HORNAGOLD & HILLS

Post Project Evaluation Report

Newham Centre for Mental Health

Prepared for ELCMHT

04 November 2003

.0 Introduction

2.1 History

Background

2.1.1 In the mid 1990's, residents of the borough of Newham with mental illness were treated at either Godmayes hospital in Redbridge or East Ham Memorial Hospital, neither of which offered a particularly suitable environment. Intensive Care beds were purchased from Runwell Hospital, some 30 miles from Newham requiring the transfer of seriously ill patients.

Further, changing plans for Goodmayes hospital meant that the trust was under notice to relocate away from this location in the imminent future.

2.1.2 In order to remedy this unacceptable situation the decision was taken to implement a project to improve mental health services in Newham and an OBC was prepared in 1996 which identified the provision of a new purpose built facility to reprovide all mental health services located on a site adjacent to Newham General Hospital as the preferred option.

2.1.3 The new Centre has been procured via the Private Finance Initiative route and has now been open and operational for over a year. Newham patients have been removed from Goodmayes and East Ham Memorial hospitals.

Parties

2.1.4 The process from inception through OBC, bidding, FBC, negotiation and conclusion of the Project Agreement was pursued by Newham Community Health Services NHS Trust supported by East London & The City Health Authority and Newham Inner City Multifund (later Newham Primary Care Group).

2.1.5 Following reorganisations in the NHS, the implementation of the project through detailed design, construction and subsequent occupation and operation phases was the responsibility of East London & the City Mental Health Trust.

2.1.6 Other key parties to the project were:

Grosvenor House Group	PFI Service Provider
Allenbuild Ltd	Construction subcontractor
Bailey Garner	Architect
Grosvenor House Group	FM service subcontractor

Project Programme

2.1.7 Key dates in the process were as follows:-

	Planned	Actual
OBC Submission	1996	1996
OJEC Notice	March 1998	March 1998
BAFO	December 1998	December 1998
Preferred Bidder	February 1999	February 1999
FBC	May 2000	June 2000
Financial Close	July 2000	
Commence Construction	1 July 2000	
Complete Construction	April 2002	July 2002
Operational	April 2002	July 2002
Rectify all construction defects	November 2002	Not yet complete

Value

2.1.8 The fixed capital value in the contract was stated in the FBC as £12.52m

2.2 Objectives

Business objectives

2.2.1 The reasons for seeking to provide new buildings and services were stated in the FBC as:-

- There is currently an unacceptably poor state of mental health provision to Newham residents. In particular the service is fragmented, poorly accessible and suffers from a very poor physical environment which is frequently criticised by the Mental Health Act Commission;
- There is an opportunity to improve considerably the quality of clinical care for clients and carers through the provision if integrated locally based services;
- Accessibility to mental health services for clients, their carers and their families needs to be improved;
- There is an opportunity to improve cost effectiveness, and
- Large, long stay institutions used by Newham residents are due for closure.

Benefit Criteria

2.2.2 The following table summarises the benefit criteria adopted at FBC:-

Benefit Criteria	Description	Group
Range of services	The service should provide a comprehensive range of services which are culturally sensitive, appropriate to need and which aim to reduce the stigma of mental illness.	Clinical Group – Group Chair – Lead Clinician, mental health services.
Accessibility	Services which offer clients safety and sanctuary and which provide alternatives to hospital admission should be accessible 24 hours a day, 365 days a year	Clinical Group – Group Chair – Lead Clinician, mental health services.
Choice	The service should inform and empower clients to make choices about the care they receive.	User Group - Group Chair – nominated representative from INUF
Partnership	The service should be organised so as to promote partnership between clients, carers, voluntary groups, local agencies and providers.	Joint mental health management board.
Locally based	Services should be based within Newham to promote a community focus and to ensure ease of geographical access for clients and carers.	User Group - Group Chair – nominated representative from INUF
Continuity of Care	Services should be organised so that clients can move between organisations, professional groups and locations offering support without disrupting the continuity of their care.	Clinical Group User Group

Benefit Realisation Plan

2.2.3 The following table summarises the benefits realisation plan as proposed in the FBC:-

Benefit Criteria	Key Factors	Timing
Improved Quality of service • 'Range of services'; • 'Accessibility'; • 'Choice'; • 'Locally based'; and • 'Continuity of care'.	• Delivery of agreed model of service; • Offer client choice for acute treatment; • Development of user involvement; and • Full implementation of HR strategy in recruiting and retaining clinicians of the highest standard.	• Main facility open October 2000; • Acute Day Hospital open October 2000; • 3 year evaluation of Acute Day Hospital model; and • Ongoing collaboration with user groups and partner organisations.
Contribute to the local economy • 'Accessibility'; • 'Locally based'; and • 'Partnership'.	• Encourage local employment practices; • Encourage use of local suppliers; and • Participate in SRB 'fit for work' projects.	• Main facility open October 2000; • Ongoing work with CHG; and • 3 year SRB project.
Contribute to Newham's Health Village model • 'Partnership'; and • 'Locally based'.	• Work with key stakeholders on the Brampton 2000 scheme to develop shared objectives for the site.	• Newham Healthcare PFI by 2004; and • Ongoing projects with Brampton 2000 scheme.

2.2.4 The extent to which these objectives and benefits have been realised is reviewed throughout this report under the relevant sections and summarised in the table in Appendix A.

Project Agreement

3.1 Introduction

3.1.1 The process of negotiating and agreeing the terms and conditions of the Project Agreement was constrained in part by some fixed programme milestones, in particular the dates for vacating East Ham Memorial and Goodmayes Hospitals.

3.1.2 At the same time the bidding and negotiating process encountered difficulties in maintaining the required timescales, leading to substantial pressure at certain key stages.

3.1.3 It has been suggested that many of these pressure points were resolved by means of less than ideal agreements involving either undue concessions to the bidder or inadequate definition of requirements in the drafting.

3.1.4 The result is that the contract has an unacceptably high number of compromises which in practice benefit the contractor rather than the Trust.

3.1.5 There is a suggestion that the Trust did not take a sufficiently active role in the negotiation and were prone to seeking routes of least resistance to resolve issues.

3.1.6 The local reorganisation which led effectively to an complete change of Trust following financial close had a serious impact, leading to a loss of continuity and a lack of accountability and ownership for the project. It is widely considered that this one factor was largely responsible for allowing many of the poor features of the Project Agreement to remain uncorrected.

3.1.7 The Project Manager acting for the Trust changed several times during the project, leading to discontinuity and leaving the Trust at a negotiating disadvantage.

3.2 Programme/Process

3.2.1 The process of reaching agreement from BAFO stage to financial close took some 2 years, generally considered to be too long.

3.2.2 Agreement was hindered by unrealistic expectations on the Trust's part over residual valuations.

3.2.3 The process was also slowed by the involvement of the CIU and PFU which was viewed at the Trust as interference rather than assistance.

3.2.4 The Trust do not consider that any additional value was derived from the extended negotiation period.

3.3 Output Specification

General

3.3.1 The specification for service provision is poorly drafted and lacks clarity of definition on very many key issues. Some fundamental requirements, e.g. laundry service, appear to have been omitted entirely.

3.3.2 The lack of clarity over the service provider's obligations is a major cause of dissatisfaction amongst staff.

Specific Issues

3.3.3 Lack of cross referencing e.g.P92 2.1 "provision of internal telephone services", no reference to where the specification is to be found.

3.3.4 The level of ambiguities within the specifications means that it is not possible to objectively review what Trust is actually asking for this begs the question how did Project Co cost the work without including a disproportionate risk provision. E.g. p 93 item 3.2.5.1 "the service provider must provide the hardware necessary to provide a fully functioning e-mail service with links to the Internet". E-mail is provided via software and hardware (modem), presumably due to the lack of reference to word, excel, PowerPoint etc these were not deemed necessary?

3.3.5 Lack of cross-referencing between Trust works requirements (schedule 1) and Project Co proposals (companies works proposals). These should be configured in a manner which allows the user to check what Project Co has actually provided, when compared with what they are contracted to provide.

3.3.6 Lot of ambiguous terms used e.g. "provision of internal telephone services" i.e. no description of what constitutes a "service". "There must be the facility to accommodate a significant backlog of messages" what constitutes "facility" & "significant". " Adequate stocks of materials and equipment to operate the service shall be maintained by the service provider " what constitutes "adequate stocks". Hotel services "P99 2.2 ""and will be adequate to meet the needs of the Mental Health services" how would the Project Co know what these are?

