake comprehensive pre-occupancy testing meant that many staff were working together for the first time with new systems and processes within the framework of new and emerging models of care. This also impacted on

the ability to identify issues and gaps with the commissioning processes.

Despite providing some avenues and opportunities, the inadequate availability of staff to undertake operational commissioning activities, in particular MCH staff linked to required 'business as usual' processes, challenged the effectiveness of the identification of defects and management of change requests. Adequate operational testing and familiarisation with actual and simulated work environments is key to operational commissioning processes. It is essential that these processes are comprehensive, all encompassing and inclusive. An example of the need for these processes was the discovery of the configuration of 3D echocardiography rooms having impeded access for patients, families and staff and the passage of equipment.

Operational commissioning processes were further compounded by ongoing building works, which restricted access, hence the comprehensiveness of testing. Commissioning processes were also dependent on equipment delivery, installation, testing and user training and acceptance processes. These factors compromised adequate scenario testing, trial processes and systems integration assessments, necessitating the adoption of work-arounds or modifications to commissioning acceptance criteria. There is documentation to suggest that client commissioning processes commenced in July 2014, three months prior to the achievement of practical completion of LCCH and CHEP 2014. As stated earlier, the LCCH building was the responsibility of the Managing Contractor until the achievement of Practical Completion (26th September 2014). Therefore, there was a requirement that personal protective equipment (PPE) was worn when accessing the building due to ongoing building works.

An example of an operational commissioning process that experienced significant challenges upon opening was Switchboard. Both the MCH and

Operational Commissioning

RCH relied on switchboard operators with significant corporate and personal knowledge of the business and individual staff members. The LCCH switchboard staff were continuing to develop their corporate knowledge and were largely unfamiliar with the services, the clinicians names and roles and the phone systems, in addition to managing higher than expected call volumes from the day of opening. This was further compounded by staff members being unfamiliar with the requirement to 'log in' to activate their desk/area phones resulting in calls being redirected automatically to switch. Callers reported experiencing delays of between 10 and 20 minutes and issues with the accuracy with which their calls were directed due to the reliability of information within the phone directories.

The phone system installed at the LCCH was functional, however user adoption of the system was poor. A telecommunication system in a large tertiary hospital which is poorly understood by staff who routinely use the devices, presents both a significant clinical risk and huge demand on a newly established Switchboard team and system. The Review Panel proposes that if sufficient time was available for scenario testing and appropriate training was provided prior to the move, that this issue with the phone system would have been detected and rectified prior to opening. As was indicated to the Panel 'the implications of the highly sophisticated phone system were not apparent until the hospital was functioning.' As stated previously, CHQ HHS established a Telecommunications Taskforce on the 2nd December 2014 to manage previously unidentified communications issues.

Further challenges encountered during the operational commissioning process included the scheduling and attendance of orientation and training. The Orientation and Training Plan from March 2014, had scheduled LCCH orientation for all front line staff across a five to seven week period. CHQ HHS requested that this program be delivered over a one week period to support issues associated with managing staff and clinical activity.

Additionally, MHS requested backfill funding for staff to attend orientation and training sessions to enable the continued safe provision of care to patients. This resulted in MHS temporarily delaying the confirmation of staff attendance at training sessions to negotiate a resolution to the issue with the DoH regarding the impact on activity associated with MHS contractual negotiations.

Other examples of challenges encountered during the operational commissioning phase that were further compromised by the compressed timeframes included:

- Internal way finding signage in the Emergency Department was incomplete posing a significant risk of patients and staff being unable to immediately navigate their way to the Department. Additional signage was implemented prior to opening
- Documentation in the Special Quality and Safety meeting on October 10th 2014 that staff within PICU did 'not yet feel safe' to move. PICU mock trials occurred on the 20th-24th October 2014 to provide staff with the opportunity to familiarise themselves with the processes, systems and environment. There is no available evidence to indicate to what extent the mock trials alleviated these concerns
- Integrated operating rooms utilised equipment, technology and systems that were unfamiliar to both RCH and MCH staff, with surgical activity reduced during the initial weeks of LCCH being operational to enable further training opportunities

An example of an issue not identified through the operational commissioning process was the Emergency Response – false Medical Emergency Team (MET) calls. Upon opening of the LCCH, there was a high number of false MET calls due to children being able to easily access the call buttons. This required the acquisition of specially designed covers ordered and installed throughout the hospital, with additional covers to be installed in early 2015.

