Post Project Evaluation(PPE) reports 2011 – Projects in excess of £5m

Introduction

This is a high level summary of the 3 PPE reports received in 2011. It is for individual Health Boards to manage the publication of their reports therefore they have not been specifically identified. The purpose of this document is to provide key issues arising from these reports to determine any learning which can be passed on to other Boards and/or projects.

This report provides an introduction to the nature of the 3 projects involved, a high level summary of each, and a summary of key lessons learned. Details of how these reports are intended to be put together are set out in the Scottish Capital Investment Manual (SCIM) Project Evaluation Guide, Annex 5.
http://www.scim.scot.nhs.uk/Manuals.htm

Summary of projects

One is the development of an integrated Palliative Care Resource Centre including In-Patient facility, Day Care, Out-Patient and Drop-Services, one is a new build dental school with specialist hospital services' and one is a Community Healthcare Centre incorporating In-patient and ambulatory care services, rehabilitation services, primary and community care services and Mental Health services.

Capital values:

Project	Estimated value	Final capital cost
A	£5.7m	£5m
B	£20m	£17.7m
C	£14.7m	£19.5m

Sections 4, 5 and 6 of the Scottish Capital Investment Manual (SCIM) guidance above covers the undertaking of the "scoring" of the features below. These sections cover time analysis, performance of project participants and health and safety performance.

Project	A	B	C
4) Time analysis	7 week delay	On schedule	26 weeks delay
5) Performance	On average 7	9 but few participants	Single score of 6
6) Health & Safety Performance	On average 7/8	On average 8	No figures but state acceptable

Summary of more narrative sections

This section aims to summarise how the 3 projects covered key areas of PPE guidance:

1. Section 7 Techniques adopted
2. Section 8 Assessment of product
3. Section 9 Lessons to be learned

1) Techniques adopted

Project A indicated that a variety of different approaches and techniques were adopted to ensure that:

a) Clinical staff understood what they would be getting at the end of the process
b) Other interested NHS staff were alerted to the project and their input was sought and considered as part of the project review process

The section then set out how users were involved throughout the development of the project.

Project B through a brief narrative indicated that a full schedule of accommodation was developed and agreed with end users at the start. This was to ensure these requirements were met. They also drew up plans to ensure adjacencies were agreed with end users for room layouts and space. What was done was signed off. There was consistent review throughout the lifespan of the project which enabled issues to be raised and dealt with.

Project C initially set out a high level view on strategic decision-making and sign-off at key points in the programme. It also set out how the constitution of the Project Board included representation from main user groups. It also set out how engagement was recorded including ad hoc meetings. A project plan was established, accepted and reviewed regularly. A risk register development is referred to and a robust change control following close of contracts was also followed.

2) Assessment of product

Project A sets out how this was undertaken, the outcome of which was firstly items positive as follows:

a) Overall staff are happy with the layout of the building
b) Light and airy space

Alongwith these successes there were areas not considered successful as follows:

a) Lack of a mortuary, since resolved through a contract with an undertaker
b) Site location

The contractor was thought to have performed well.

In relation to the quality of the finished product the 'physical' works have been completed, by large, to a very high standard with a minimal amount of construction defects carried over into the post contract phase.

Project B provided high level summary of first stage Post Occupation Assessment indicating more time required for second stage. It did however provide more detailed information as an appendix.

With regard staff the focus appeared to be on negative issues around commissioning and availability of some accommodation. Patients on the other hand seemed pleased with the new facility. Biggest issue was around car parking difficulties.

It will be important to see how these issues have been addressed in the second stage Assessment which is awaited.

Project C – The report indicates this section will be completed in due course.

3) Lessons to be learned

Project A

The section says the project has generally been a success on all levels, albeit there are areas, which, with hindsight, would have been tackled differently or the approach improved upon.

The provision of a comprehensive brief, the use of workshops and the in-depth consultation with all clinical staff was seen as being extremely beneficial.

The Architect selected for the project was well versed in such projects and this was a benefit to the project.

On the negative side issues over changes in the commissioning period were identified and rectified for future use. Similarly input from Estates Maintenance throughout was not provided. Some improvement has been achieved.

Finally for future projects it is felt more dedicated project management would relieve Clinical team time.

Project B

This section of this report was very brief and covered 3 areas – commissioning, equipment and post occupation assessment.

On commissioning the need to give it time was indicated.

On equipment procurement the need to have a dedicated officer to ensure a system to track and log received and checked equipment/instruments. Thereafter it also

needs to be properly processed for installation and correctly registered for future maintenance and renewal.

Finally on post occupation assessment improved methods of processing was identified for future projects. A process to ensure confidentiality was also identified. Such a process may also enable more balanced responses not just dissatisfaction.

Project C

This document provided an appropriately detailed lessons learned summary. This document includes the recommendations identified within each theme. The full document is available to CIG members on request.

Planning of Project. The governance structure should be explicit, straight forward and uncomplicated allowing the Project Board in particular to undertake a role in managing and controlling the strategic risks identified by the Project Manager thereby ensuring the business benefits are realised.

The project team must understand the scope of the project prior to recommending the proposed design to the Project Board. All reasonable steps should be taken to minimise the potential for design failure and contractual disputes through the risk assessment process.

As there is much more to understanding user requirements than is written in the statement of requirements, the project manager must develop a real understanding of all the requirements both at a high level and at departmental level.
This can be achieved through the communication process between the project team and individual departmental representatives utilising 3D graphics to support the development and understanding of the 1:50 drawings. The approval process should be formal with decisions being recorded allowing regular reviews at key dates in the programme to ensure a holistic design solution is achieved.

Construction Phase. The Project Manager must allocate sufficient time to track and monitor progress on site and challenge the critical assumptions and information provided by the construction company and technical advisors.

The Project Manager should identify key deliverables and decision points to enable the Project Board to initiate formal performance reviews to ensure informed action is taken at the earliest opportunity to address potentially contentious issues that require resolution.

Service Disruption. As communication is key to maintaining the goodwill of staff who deliver services, key stakeholders, staff representatives and the Board's communication department should be routinely advised of progress to enable accurate information to be disseminated to staff and the media.

Commissioning. A commissioning plan should be informed and developed with stakeholders. Changes to the plan should be routinely reported through formal meetings enabling stakeholders to be advised of issues.

National contracts should incorporate an options clause to provide greater flexibility with regard to delivery dates

The provision of IT is critical to the smooth transition of healthcare services and should be appropriately resourced.

The contract with the developer should provide for the recovery of incidental costs in the event of a delay to the programme.

Project Management. Changes in key personnel should be anticipated with a dedicated project manager being allocated to the project from within the departmental management structure to ensure internal resources are available to support and maintain continuity of purpose. The use of external project managers was expensive and had limited success, in particular the construction company implemented changes to the approved design that were not identified and brought to the attention of the Board's representative.

Evaluation of Building in use. Major capital schemes should be client led with appropriate representation from each clinical and non clinical service taking an active role in the project.

The involvement of clinical staff and patient representatives throughout the process will ensure the evaluation process is informed, encouraging open discussion.

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