3.3.7 A specific query has been raised during interviews which refers to the provision of vending machines and the fact that Project Co are allegedly planning to remove them unless a variation is raised and an additional fee paid. P107, 3.5.1 only refers to vending machines for staff and visitors, it would appear that the Project Co is under no obligation to provide for patients. P105, 3.1.1 obliges Project Co to provide six beverages a day to all inpatients, therefore they are within their rights to remove and re-provide six drinks, the extra over cost of this should be nil.

3.3.8 Have been unable to find "Minimum Acceptable Availability Criteria" i.e. a description of room temperatures, lighting levels etc that are then used as the criteria to assess the product being delivered. This is essential because it removes any potential confusion as to whether what is being delivered matches what the Trust and Project Co have contracted to receive/deliver. This is a key component of deciding unavailability and therefore payment deductions.

3.3.9 There does not appear to be any key functional areas identified and the payment mechanism weighted accordingly, all areas seem to be treated equally. This means that Project Co are not incentivised to focus on key areas e.g. wards, therapy and seclusion room.

3.3.10 Not clear who is providing a variation cost checking service, interviewees stated costs of new hinges in a range between £10k and £43k. In order to judge value for money a quantity surveyor would normally be employed to check quoted cost against a benchmark. Similarly it is not immediately apparent if the financial and legal advisers are on a retainer to provide ongoing advise to the Trust. This is essential to minimise the opportunities for Project Co to exploit the contract.

3.3.11 The project managers (4no) seem to have all been Trust employees with limited PFI experience. PFI is a very specialised area and the Trust was exposed by not employing a specialist PM to work alongside the Trust staff to augment their building & estates and clinical skills.

3.3.12 Bedding in period – it is not clear if a bedding in period was allowed for in the contract. Usually in PFI deals the first month (post ACD) has a reduced ASP being levied due to the whole of the service not being available on day one (i.e. 25% reduction in ASP week one, 50% reduction in week two etc). With out the commissioning programme it is unclear if the service was planned to be "fully up and running" on day one (i.e. all Project Co commissioning complete) or if a reduced service was agreed, for a reduced fee for a stipulated period. P 136 v states that "no

unavailability deductions shall be made.....where any such availability arises as a result of the occurrences during the period of 90 days following the completion date of any unavailability mainly caused by the commissioning or start up problems affecting the works, the services or the equipment provided the company is using all reasonable endeavours to minimise such unavailability". This statement contradicts best practice, as there is no incentive for Project Co to "hit the ground running".

3.3.13 Independent tester – P 25. 10.2 states " ....that the IT shall inspect the works .....to establish whether the following conditions have been satisfied" (a) states" the works have been completed in accordance with the Trusts works requirements and the companies works proposals", this relies upon the Trust works being described in unambiguous terms and the RDS's being complete and signed off. The TWR are ambiguous and the RDS's were not signed off. It is unclear how the IT could judge completion.

3.3.14 The Payment Mechanism cannot stand-alone; it must link to the specification elements that describe construction requirements e.g. room temps, FM specs, and paymech formulae. It is unclear how these schedules have been cross-referenced.

3.4 Operation and Monitoring

3.4.1 It has been suggested that little effort is made to check the content of the specification where questions arise about how well Grosvenor are meeting their obligations.

3.4.2 There is also the suggestion that only data relating to the acute wards is monitored, other areas, e.g. occupational therapy, are ignored.

.0 Design/Construction

4.1 Location

4.1.1 The site was defined by the Trust, there are a number of issues related to the location of the Centre:-

- The site is located within the borough of Newham and is local to many of the service users
- The site is adjacent to Newham General Hospital which is effective in reducing the stigma of mental illness
- The land is heavily contaminated and releases large quantities of methane gas which is non-poisonous but inflammable
- The contaminated nature of the site leads to a requirement for additional work to produce safe buildings and may also tend to restrict the nature of the external planting scheme
- The site is not well served by public transport and while a green travel plan is in operation and a dedicated bus service has been arranged, the situation remains less than satisfactory

It is evident that the site is not "perfect" but in a highly developed area such as Newham the availability of a site of sufficient size for such a facility must be very limited.

4.2 Design Process

Introduction

4.2.1 The architects, Bailey Garner, are a well established and experienced practice with a long involvement in healthcare facility design. They were initially retained by Grosvenor House Group to provide design services during the bid process and at financial close were novated to the Design and Construction Contractor.

4.2.2 The architect has made the observation that their initial appointment by Grosvenor did not allow for the payment of any fees. This imposed significant financial hardship on the architect and although design fees were payable by the D & C contractor these were not necessarily sufficient to cover all the work undertaken.

4.2.3 In particular the lengthy period between BAFO and Close resulted in substantial abortive work by the architect for which no payment was ever made.

4.2.4 It is a matter or record that reorganisation within the NHS meant that the Trust with control of the project changed at roughly the time of Financial Close. It has been suggested that a greater degree of compromise over the content of the contract may have been accepted by the outgoing Trust in order to secure Close before reorganisation took effect.

4.2.5 Had Financial Close not taken place first, it is very likely that a change in the Trust personnel arising from reorganisation would have led to the project being re-revaluated before proceeding further, leading to significant renegotiation and delay in concluding negotiations. There were, therefore, sound reasons to seek closure before changes occurred although in this case there is evidence that the project was compromised as a result.

Briefing

4.2.6 It is evident that the initial briefing given by the Trust was not sufficiently well developed in some areas (vision panels in wards being a good example) and was insufficiently robust in others (e.g. gender segregation of wards).

4.2.7 It is reported that the original design made no allowance for the provision of administrative offices despite it being clear that these would be necessary. The result is that offices have been "squeezed in" with consequent compromises in the design. The management suite is located in an area originally designed to accommodate the Out Patient department leading to an unsatisfactory result (e.g. toilets in inappropriate locations, power sockets on the "wrong" side of the room).

4.2.8 In other areas there is a suggestion that the Trust accepted compromise proposals from the contractor which might better have been rejected (e.g. landscaping and internal finishing proposals).

Design Modifications

4.2.9 The original design was undertaken at an early stage in accordance with a brief provided by the trust originally responsible for the project. This was subsequently revisited by the replacement trust and a number of significant layout changes made at a time when the form of the building envelope was finalised. The result of these changes is that some aspects of the internal layout are not ideal, leading to the feeling that the design has not been driven by requirements of use but that the uses have been forced into a particular envelope. Specific instances are noted in the following sections.

4.2.10 Once construction commenced the architect was employed by the D & C contractor who severely restricted their access to the working design, much of which was prepared by the specialist subcontractors installing the works. While this approach is not unusual it is usual to arrange for the architect to check design by such companies for compliance with the original design intent, this does not appear to have happened in this instance.

4.2.11 The architect was not appointed to inspect the works, certify completion or schedule defects post completion.

4.2.12 The architect has been unable to prepare detailed as-built drawings due to their limited involvement with the working design.

4.2.13 The architect has commented that there must be some doubt about exactly what has been provided and whether this complies with the Trust's expectations.

4.2.14 The architect has indicated that he would welcome a formal project close-out and an opportunity to evaluate the effectiveness in use of his design by reference to detailed feedback from staff and service users, especially in connection with the operation of the Day Hospital.

Consultations

4.2.15 It appears that a concerted effort was made in the early stages of the design process to involve interested parties and stakeholders including trust staff and service users representatives and the view of those involved is that the consultation process was comprehensive. The architects initial designs were informed by the outcome of these consultations.

4.2.16 Translating the initial designs into practice inevitably involves some compromises and it would be most unusual if all the aspirations of the consultees were met in full. However, there appears to be a high level of resentment among those who were involved in the consultation process, the general view being that the views expressed have been ignored and that the process has been a waste of time. The blame for this situation is placed by the consultees equally with the Trust and Grosvenor House Group.

4.2.17 It is evident that the decision making process surrounding the development of the design was not properly communicated to the consultees.

4.2.18 It appears that a number of revisions were made to the design which were not referred back to the consultation groups nor sufficiently explained. In the end, the final design was presented to the staff as a fait accompli, without the opportunity to comment being given.