Operational Commissioning

Another area which experienced problems upon opening were specialist outpatient services. A failure to successfully transition all patient appointments into the LCCH HBCIS program in weeks 1 and 2 meant a large number of unexpected patient arrivals (mainly from MCH) and Fail to Attends (FTAs). The outpatient clinic and patient lists received from MCH did not match the specifications of the data migration tool developed to enable the transfer of patients onto the HBCIS scheduling system. This was linked to reported dissatisfaction from medical staff and families in the outpatient transition process. There were also instances in which, patient medical records were not available (both physical charts and through iEMR) at the time of patient review.

Limited HBCIS training opportunities for new LCCH staff (particularly former MCH staff unfamiliar with the system), impacted the organisations ability to deal with appointment issues in clinics as they arose. Limitations to training opportunities were compounded by the late appointment of administrative staff.

A further issue which became acutely evident upon opening of the LCCH was the uneven and bumpy surface for the transition of patients on the Helideck. The helicopter landing site was closed on the 19th December 2014. Effective operational commissioning and subsequent testing of the helipad should have detected issues with the surface and impact on the trolleys procured for the transition of patients. In the interim, CHQ HHS utilised the MHS helicopter landing site until the LCCH site was able to reopen on the 25th February 2015 once defects were rectified and new patient transport trolleys were procured. The LCCH was fortunate that they were able to access the MHS helipad during the three months closure of the helipad.

As late as the Wednesday prior to opening, it was identified that inadequate hand gel and soap

dispensers had been installed throughout the building, and posed an infection control risk.

The compressed commissioning timeframes and significant activity requirements, challenged the operational readiness of the LCCH for opening day. An example of this was the emergence of Cardiac Services as an extreme risk. As at the 26th November 2014, Cardiac Surgery services were not ready to be transitioned to the LCCH because of issues with the readiness of the ICU space and an unexpected surge in complex deliveries requiring cardiac intervention. Consequently, Cardiac Services remained at the MCH until the 10th December, 2014, with mock trials not commencing until the 1st December 2014.

At the time of opening, the Ronald McDonald House family accommodation had not been completed, and at the time of the report was not due for completion until 2016. The design of the LCCH enabled a parent bed to be located next to each patient bed and also internal family accommodation on Level 6 and emergency accommodation available within the hospital, which is also favourable. The completion of the external family accommodation near the LCCH site, will be a welcome addition to the currently provided accommodation services and relieve the current inadequacies for families utilising offsite external accommodation facilities.

Effective operational commissioning processes were met to varying degrees, including:

- Development and implementation of Models of Care and Models of Service Delivery
- Emergency preparedness planning
- Workspace/area allocation and setup
- Risk identification and management
- Planning and scheduling of activities
- Reporting and communications
- Post occupancy evaluation

Operational Commissioning

Lessons Learnt

- Continually assess and quantify the risks associated with all options for the transition of patients, staff, systems and services between facilities and ideally maintain multiple service provision options for as long as possible
- Allow sufficient time to undertake comprehensive scenario testing including the integration of systems, processes and personnel
- Adequately test policies, protocols and procedures on site to provide a robust assessment of the integrity and functionality of the proposed service models
- Staff orientation, training and work environment familiarisation is integral to the smooth transition to a new hospital build
- Early establishment of the workforce and implementation of cultural integration processes to facilitate the embedding of models of care well in advance of the opening of the hospital
- Integration of standard operating procedures supported by adequate orientation and training is critical to support the implementation of effective clinical pathway processes
- Planning, testing and user acceptance of clinical and non-clinical areas must be cognisant of the required functionality to optimise process flow and efficiencies

Recommendations

18. Clearly articulate and adhere to realistic and comprehensive building and operational commissioning objectives and timeframes that enable staff to feel confident that they can effectively undertake all roles and responsibilities associated with their organisational position

19. Establish and adhere to agreed good practice guidelines which identify minimum standards for orientation and training, worksite familiarisation and operational readiness

Food Retail Services

Patient, families and staff of children's hospitals require access to a range of food services to conveniently accommodate their dietary requirements throughout the day and night. The canteen and café settings in a hospital are also utilised as crucial avenues for retreat and relaxation and to enable a connection with the broader community. The design of the LCCH precinct includes the option for seven retail tenancies within the main LCCH building and four tenancies within the CCHR building.