4.2.19 The inference drawn is that a fully inclusive design was initially prepared which included responses to the suggestions of the consultation groups but that over a period of time this was diluted without further consultation taking place. It is suggested that this was in part at the behest of the Trust and in part the Contractor.

4.2.20 Within the consultation process it is evident that a number of staff members experienced difficulty in understanding the information presented due to lack of familiarity with drawings and similar material.

4.3 Vision Panels

4.3.1 This aspect of the design has been identified as a major area of concern and serves to highlight some of the specific problems associated with the briefing, design and construction process.

4.3.2 It is evident that the question of whether to install vision panels in ward doors was not resolved internally within the Trust before the project commenced. This report does not seek to engage in the debate on the desirability of this feature but it is clear that different parties to the service have strongly held and often incompatible views.

4.3.3 The original design brief was issued before this matter was resolved, resulting in the need for the debate to continue during the bid evaluation and ultimately the design and construction phases of the project. Indeed, there is evidence that the debate remains to be concluded even now.

4.3.4 In the event, the Elderly persons wards were provided with vision panels in all ward doors in response to the views of the ward manager and service staff that this was the appropriate approach for that service. Elsewhere a compromise was implemented whereby 5 rooms on each acute ward were fitted with vision panels.

4.3.5 It is likely that the process of introducing these features during the construction phase will have meant that the procurement was not achieved at best price and there is always the added danger that such variations can cause, or be used as the excuse for, significant disruption to the design and construction process.

4.3.6 It is also true that resolution of such matters in the context of the pressing time constraints imposed by the construction process tends to lead to less than ideal solutions being adopted. It is evident that there remains a significant level of dissatisfaction with the implemented solution in this case.

4.3.7 The lesson for the future is that Operational Policies and the consequent output specifications need to be resolved before the project is implemented and where such resolution is not possible an interim measure needs to be agreed and rigidly imposed for procurement purposes on the understanding that it will be reviewed and if necessary revised in due course in the light of experience in use.

4.4 Bed Numbers

4.4.1 The total number of beds provided is smaller than that previously available. This reduction in capacity has given rise to several problems during the project.

4.4.2 Prior to the move it was necessary to reduce the number of service users so as to match the number of available beds. There is no suggestion that these discharges were inappropriate but they represent another pressure on the service at that time.

4.4.3 It is apparent that the smaller wards and lower overall capacity is giving rise to difficulties in using beds efficiently. New admissions to certain wards are not infrequently obliged to be accommodated in an alternative ward due to lack of space and on occasion users are moved from ward to ward several times due to pressure on bed availability. This is expected to have an adverse effect on their treatment.

4.5 Seclusion Suite

4.5.1 This is another instance of compromise in the design briefing. The location of the seclusion suite was determined and agreed by the Trust during the design process and based on internal consultation, however there is now feedback that in use the suite would be better located closer to the wards.

4.6 Water Storage

4.6.1 The main cold water storage tanks have been located at ground level such that all water must be pumped into the building.

4.6.2 This system appears to have proved problematical at opening when there are reports of a total failure of the water supply.

4.6.3 For the future, the system remains vulnerable and a risk for all parties as a failure will render the entire facility unavailable.

4.7 Layout related problems

4.7.1 In support of the new building, there is a general consensus that the internal arrangements work far better than was the case at East Ham Memorial and that the adjacencies work well.

4.7.2 Wards are generally designed with a number of "dead end" corridors. This limits the ability of service users to move around, an especially important feature of the Elderly Persons wards and made more significant by the lack of external space to walk.

4.7.3 All of the wards have been designed in accordance with the design requirements of acute wards and are not appropriate for other uses, e.g. Elderly Persons.

4.7.4 The building layout lacks flexibility, the opportunities for alternative uses of spaces are reported to be limited.

4.7.5 The arrangement of wards is such that true gender segregation by ward is impossible given the fluctuating size of the respective male and female patient populations. The current situation achieves segregated accommodation by virtue of the single occupancy rooms but in most wards communal areas are used by both men and women.

Views appear to be divided on this point, in the main it is considered that this represents an unacceptable situation for the following reasons:-

- The current arrangement does not comply with guidelines on gender segregation
- Mixed gender day rooms are not acceptable
- Patients pass alternative sex bedrooms
- Some bedroom doors are not in line of sight of nurse stations creating the potential for harassment to occur

- Better arrangements were designed initially and agreement on segregated wards reached with Grosvenor who now only accept the principle of mixed accommodation

On the other hand there is acceptance that the changing mix of patients effectively rules out segregated wards without consequent inefficiencies in bed usage. Segregation is therefore viewed as a management issue requiring appropriate levels of supervision on the wards and while this results in additional staffing costs this is considered acceptable given that it allows full occupancy.

It is not clear if this is an "acceptance of the inevitable" or a viable approach to bed management. It does appear that the building design could have been improved so as to reduce the scope of the problem, albeit at greater capital cost, it is not clear, however, what the associated staff costs would have been.

The original design is reported to have been more flexible in this respect but design changes introduced at a later stage have reduced this flexibility.

The current arrangement leads to a need for a higher level of staffing than is ideal, at an enhanced cost.

4.7.6 Layout changes led to the Elderly Persons bathrooms being moved into a smaller room which is not adequate for the purpose.

4.7.7 Comments have been made that the wards include too many doors, leading to a "closed off" atmosphere with inadequate contact between users and staff. In some locations fire doors appear to be propped open to offset this effect.

4.7.8 Several interviewees made the point that the distribution of space is not ideal, especially that communal areas are too small and that there is insufficient "activity space", while corridors are wider and bedrooms larger than necessary. Some communal space proposed at design stage was not included in the final building, e.g. at first floor landing.

4.7.9 Some users of the building have complained that temperature control and ventilation are poor in some areas. In part this can be attributed to initial problems with the heating system, leading to cold conditions during the last winter but the problems with ventilation may be a result of layout changes leading to the original concept of cross flow ventilation being compromised.

4.7.10 The original design appears not to have included all the necessary offices leading to the need to introduce such spaces by subdivision of areas with consequent reduction in the quality of the space. In addition, the area originally designated for Outpatients has been used for management offices.

4.7.11 Consultant and Secretarial offices are dispersed in the wards rather than centrally located. This appears to have been dictated by the Trusts but has led to some adverse comment, specifically:-

- Poor security, administrative staff are sometimes intimidated by service users and are obliged to pass through wards when entering or leaving their offices or are subject to users knocking on their doors

- In order to maintain security of administrative offices there is a need for a security lock on each office door, this leads to an excessive number of such locks which would have been significantly reduced by centralisation

- Staff are reluctant to place name cards etc on office doors causing problems in locating specific offices/persons for those not fully familiar with the layout

It has been suggested that a centralised office "block" would have been beneficial in reducing the number of secure access points needed and allowing easy location of individual staff members. It is also implied that admin staff would find the working environment preferable.

4.7.12 Provision for storage generally is inadequate.

4.7.13 There is some confusion about the status of Room Data Sheets, the content of some of those included in the Project Agreement were varied by the Trust during design and construction but the sheets were not updated. At the time of variation the changes were agreed as being at no cost, additional features being traded off against others which were omitted. Failure to update the sheets and formally record the agreements reached means that it is now difficult to verify that construction matches the finally agreed design and in some cases Grosvenor are now seeking additional payment for the changes contrary to the agreements made at the time.

4.7.14 No inventory of the building contents was made at the time of occupation.

4.7.15 There have been suggestions that some aspects of the layout design do not follow HBN and other guidance.

4.8 Construction Process

General

4.8.1 The contractor, Allenbuild, is reported to have progressed the construction of the facility diligently until late in the process when changes in the project management led to some loss of impetus.

4.8.2 A total of 23 Trust Change Notices were issued during the works to deal with matters not included in the Project Agreement. Some of these had a delaying effect on the construction process and an extension to the contract period was granted to Allenbuild. The change procedure was found to be unwieldy in use, causing undue delay and prices quoted by the contractor were inflated, apparently in order to discourage pursuit of the variation.

4.8.3 Delays also arose as a result of the collapse of the roof timber subcontractor.

4.8.4 It is a matter of record that completion of the works was later than the date set in the contract as extended by the additional time allowed in response to Trust changes.

4.8.5 The contractor appears to have experienced some difficulty in completing the building works and in particular in co-ordinating final operations to complete specific areas. There appears to have been a vicious circle of tradesmen engaged in completing one aspect causing damage to another with tradesmen rectifying that defect then causing further damage through a number of iterations.

4.8.6 Completion of the building was delayed several times with a series of provisional completion dates being missed until the works were finally declared complete with very little notice.

4.8.7 In the event, the building appears to have been incomplete at handover and occupation with many defects remaining, some of them so serious that occupation would not have taken place had they been known in advance. This aspect is covered in more detail in section 4.

4.8.8 The delayed completion and urgency of achieving handover led to the final commissioning being carried out in too short a period with consequent poor performance post occupation.

4.8.9 A large number of general defects were identified post occupation. It is reported that even now many of these remain. It appears that Grosvenor are seeking to conclude these matters with their subcontractor before any redecoration or similar works are undertaken, this is effectively delaying the process of rectifying other problems (e.g. redecoration).

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Supervision

4.8.10 No organisation or individual was formally appointed to act as Employers Agent and there appears to have been little or no checking of the as-installed works.

4.8.11 On a number of occasions staff were given the opportunity to visit the works during construction. While this was presumably intended as a communications exercise it also allowed several defects in the works to be identified, for example:-

- Baths provided in the Elderly Persons wards were of a standard type rather than the Agio type required. Replacement proved problematical as the new baths were too wide to pass through the doors.
- The same bathrooms were too small to allow installation of the hoists provided, this deficiency was not resolved by the contractor for a number of months and was only finally dealt with when the ward manager contacted the supplier directly.
- No provision was initially made for serving hatches between the dining rooms and kitchens and these were only cut after walls had been constructed.

4.8.12 An Independent Tester, Nesbitts, was appointed, the nature of the duties required of them is not known. The implication to be drawn from the condition of the building at occupation is that for whatever reason the Independent Tester was not particularly effective.

4.9 Specific Building defects

Drainage

4.9.1 At occupation it was established that a number of toilets were not connected to the underground drainage, leading to obvious problems. It is difficult to understand how such a fundamental defect could have gone undetected given the scope of testing and inspection normally devoted to this aspect of a building by Building Control inspectors.

4.9.2 There is a suggestion that this aspect has not been fully resolved to date.

Ventilation

4.9.3 The original design did not include any provision for administrative offices, these were introduced at a later date by subdivision of larger rooms. These internal layout changes have introduced partition walls which have the effect of:-

- obstructing air flows designed to cool and ventilate offices
- restricting or removing natural daylighting from secretarial offices

4.9.4 Mechanical ventilation introduced to compensate for lack of natural ventilation appears to be of limited effect leading to poor air quality.

4.9.5 High level clerestory windows provided in some offices provide some daylight and can be opened for ventilation but there is then a tendency for debris from the roof (especially feathers) to fall in.

4.9.6 Some areas of the building are air conditioned, there appears to be a need for some fine tuning or re-balancing of the system, some users report unacceptable conditions arising as a result of occupiers in other areas adjusting thermostats.

Windows

4.9.7 The architects report that they prepared a design for a specific window which incorporated all the features required of a mental health establishment. However, it appears that the windows actually installed do not comply with that design and are instead a "standard" item purchased from a window manufacturer.

4.9.8 Adverse comments on the windows have been made by staff, the most serious relating to the ease with which they can be forced fully open, and the consequent lack of security and the presence of specific ligature hazards. The fragility of the handles, a number of which have broken, is also a source of complaint.

4.9.9 Deficiencies in the windows lead to several problems:-

- Broken handles mean room cannot be secured and therefore has to be taken out of use
- Ability to force window open creates a risk of escape
- Ability to force window open creates a suicide risk from upper floors

Roof Coverings

4.9.10 The roof has a complex shape as dictated by the building layout and the high level ventilation provisions. At design stage the architects prepared design details to cover all of the detailing, to assist the contractor to achieve the complex shape while avoiding features which might have been prone to causing leaks. The architects are concerned that they were not afforded the opportunity to either review the construction working drawings or inspect the roof during or after construction and therefore are unable to verify that the works have been carried out in accordance with their initial designs or otherwise in an acceptable manner.

4.9.11 It is understood that roof leaks were occurring until very late in the construction process.

External Landscaping

4.9.12 It is understood that the scope of external landscaping was reduced by the D & C contractor in a bid to cut costs.

4.9.13 Irrespective of the scope of the original specification, the quality of the external areas and planting is poor. Specific complaints relate to the absence of external areas where service users can safely go for exercise, the non-provision of seating in the internal gardens and the lack of any tree screening to the main A13 road and Beckton sewage works, both of which are in close proximity.

4.9.14 The site is known to be highly contaminated and releases significant quantities of methane externally to the building. Concerns have been expressed about the safety implications of smoking in this area and especially on the terrace by the restaurant.

4.9.15 The external landscaping does not offer the opportunity for Occupational Therapy to carry out enhancement work. This is viewed as a missed opportunity as such work is considered to be very valuable therapy.

4.9.16 The paving to the car park include a detail involving a kerb laid flush with the paving. It is not clear why this detail was selected but in practice a small step of inconsistent height has been introduced in many locations. This has proved difficult to see in use and has resulted in some accidents, the worst involving a broken foot. To mitigate the problem all kerbs have been painted yellow, to date it is not confirmed if this is effective or how long the paint will last.

Internal Finishes

4.9.17 The architect advises that this is another area where quality was reduced by the D & C contractor to limit costs and that the final product does not comply with the original design. Staff and users have also commented that the finishes are not of the same standard as those promised during the design phase.

4.9.18 In practice the internal appearance is bland and institutional, lacking the colour variations and wall decorations originally proposed.

4.9.19 Staff have complained that the finishes are not suitable for the facility, specifically, the walls are not capable of being cleaned, the door frames and skirtings do not appear to have been properly finished at all and the floor coverings are blistering and cracking in a number of locations leading to safety hazards (e.g. Ruby Ward).

4.9.20 Within the Centre there is insufficient direction signage and in consequence wayfinding is difficult.

Panic Alarms and Nurse Call Systems

4.9.21 These are viewed as ineffective, the original panic alarm system was apparently too complex and failed to work properly, it has now been replaced but it appears that the new system is not well thought of. In particular the response time by security is far too long.

4.9.22 The call system is inadequate and limited by the shortage of remote call devices, requests to supply additional hand sets have not been fulfilled to date. The system is also unreliable.

4.10 Equipment Provision

4.10.1 There were expectations on the part of the Trust as to the nature and scope of the non-fixed equipment (e.g. fax machines, photocopiers, ECT, Resuscitation, chairs etc) that would be provided by Grosvenor.

4.10.2 Some of the expected equipment was not provided at occupation and has not been provided to date.

4.10.3 There are some discrepancies in the contract documentation, e.g. drinks vending machines for the wards are included on the equipment schedule but Grosvenor have adopted the position that these are only available at extra cost.

4.11 Outcome – compliance with objectives

4.11.1 There is a general view that the new building has some good features and represents a substantial improvement on the previous facilities.

4.11.2 In particular the spacious and bright aspect is well received and marks a substantial advance from the environment at East Ham Memorial Hospital.

4.11.3 It is also agreed that centralising the service in one location under the Trust's direct control has been a worthwhile step and creates a foundation from which a first class service can be developed.

4.11.4 There are, however, many more negative comments, views appearing to agree that the building has been poorly constructed and finished, is remote from transport links and lacks the outdoor space generally viewed as important for mental health facilities.

4.11.5 With reference to the specific objectives, the reactions are summarised in the following table:-

Benefit Criteria	Reaction

5.0 Handover/Occupation

5.1 Compliance with programme

5.1.1 As noted above, the completion of building works was delayed several times and the Trust did not have the benefit of a firm date for occupation to allow a well managed occupation to be achieved.

5.1.2 It had been planned to allow a period of 1 – 2 weeks prior to moving for familiarisation, checking, training and final preparation. In the event only 1 – 2 days notice was given.

5.1.3 The uncertainty over the eventual move date caused problems for staff who were unable to plan holidays and other work and private commitments. In the case of the Elderly Persons Service the Ward Manger was actually on holiday at the time of the move.

5.2 Staff Training and Familiarisation

5.2.1 The Trust properly had a plan to provide training to staff to prepare them for occupation of the new building by instructing them on the emergency procedures and familiarising them with the layout of the building and location of key features.