Filling a number of these tenancies with suitable food options was originally within the remit of the LCCHP. Following the establishment of the CHQ HHS as a statutory authority, this responsibility was transferred to CHQ HHS. Later the emergence of the Government's 'contestability agenda' meant that CHQ HHS were able to consider commercial retail services that could potentially provide best value for money and revenue generating opportunities within the LCCH precinct. In February 2014, CHQ HHS sought market responses from prospective tenants for retail tenancies at both the LCCH and CCHR.

Queensland Health leasing guidelines require Standard Food Clauses such as the 'A Better Choice' strategy to be met with the aim of providing consumers with healthy options. This mandate was reinforced by feedback from staff to the CHQ HHS Board and Executive suggesting that managing unhealthy choices within food options at the LCCH was essential to avoid incorrect messaging.

The design of the retail services areas within the LCCH precinct proved to be inappropriate and were characterised by technical issues, including minimal drainage points. Despite the initial appointment of a preferred vendor, the significance of the technical issues was not realised until after a period of time from appointment. In fact, it was not until the 17th November 2014 that CHQ HHS was informed by the Managing Contractor, via the LCCHP that the engineering issues were unable to be rectified. The LCCH retail spaces were designed and constructed in accordance with the

advice provided to the architects in regards to the requirements for retail spaces, including plumbing. As a result of this series of events and changes in policy, transfers of accountability and building design issues, food service providers had not been appointed and no food outlets were open at the time of opening of the LCCH.

CHQ HHS, as an interim measure, provided staff and families with food packages on Move Day to LCCH. CHQ HHS report that families could be provided with meals at their child's bedside from Day one of opening. CHQ HHS Board negotiated with the hard and soft FM contractor to provide temporary 'café and sandwich' carts, which commenced with a temporary facility on the 1st December 2014 on Level 2. It was not until the 5th January 2015 that a second service was provided on Level 7 and a third service on the 12th of January 2015. Access to the temporary carts is significantly limited after 6pm on weekdays and after 2pm on weekends. At the time of writing this report, a number of internal retail food providers have commenced operations. At the time of opening of the LCCH, the families and carers were initially heavily reliant on the nearby location and utilisation of external retail food outlets, to supplement limited onsite retail options.

LCCH has received significant negative publicity in response to the limited food options for patients, family and staff. Of the 203 staff who responded out of approximately 2600 survey requests to the Review Panel's independent survey, 85% disagreed that there were appropriate patient or family canteen or café services and 80% disagreed that there were appropriate staff food services.

A second tender process was not able to be undertaken until March 2015 with the lease agreement not occurring until June 2015.

Whilst not directly linked to the physical safety and quality of the care provided at the hospital, the patient and public reaction indicate the importance

Food Retail Services

of the availability of food services in the broader patient and family experience, and appears to have influenced the public's perception of the readiness of the facility.

Lessons Learnt

- Comprehensive liaison with prospective providers or commercial expertise in the design phase of the hospital is critical to enable appropriate real estate specifications to be determined for food and retail vendors
- Complex multi-year infrastructure projects must have built in redundancies in the project timeframes to allow for possible changes in Government policy
- Consider the impact on the whole patient and family experience of non-clinical facilities and services including food
- Provide advanced and effective communications to patients and their families regarding non-operational retail services

Recommendations

20. Appropriate and accessible retail food services must be available for families and staff at the time of opening of the hospital

21. Utilise appropriate planning processes in the design of retail spaces so that tender specifications are well defined, to enable the timely and appropriate selection of suitable vendors

Engagement and Communication

CHQ HHS like many other paediatric health services nationally and internationally, recognise the tremendous value in engaging patients, carers, families, staff and the broader community in decision making processes. Children's hospitals have traditionally enjoyed favourable media coverage and enormous community support as a result the valuable and high profile nature of the care they provide. Both the LCCHP and CHQ HHS endeavoured to tap into wider perspectives and tremendous community support as a source of valuable information and ideas and potential solutions for the improvement of services. The perceived value, depth, breadth and content of the dialogue with the community and stakeholders wavered across the duration of the project, according to information available to the Review Panel. Full engagement and maintenance of an effective dialogue with all relevant organisations and stakeholders appears to have been compromised throughout the project.

Family and Youth stakeholder groups established to provide input into the planning of the LCCH had issues raised at these stakeholder forums captured through an 'Issues Register' administered by the Project Team and then subsequently reviewed by the Project Executive Team.

The stakeholder groups indicated that they had provided feedback that the lack of car parking and food outlets would be an issue but they expressed the view that they did not feel they were listened to by the CHQ HHS Executive.

Consumers interviewed indicated that they had been engaged in the early stages of the design but that as the project progressed they felt progressively less engaged and less involved in the project. An example was given that they had spent a month discussing potential names for the new hospital but at no stage had the name Lady Cilento been discussed. They were surprised when the name was announced, unilaterally by the Government at the time, and felt that their time had been wasted.

Concerns were expressed about the issues with some ICT applications which resulted in missed appointments and a lack of understanding of patient's complex needs. Consumers expressed they felt and continue to feel, disenfranchised from 'their' hospital. However, consumers highlighted that the Connected Care service worked well.

Consumer engagement and communication is critical within a paediatric tertiary environment, Available patient safety complaints data reports that it "is noteworthy that the number of complaints received has significantly increased in the January 2015 – March 2015 quarter and is consistently higher in the following quarter. In January 2015, it is reported that out of 132 consumer feedback reports provided, 73% were complaints and 27% were compliments. Main issues of concern related to the environment and facilities, access and communication. In February 2015, 192 consumer feedback reports, were received with 65.6% being complaints and 34.4% being compliments.

Greater acknowledgement of, and planning for, the perceived negative impact on patients and families regarding services such as food and parking supported by adequate proactive communications may have alleviated some patient and community concern associated with the insufficient provision of these services. The LCCH has a committed and highly trained cohort of staff, who through the outstanding quality of care they provide, supported by effective consumer engagement and communication strategies, will rapidly be able to reverse this current consumer feedback complaints and compliments ratios.

On the 5th September 2014, a staff survey was conducted by the CHQ HHS Patient Safety and Quality Service to determine staff perceptions pertaining to the transition to the LCCH.

Engagement and Communication

The survey had a response rate of approximately 50 from a distribution list of 3000, with survey findings of note including:

- 55% of staff who responded not feeling completely safe and confident about the move to LCCH
- 67% of staff who responded did not feel that they were receiving sufficient information regarding the move to LCCH
- 70% of staff who responded did not have an appropriate level of understanding regarding their roles and responsibilities on move day
- 53% of staff who responded were unaware of the contact options to garner additional information pertaining to the transition to the LCCH

The Review Panel conducted an independent survey to enable staff to provide comment and inform the Panel of their experience with the operation and building commissioning processes of the LCCH. In total, 203 LCCH staff responded out of approximately 2600 emailed survey requests. The Review Panel is very grateful to the staff who responded to this survey who felt it was important to contribute in this way to provide further insights to guide future building and commissioning processes within Queensland. Points of note from the staff that responded included:

- 75% of respondents disagreed that the LCCH was ready to be opened on the 29th November, 2014
- 67% of respondents disagreed that they received adequate support to integrate the Mater and Royal Children's staff prior to opening
- 63% of respondents disagreed that they underwent adequate orientation to the LCCH prior to commencing work at the facility

Lessons Learnt

- Early, on-going and transparent communication with patients, carers, families and staff regarding anticipated challenges and non-operability of services is crucial
- Engagement and integration of hospital staff needs to be considered as paramount throughout the project lifecycle and beyond the opening date with periods of heightened support provided as required
- Communicate the options and availability of food, transport, parking, way-finding, and accommodation early in the process to manage patient, staff and community expectations

Recommendations

22. Maintain genuine and meaningful engagement throughout the project lifecycle with patients, families, carers, staff and the broader community

23. Provide early and transparent communication regarding anticipated project challenges and issues with specific service profiles