5.2.2 Delays to the construction process made the timetabling of training sessions very difficult with the contractor unable to provide access due to the constraints of the works in progress. This resulted in staff moving to the new building insufficiently trained and requiring the process to be repeated after the move.

5.2.3 Lack of adequate staff orientation at opening was criticised by many.

5.2.4 Additionally, no facilities (i.e. chairs etc) were made available for training sessions.

5.2.5 It remains the case that there are very limited facilities available for training and other group sessions at the Centre which causes problems with arranging such events.

5.3 Condition of works

5.3.1 At handover there were numerous minor defects in the works and some more serious deficiencies as follows:-

- Drains were not connected to toilets, preventing use
- Water services were not fully operational, leaving areas of the building without running water for several hours at a time
- Various emergency systems were not working
- The telephone system was not operational
- Staff were not trained in the operation of the fire alarm system, faults with which could not be cleared resulting in alarms sounding for many hours at a time, including during the night
- Significant items of equipment (resuscitation trolleys, ward equipment, Oxygen etc) were not available at occupation
- A number of pipework leaks arose leading to flooding of wards

- Items such as curtains/blinds and shelving were not provided and were only obtained after extensive efforts

- Non fixed equipment items were very slow to be delivered

5.3.2 When these matters were reported to Grosvenor, the initial reaction was slow but following further contact additional staff were made available to assist in overcoming problems.

5.4 Move Process

5.4.1 All those staff interviewed who were involved in the move process have reported that the physical move process proceeded smoothly. Delays arising in the construction process did not have any adverse impact on the actual move, indeed the additional time available for preparation may have assisted by allowing planning to be better developed.

5.4.2 It was intended as part of the move process that staff would have the opportunity to visit and inspect the new premises to satisfy themselves that the facilities were in a fit condition to house the service in advance of the move. Such visits would also provide an opportunity for staff to familiarise themselves with the new layout and for training sessions to be held covering the procedures in the event of emergency etc.

5.4.3 The delays to completion resulted in such inspection, familiarisation and training visits being impossible to arrange and in the event the requirement to move arose at very short notice and while plans for physically moving the service were well developed and in practice were well implemented the opportunity for preparation was lost.

5.4.4 The response to problems by Grosvenor House has been criticised. There are reports that individual members of the construction contractors staff gave assistance but that there was no co-ordinated response and no single point of contact with Grosvenor.

5.4.5 A number of interviewees reported that Allenbuild staff were active and helpful in resolving difficulties with the building.

5.5 Impact on Service Users and Staff

5.5.1 As noted above, on arrival at the new building there were many defects, some of which were serious. The short notice to move meant that staff were unaware of these problems in advance of arrival at the new premises and were then forced to cope as best possible. This was a very unsatisfactory situation and could easily have developed into something much more serious.

5.5.2 In general the service users coped well with the move and are reported to have settled in quickly.

5.6 Staffing Issues

TUPE

5.6.1 A small number of Estates and Facilities staff were transferred to Grosvenor at occupation, while the process was covered by TUPE there were a number of problems.

5.6.2 It appears that during negotiations undertakings were given to staff to the effect that their employment conditions would be protected. In practice there is evidence that this has not happened in practice.

5.6.3 During negotiations the transferring staff had many questions which were posed to their own HR representatives. It was considered that Grosvenor were not sufficiently involved in the process at an early enough stage.

5.6.4 The actual transfers took place only days before occupation, the implication is that this fundamentally unsettling event was undertaken too quickly. Given the long service and high level of loyalty of the staff in question, this has caused an unnecessary degree of friction.

5.6.5 Trust records on employment conditions appear to have been poorly kept leading to difficulties confirming the actual terms and conditions of employment of affected staff. Consequently, details provided to Grosvenor appear to have missed some information on guaranteed overtime payments, London weighting etc.

5.6.6 In the event, a clause was included in the contract whereby Grosvenor accepted liability only for "known" costs, leaving the Trust responsible for the remainder. This is reported to represent a charge of some £55,000 per annum to the Trust for an element that should properly have been included in the financial model.

5.6.7 The actual sum involved is small in the context of the overall contract but resolution of this point has proved difficult and has provoked some heated argument. To date the issue is not resolved.

5.6.8 It appears that this matter is making a major contribution to the poor relations which currently exist between the Trust and Grosvenor.

Double Running costs

5.6.9 The delay to completion and handover resulted in many new staff being appointed earlier than necessary (to comply with the anticipated programme) and then having to perform inappropriate tasks until such time as the facility was able to open.

5.6.10 The results of this situation were an adverse impact on the morale of the affected staff and unforeseen additional costs.

6.0 Operational Phase

6.1 Output Specification

General

6.1.1 Among those staff interviewed who expressed a view there was a unanimous opinion that the specification included in the Project Agreement was far from satisfactory. Surprise was expressed that the agreement could have been concluded with such poor drafting in place.

6.1.2 There was also a suggestion that Grosvenor may not have priced the service provision properly, leading to difficulties in delivery which could naturally be expected to drive them to the position of working to the letter of the contract. The poor drafting means that enforcement of the conditions is unlikely to benefit the Trust.

6.1.3 The responsibility for this situation was universally placed with the Trust that negotiated and concluded the agreement.

6.1.4 It was also generally agreed that relations with Grosvenor were extremely poor.

6.2 Access to the Centre

6.2.1 The Centre is accessed via a roadway (Glen Road) from Prince Regent Lane which passes the Newham General Hospital and also gives access to various car parks and the A&E ambulance entrance. The road connects also to local roads leading northwards but this route has restricted access (buses only).

6.2.2 Construction of the road was completed some time after the Centre opened. The alignment includes some sharp curves and the carriageway is narrow and subject to parking alongside the General Hospital. There is a footway on one side only (furthest from the Centre entrance). No specific provision has been made for disabled ramps.

6.2.3 Large vehicles use the road and represent a hazard to both other road users and pedestrians. Traffic hold-ups are commonplace at peak times.

6.2.4 The access drive into the centre has no footway as far as the car park and no provision for disabled access ramps.

6.2.5 The Green Travel Plan agreed as part of the planning permission is reported to have included provision for a bus service to enter the site with a bus stop within the car park close to the main entrance. Re-design of the car park to increase the number of spaces affected the layout such that the turning circles were changed with the result that the bus company refused to enter the site and the bus stop is now remote from the Centre.

6.2.6 The combined result is that access for all visitors to the site is more awkward than originally envisaged and particularly so for disabled or elderly visitors. The access arrangements are thought by many to be inappropriate for an acute hospital.

6.3 FM Services

General reactions

6.3.1 In the interviews there were many negative responses to the standard of service provided by Grosvenor House. These are dealt with individually in the following sections.

6.3.2 Certain issues became evident during interviews:-

- The output specification in the Project Agreement is too imprecise to allow clear definition of the service level to be provided
- There is some lack of understanding amongst staff as to the true content of the contract such that complaints are based on failure to provide a service that is not part of the obligation
- Grosvenor House are disposed to adopt a contractual and adversarial approach and are unwilling to enter into a partnership in pursuit of the solution to perceived problems
- Reported problems take too long to resolve leading to a general feeling that reports of problems are ignored
- Apparently small requests, e.g. for additional keys take excessively long times to be dealt with
- Reported problems are not effectively prioritised, a request for additional security on a door within the secure ward was ignored for some time, creating a major security risk
- There is a widely held perception that Grosvenor will only respond to problems if the Trust agree to pay for the works, irrespective of the requirements of the Project Agreement
- Failure to address problems within a reasonable time or at all is leading to premature deterioration of the building and in time will affect it's ability to remain acceptably functional for the intended lifespan of the Project Agreement
- Some staff have taken to contacting the handyman direct to secure minor repairs on the grounds that calls to the helpdesk produce no visible action
- In more serious cases, suppliers have been contacted directly in order to secure remedial action
- There is reason to believe that, in some cases at least, the delay to response is a direct result of contractual disputes between the supplier involved and either Grosvenor or Allenbuild. Such disputes are not made known to the Trust and are only discovered when direct contact with the supplier is established
- It is reported that Grosvenor staff do not have experience of working with acute mentally ill patients and react to the service users in an inappropriate manner
- There has been a significant turnover of Grosvenor staff, including at management level
- Despite adverse comments, there is some evidence that the situation has improved since occupation and that efforts to improve response times are being made

6.3.3 It is notable that there is no FM office within the new building, the management team occupy a temporary building in the car park. This is not conducive to good communications and seems unusual.

6.3.4 The site handyman has no dedicated workshop and is reported to provide his own tools.

6.3.5 The Trust acknowledges the poor state of relations with Grosvenor and accepts that this must be remedied before a satisfactory situation can be achieved. To this end there is a genuine wish on the part of the Trust to resolve the outstanding disagreements, especially the question of TUPE transfer costs, as soon as possible.

FM staff approach

6.3.6 While acknowledging that an acute mental health centre is a difficult environment in which to operate, clinical staff and users consider that Grosvenor appear to lack experience of the environment and frequently react in an inappropriate manner to events.

6.3.7 Examples range from a failure to properly prioritise security or safety critical repairs (e.g. window and door lock defects) to a failure to understand that bizarre events do happen in such an environment with the consequence that the response is inappropriate (e.g. the closure of the cafeteria and access to gardens following the discovery of a pigeon in the microwave).

6.3.8 It is suggested that Grosvenor management lack experience of the provision of soft FM (hotel) services.

6.3.9 There is some doubt about whether the services (e.g. housekeeping) are in compliance with NHS guidelines.

Reception

6.3.10 The main reception desk has limited visibility for visitors, many of whom do not sign in. No identity badges are issued to visitors. Control of persons leaving the building is also of limited effect.

6.3.11 There was evidence of frequent unauthorised access, ranging from sales representatives arriving at administrative offices without being announced first to reports of drug use in toilets by persons not associated with the Centre.

6.3.12 Further security problems arise as a result of the number of access points to the building.

Car park

6.3.13 The car park is not controlled, there are no barriers and no attendant.

6.3.14 It was reported that barriers were envisaged at design phase and that the provision of an attendant was discontinued on cost grounds.

6.3.15 On occasion staff and legitimate visitors are unable to park due to unauthorised users, there is evidence of the general public using the car park when not actually visiting the centre at all.

Catering

6.3.16 The quality of food provided is variable with limited choice and inadequate mechanism for responding to staff and service users preferences and needs.

6.3.17 Users had been led to expect a daily menu with a choice including culturally sensitive options, in practice a standard menu is uses which offers little choice and rotates on a 2 weekly cycle. There is no culturally sensitive option and no response to the special needs imposed by certain medications.

6.3.18 The quality of service within the wards exhibits a lack of sensitivity with poor standards of hygiene and assistance often being provided by ward staff.

6.3.19 Food holding is not adequate, the contents of the cold cabinets in the cafeteria are frequently warm.

6.3.20 There is limited access to cold drinking water throughout the building, it is considered that this should be widely available.

6.3.21 The provision of drinks to service users on the wards has become an issue with the proposed withdrawal of the vending service. The contract provision requiring drinks to be served at intervals during the day is considered overly institutional and an inadequate response to users needs. Service users also consider that there should have been consultation over proposals to withdraw the vending machines, it is understood that such consultation did not take place because it was known that the users would object.

Cleaning

6.3.22 Individual reactions to the standards of cleaning are variable. In some cases broad satisfaction was expressed during interviews, in others the reaction was more critical. There were no entirely positive responses.

6.3.23 The standard of cleaning staff employed appears to vary, some are diligent and hard working, others less so and there is a large turnover of staff.

6.3.24 Some cleaning problems are not the fault of the staff, poor finishing to building elements, especially paintwork to walls and joinery is blamed for some of the problems.

Laundry Service

6.3.25 It appears that this essential service was not included in the service specification and therefore is not contractually a Grosvenor obligation.

6.3.26 In practice a laundry service has been provided and initially this was good quality. More recently the standard has fallen to an unacceptable level and Grosvenor have made clear that they do not intend to restore the former level of service.

Telephone system

6.3.27 The telephone system is basic in nature and while it does now function it is not considered suitable for an acute hospital.

6.3.28 Problems persist with e.g. crossed lines but no action is perceived to be taken.

6.3.29 There is insufficient provision for fax machines.

6.3.30 The facility for providing additional lines/extensions or fax machines is limited and has now reached it's limit, without having met demand.

Safety

6.3.31 In some respects the new building is considered safer for service users and staff than East Ham Memorial, e.g. the radiators have been designed with safety in mind.

6.3.32 Staff safety is generically improved when compared to the layout of the previous premises as there are no areas which are infrequently accessed and other staff are always nearby.

6.3.33 The magnetic locks on external fire escape doors are easily forced (i.e. they are not strong enough).

6.3.34 Safety systems are not operational, in a recent cardiac arrest exercise the resuscitation team failed to attend within the specified time due to their contact telephone number having been accidentally erased from the computer system.

6.3.35 The failure of the emergency alarm systems is cited as a factor in the three patient deaths which have occurred.

6.3.36 The CCTV system does not inspire universal confidence as it is not adequately monitored and the tapes are frequently missing or damaged. There are blind spots in the system.

6.3.37 Staff, visitors and service users all use the main staircases. These have blind corners which are potential hazard points and it was suggested during interviews that these should be provided with mirrors.

6.3.38 The panic alarm system is reported to be adequate in principle but prone to frequent failures in use.

6.3.39 Frequent false alarms have had the effect of undermining the effectiveness of the fire alarm system.

6.4 Building Maintenance

Routine Planned Preventative Maintenance

6.4.1 This aspect of Grosvenor's work is described as being dealt with in a methodical manner and apparently to an acceptable standard.

6.4.2 It is understood that the current Facilities Manager on site is experienced in hard FM.

Non-routine repairs

6.4.3 There are a number of problems with the building which are a consequence of inappropriate or unsuitable choices of material or particularly heavy wear and tear on specific areas. Particular problems have been experienced with the following:-

- Paint finishes which cannot be cleaned effectively
- Floor finishes which are blistering and cracking and which will develop into trip hazards unless remedied
- Door hinges which are failing causing doors to drop and bind on floors, this is a particularly serious problem in wards where it may prevent rapid access to patients
- Serving hatches in dining areas which have broken in use
- Windows which are not sufficiently robust or appropriately designed
- Cracking and damp patches within the building
- Inadequacies in the nurse call system which is unreliable in use and not sufficiently versatile

6.4.4 Areas of particularly heavy use, e.g. smoking rooms need more frequent attention. There is no provision in the contract for this and no action has been taken. Suggestions that service users could undertake such work have not been accepted (see 5.4.9).

6.4.5 The response to damage caused by service users at times of crisis requires prompt attention in order to restore the appropriate atmosphere and to ensure the room is returned to use as soon as possible. On occasions it is reported that Grosvenor have chosen to defer remedial work until it is due under the planned maintenance programme, leaving the room in an unsuitable condition.

6.4.6 It is reported that few, if any, spares are kept on site to allow minor repairs to take place. Whenever damage occurs it is necessary to purchase replacement parts individually, which results in delay in completing the repair.

6.4.7 A particularly serious situation arose early in the life of the Centre when a service user was able to commit suicide by hanging using the door hinges. The staff perception is that Grosvenor were too slow to respond to a request to change all hinges to avoid a repeat and that the cost of the work was excessive.

6.5 Clinical Services

Staffing Issues

6.5.1 There is a considerable variance between the perceptions of the users representatives and the approach of the Centre management. The two are not necessarily incompatible but the users view point implies that the initiatives in place to develop the service need more time before a first class service emerges.