Section 5

Recommendations

Recommendations

#	Project Timeframes
1	<i>Establish an experienced health infrastructure commissioning group upon which future projects can draw upon for independent insight, commercial advice and strategic partnering</i>
2	<i>Establish and agree in advance good practice guidelines for building and operational commissioning and make sure that progress assessments are undertaken against these guidelines, including an appropriate 'Go/No Go' assessment</i>
3	<i>Clearly articulate and adhere to minimum mandatory operational commissioning timeframes and activities</i>
Governance	
4	<i>Enable lead clinicians and critical staff members to directly engage and discuss patient safety and quality risks with the Hospital and Health Service Executive leadership and Board members to appropriately inform critical milestones of the project</i>
5	<i>Implement a robust, effective and easily understood governance framework</i>
6	<i>Schedule regular assessments of the efficacy of the governance framework including its ability to connect the objectives and timeframes of both the project and the operational components of the business</i>
7	<i>Provide control, accountability and authority to the Hospital and Health Service as early as possible in the operational commissioning process</i>
8	<i>Continually assess the safest and most appropriate approach for the determination of the transition to the hospital opening (eg hard opening versus staged approach)</i>
Information and Communications Technology	
9	<i>Utilise an integrated risk approach to ICT delivery in which the total weight of combined risk, operations and interdependencies is appropriately assessed and managed</i>
10	<i>Adhere to adequate commissioning timeframes, especially post practical completion, to enable the comprehensive integration of ICT systems and staff training and familiarisation with equipment, systems and processes</i>
Our People	
11	<i>Establish the workforce well in advance of the hospital opening date to enable comprehensive workforce and service integration processes in order to embed models of care, 'ways of working' and team cohesiveness</i>
12	<i>At the commencement of the project, engage relevant expertise to facilitate cultural and behavioural integration</i>

Recommendations

#	Furniture, fittings and equipment
13	<i>Utilise a team with comprehensive expertise in the management and procurement of FF&E to appropriately manage risks and deliverables associated with project timeframes and operational commissioning</i>
14	<i>Develop service plans that detail the FF&E requirements for the effective delivery and testing of service requirements that are cognisant of comprehensive clinical review processes, integration requirements and vendor support processes</i>
	Contract Management
15	<i>Engage appropriately skilled personnel in contract development, negotiation, and management to undertake robust contract management processes to leverage productive and accountable agreements</i>
16	<i>Utilise 'competitive dialogue' approaches to contract negotiations to provide an accurate assessment of the capacity and performance of preferred tenders</i>
17	<i>Finalise contract negotiation processes well in advance of the hospital opening date to minimise the risks</i>
	Operational Commissioning
18	<i>Clearly articulate and adhere to realistic and comprehensive building and operational commissioning objectives and timeframes that enable staff to feel confident that they can effectively undertake all roles and responsibilities associated with their organisational position</i>
19	<i>Establish and adhere to agreed good practice guidelines which identify minimum standards for orientation and training, worksite familiarisation and operational readiness</i>
	Food Services
20	<i>Appropriate and accessible retail food services must be available for families and staff at the time of opening of the hospital</i>
21	<i>Utilise appropriate planning processes in the design of retail spaces so that tender specifications are well defined, to enable the timely and appropriate selection and management of suitable vendors</i>
	Engagement and Communication
22	<i>Maintain genuine and meaningful engagement throughout the project lifecycle with patients, families, carers, staff and the broader community</i>
23	<i>Provide early and transparent communication regarding anticipated project challenges and issues with specific service profiles</i>

Appendix A
LCCH Program Governance Chart

Glossary of Terms

Glossary of Terms

'A Week'	Orientation Week (Administrative staff)
AHIA	Australian Health Infrastructure Alliance
CCHR	Centre for Children's Health Research
CHEP	Children's Health Energy Plant
CHQ HHS	Children's Health Queensland Hospital and Health Service
CHQ HHS Board	Children's Health Queensland Hospital and Health Service Board
CHQ HHS Executive	Children's Health Queensland Hospital and Health Service Executive
CSI	Clinical Services Integration
DoH	Queensland Department of Health
EDMS	Executive Director of Medical Services
EDNS	Executive Director of Nursing Services
FF&E	Furniture, Fittings and Equipment
HIB	Health Infrastructure Branch
HSCE	Health Service Chief Executive
ICT	Information and Communications Technology
iEMR	Integrated Electronic Medical Record
LCCH	Lady Cilento Children's Hospital
LCCHP	Lady Cilento Children's Hospital Program
MCH	Mater Children's Hospital
MHS	Mater Health Services
'O Week'	Orientation Week (frontline clinical staff)
PC	Practical Completion
QPCS	Queensland Paediatric Cardiac Service
RCH	Royal Children's Hospital
SPA	Separable Portion A (Pathology, link tunnel and Level 1 Store)
SPB	Separable Portion B