6.5.2 The service users views are predominantly negative and include the following issues:-

- Nursing staff are not adequately trained to deal with the requirements of the users and there is a high proportion of agency staff which is felt to be prejudicial to the quality of care
- There are cultural differences between the nursing assistants and the users which can cause friction
- The regime is overly regimented
- Communication between ward staff and users is inadequate, staff make little effort to support or develop users
- Nursing staff are reported to spend too much time in the nurses station and restroom/kitchen behind rather than supervising the ward
- In response to difficulties in recruitment there is a move towards employing psychology graduates in assistant roles. Users object to this on the grounds that they feel they are being used to test new ideas without their consent
- The approach by staff lacks consideration, e.g. users are forced to wait for long periods, even all day, for ward rounds which are then cancelled at short notice
- Similarly, smoking rooms are locked at night denying access to users unable to sleep
- Timetabling of interviews under the Care Programme Approval system also lacks consideration for users and it is considered that the intended holistic approach is not being achieved, leaving users without the necessary support following discharge
- The HAS report identified that the Centre is over-staffed with poor interaction between staff and users
- It is considered that the environment in respect of staff/user relations is worse than existed at East Ham Memorial and that opportunities for improvement are not being pursued
- Use is not being made of the facilities for therapy, each ward has provision for cookery, beauty, sports and art but the opportunities to use these are limited. A combination of ward managers, consultants, occupational therapy and nursing staff are blamed for this situation
- In the day hospital the requirements of the innovative model of care has seriously restricted recreation opportunities for users (e.g. offer of board games for use in quiet periods was refused as it would interfere with the research)

- The regime in the day hospital is so strict as to intimidate users, some of whom fail to return if they miss a session

- It is reported that a high percentage of day hospital users return to the wards within a short time

- There is little confidence in ward managers who are seen as unwilling to cater for or support service users

- Insufficient notice is taken of the views of service users, problems within Topaz ward were reported but no action taken until two suicides had occurred

- Control of access to the wards is inadequate, there have been instances of bailiffs or solicitors serving writs on users without nursing staff even being present

- Some staff (especially consultants) do not wear security passes making identification difficult

- There is uncertainty about the operational policies in force with a tendency to cease to apply the current policy before the revision is fully in place

- There are inconsistencies in policies, e.g. staff are given counselling following incidents on the wards but service users are not

6.5.3 It appears that these concerns and criticisms might be related to the early performance of the Centre and may possibly be less relevant now. The Trust response provides a different view:-

- It is acknowledged that the opening of the new centre created a need for a significant number of new ward and other staff, recruitment of whom was necessarily carried out over a comparatively short period

- It is also acknowledged that the quality and experience of the new staff was very varied, while some were very competent others had less than the required level of ability. On deployment staff were well mixed but it is likely that the presence of a number of inexperienced staff within the wards would give rise to the comments from users noted above

- The Trust has implemented a range of initiatives to develop and train staff in order to overcome problems arising from lack of experience

    - The issue of inconsistencies between the individual approaches of Ward Managers has been addressed and a common philosophy established to provide cohesion in working

    - A development plan for Ward Managers is being run by an external consultant which has been effective in delivering improvements

    - A process of monthly audits of standards is now in place to allow problems to be identified at an early stage

    - The Independent Newham User Forum (INUF) has been engaged in the development of a charter for acute care, which is reported to be progressing well

    - Personal development plans are being developed and will be in place for all members of staff by the end of 2003 and an Appraisal process has been developed and is being implemented

- All new staff are given a 2 week induction and there is a monthly training programme covering practical application of policies
- A 6 month preceptorship has been introduced for new D grade staff and a competency pack is in use for E grades
- An F grade development process has recently been established
- The Trust is supporting staff at all grades in securing NVQ qualifications
- All staff are subject to a programme of mandatory training courses
- A training database has been established

- All of the above measures are aimed at developing a sound foundation of competent and dedicated staff at all levels to support the provision of a first class service

6.5.4 The Trust acknowledges that it has taken a major effort to address this issue which has been described as "overwhelming" and that it will take some time before the required standards are fully met

Ward Layouts

6.5.5 The change from open wards to individual en-suite rooms has been generally welcomed as a major improvement in standards of dignity and privacy for service users. It is considered by staff that they have the opportunity to deliver a higher standard of service than was the case at East Ham Memorial.

6.5.6 It is acknowledged that the increased privacy brings greater potential for patients to come to harm as they cannot be observed as easily, however this is considered to be offset by reductions in the risks associated with communal bathrooms etc.

6.5.7 It is acknowledged that ward staff need to adopt a different approach when dealing with individual rooms and it is suggested that adaptation to the changed culture was slow initially and may have led to problems. It appears that the improved standards of privacy may lead to a reluctance on the part of staff to intrude and a consequent reduction in standards of supervision.

6.5.8 It was suggested during the interview process that the two suicides which have occurred since the facility opened may have arisen in part due to staff being unfamiliar with the requirements of the new ward layouts.

Bed Numbers

6.5.9 Fewer beds are now available as compared to the situation previously at East Ham and Goodmayes. This results in serious over occupation and imposes significant pressures on the management of admissions.

6.5.10 It is suggested that patients are either sent on leave or discharged sooner than is ideal leading to a higher than desirable rate of readmissions.

Recreation and Work opportunities

6.5.11 On the subject of recreation the view was expressed several times that there were insufficient facilities. The proposal for a Gym was not included in the final contract although some staff appeared unaware of this. Proposals to share facilities at Terrence McMillan appear not to have been pursued.

6.5.12 Within the wards facilities are restricted, the acute wards have no pool tables nor access to kitchens (apparently in response to fears of injury or damage) although the secure ward has a pool table and the day hospital has a kitchen open to service users.

6.5.13 Service users with artistic abilities have offered to donate items of their work to be displayed within the building to relieve the blank walls. Occupational Therapy have apparently rejected this proposal as a result of concerns about the possible subsequent impact on individuals of the display of works prepared during crisis periods. Service users are apparently dismissive of these concerns.

6.5.14 The opportunity for users to benefit from the therapeutic effects of work (and to earn wages) and for the facility to have the benefit of their efforts also appears to be very limited. Grosvenor have advised that they do not carry insurance to cover service users or former users engaged in this way, even on a voluntary basis. The view was also expressed that the condition of the external areas is such that gardening activities, which are a common form of therapeutic activity in other mental health facilities, are not possible.

6.5.15 There was considerable discussion pre-contract on the subject of recreation and work opportunities which were seen as central to the therapeutic environment and a number of possible initiatives were proposed. It appears that none of these have been implemented in practice which has to be seen as a lost opportunity.

Interaction with other services

6.5.16 It is reported that the location of the Centre adjacent to and effectively on the same site as Newham General Hospital has led to an assumption within the wider health community that the Centre receives all it's services from the General Hospital Trust.

6.5.17 This assumption has led to certain SLAs being withdrawn in the belief that they are no longer necessary leading to generally poorer integration with other health services.

6.5.18 At the same time, the quality of service from Newham General is not improved as a result of the close proximity and the poor state of the access road means that transfers of patients still requires the use of an ambulance, especially at night.

6.5.19 It has been noted that there are no X-ray facilities at the Centre, although these were available at East Ham Memorial.

6.6 Achievement of Objectives

Response to Surroundings

6.6.1

Benefit Criteria	Reaction
Range of services	The necessary range of services is provided but opportunities have been missed, e.g. unusable external areas, limitations to occupational therapy due to lack of employment and recreational activities.
Accessibility	Service is locally based and available to those with need. Physical access for service users and their visitors/carers is difficult due to location and poor transport links.
Safety	Do not appear to have been any improvements to the safety of service users, e.g. security is poor, ligature hazards have been identified, serious incidents have occurred.

Choice	
Partnership	Integration with other services has not improved. Newham General A&E department is difficult to reach, especially at night.
Locally based	The service is locally based which represents a benefit over previous arrangements.
Continuity of Care	Movement of patients and co-ordination with other services is no worse than elsewhere but fails to deliver excellence at present.

7.0 Financial Performance

7.1 Introduction

7.1.1 It is understood that KPMG have been appointed to carry out a full audit of the financial aspects of the project and that this work is under way and nearing completion. Pending publication of their report it is understood that the financial model remains favourable and within the original parameters despite changes which have been introduced since financial close.

7.1.2 It is not proposed to comment in detail on the financial model in this report, but the following sections detail the information which has been reported during the interview process.

7.1.3 Overall, the view of the Trust finance director is that the contract as signed provides poor value to the Trust and it is difficult to understand how the agreement was reached on such a basis.

7.2 Transitional Costs

7.2.1 During the handover process a degree of "double running" was required in order to achieve a smooth transfer to the new facility. It appears that the associated costs were not accounted for within the financial model or Trust accounting and it was necessary to negotiate with the purchasing PCTs to cover these. These negotiations are understood to have been completed successfully.

7.2.2 The final agreement with the Purchasers is reported to be more beneficial than the original.

7.2.3 As noted earlier, additional costs arose as a result of the need to employ new staff from a date to suit the original programme who could not then be effectively deployed until later as a result of delays to completion.

7.2.4 The Liquidated and Ascertained Damages included in the Project Agreement were not adequate to cover the full costs incurred by the Trust as a result of the delay.

7.3 Financial Performance

Construction Budget

7.3.1 It is reported that the construction works were completed within the original budget set.

7.3.2 Grosvenor House have stated to the Trust that they incurred a loss on this element of the contract and given the very competitive nature of their costing this seems very likely.

7.3.3 It is thought that the poor standard of finish to the building is a result of two factors:-

- Time pressures arising from late completion and consequent attempts by the contractor to complete as rapidly as possible in order to avoid incurring Liquidated and Ascertained Damages
- Specification changes designed to reduce costs in the face of serious overspending

7.3.4 Neither of the above is of any benefit to the Trust but it is generally accepted as true that the completed building represents very good value for the price paid.

Backlog Maintenance

7.3.5 The project is reported to have successfully met the objectives for the elimination of backlog maintenance.

Unitary Payments

7.3.6 The payments are in accordance with the contract and are based on the output specification.

7.3.7 No deductions for poor performance have been made despite the many complaints and apparent causes for penalties to be imposed. It is not clear if this is a result of insufficient monitoring on the part of the Trust, insufficiently clear definitions in the contract or other reasons. It is now understood that the Director of Estates & Facilities is taking control of the monitoring process.

7.3.8 It is reported that electricity charges are very high. There is no incentive within the Project Agreement for Grosvenor to use low energy fittings (lamps, pumps etc). These items generally have a higher purchase cost which Grosvenor would be obliged to meet, whereas energy costs are passed directly through to the Trust.

7.3.9 In connection with running costs, the building design was not subject to value engineering aimed at reducing costs in use.

Other payments

7.3.10 The long period between OBC and Financial Close provided the opportunity for the Trust to review and revise the design and build in a number of changes, the full implications of which were not always understood. It is suggested that some relatively small capital cost items, for which the Trust made direct payment, had a disproportionate associated running cost.

7.3.11 There is also a suggestion that the Trust may have been overcharged for some items and that the "mark up" applied by Grosvenor to all payments is excessive.

Staff Transfers

7.3.12 As noted earlier, the financial arrangements in the contract relating to TUPE transfers of staff appear to leave the Trust with much of the associated financial risk. Rather than establishing the cost of transfers and making due allowance, Grosvenor appear to have accepted the risk for those costs that they knew at financial close, the remainder are the responsibility of the Trust.

8.0 Action Plan

8.1 Principles

8.1.1 This report highlights a number of specific areas of concern, in general these fall into two categories, those that can (in theory, at least) be remedied and those that are now past but from which lessons can still be learned.

8.1.2 The following section summarises the individual items under these sub headings and makes suggestions as to how to respond to each.

8.2 Specific Issues

Items where there are lessons to be learned

Problem	Suggestion
Apparent omissions from initial design brief	Involve all interested parties in definition of the requirement, ensure a clear view is achieved of the required purpose and performance of the proposed facility and that this is clearly stated in the brief. Fully describe all features required. Level of definition to reflect level of importance to Trust.
Lack of attention to detail in Output Specification	Accept that this must be fully detailed, avoid any "short cuts" in defining the service requirements. Level of definition to reflect level of importance to Trust.
Perceived poor consultation during design process	Ensure consultation is comprehensive, take due account of outcome. Provide transparency in design decision making process, ensure those consulted know what is being put in/left out and why.
Criticisms or deficiencies in as built layout	Transparency of design decision making process will help all parties to understand reasons for compromises and will help avoid unacceptable features.
Design modifications carried out in ad-hoc fashion when changed requirements identified late in process or during construction	Can be minimised by thorough development of brief and underlying design. Where late changes arise do not compromise the change control process
Lack of control over working design content	Appoint an independent party to check design against input/output specifications agreed and included in Project Agreement. A "high level" check should be sufficient.
Lack of control over quality of site works	Appoint an independent tester to inspect on site and report at regular intervals, including at completion. Appointment to be in accordance with SFPAv3.
Change control difficulties, e.g. Room Data Sheets not updated to reflect agreed changes, agreements for changes at nil cost not recorded.	Define a clear change control process and ensure it is implemented. Record in writing all agreed changes, even when at nil cost.
Costs arising from delayed occupation not covered by damages recoverable	Consider implications of possible delay with care and define damages to cover anticipated costs. Apply sense check to ensure amount

Problem	Suggestion
	included is not disproportionate, i.e. too low or too high.
Poor standard of building finish generally	Define requirements clearly and check input specifications from contractors carefully. Do not accept vague descriptions.
Lack of notice prior to occupation	Define handover procedure in terms of actions and timescales following certified completion of building works and do not vary however late the contractor is. Seek to define damages as payable up to date of occupation.
Lack of staff familiarisation training prior to occupation	Staff training to be part of handover procedure, contractor to have obligations to support process.
Problems with TUPE transfers	Trust to make all details available to bidders to avoid uncertainty over costs and any need to compromise on risk transfer.

Items where there is scope for remedial action

Problem	Proposal
Lack of confidence in ward staff (managers, nurses, nursing assistants), inconsistencies in practice between wards etc	Publicise more the training and development programme under way and monitor improvements in performance.
Ongoing general building defects	Seek to identify and resolve matters of quality outstanding from completion. Encourage Grosvenor to admit where delays are being caused by disputes with their contractor.
Unsuitable window design	Establish initially what needs to be done given that comprehensive replacement may not be appropriate. Establish if windows meet contract specification, pursue contractor if not, otherwise define scope of essential works and investigate means of implementation
Poor definition of obligations within Project Agreement, lack of alignment between Payment mechanism and Output Specification.	Scope for renegotiation of specifications is restricted, need to identify key problem areas and seek resolution by negotiated agreement on service to be provided.
Inadequate monitoring of FM performance	Allocate appropriate resources to implement monitoring, define procedure and involve clinical and management staff where appropriate.
Poor quality of external spaces, unsuitable for recreational/therapeutic use.	Ensure that contractor has provided what he is obliged to provide (including ongoing maintenance and replacement of failed plants). Establish what can be achieved under the FM contract and by means of work by service users.
Poor performance of nurse call and alarm systems	Contractors should ensure that what has been provided actually works properly, FM should include maintenance, repair and proper monitoring of calls, response etc.
Shortages of essential equipment	Establish what has or has not been provided against what is in the contract. Contractor to make up shortfalls. Seek proper operation of refresh process.
Bland internal finishes	Ensure routine redecorations use more imaginative colour schemes. Investigate

Problem	Proposal
	provision of art works and other local features.
Poor access and transport arrangements	Ensure Green Travel Plan is meeting obligations. Investigate with local highway authority and bus companies what improvements can be made. Investigate improvements to access road, provision of disabled facilities and footpaths.
Deficiencies in hotel services	Review with service provider and seek agreement on service levels.
Inadequate response to helpdesk calls on non-routine maintenance issues	Seek agreement with service provider on improvements to response. Seek to enforce contract conditions where appropriate.
Lack of integration between FM and clinical staff	Instigate formal and informal communications, seek to engender higher levels of partnering.
Reception deficiencies, poor security arising from lack of access control, multiple access points	Provide better access control on all secondary doors into/out of building. Improve visibility of reception. Enforce wearing of identity badges.
Uncontrolled car park	Investigate provision of barriers or other controls to prevent unauthorised access.
Trip hazards in car park	Obtain expert advice on extent to which this is a construction fault and seek remediation as appropriate.
General catering problems, quality of menu, storage and serving.	Instigate discussions with service provider with a view to improving the quality.
Provision of 24 hour drinks service	Ditto.
Laundry service	Ditto
Telephone system	Ditto
Safety and security issues	Very important that service provider understands the wider implications of these prior to reviewing means of providing acceptable service levels.
Provision of therapeutic activities, work	Investigate means of overcoming the insurance problem that appears to be preventing this. All parties stand to reap significant benefits from introduction of a suitable programme.
Integration with other services	Trust issue related to establishment of appropriate SLAs etc with other organisations
Costing of variations	Appoint professional advisors to revue costs and advise on acceptability/negotiate fair market rates where necessary.

8.3 Next Steps

8.3.1 Grosvenor House Group have agreed in principle to participate in a workshop with other stakeholders to review problems and consider means of rectification. This should be implemented at the earliest opportunity, possibly using this report to define the agenda, facilitated by an independent person or organisation.

8.3.2 Following the workshop, additional working groups will probably be needed to consider individual aspects and to seek appropriate solutions.

8.3.3 Where possible solutions should keep within the existing definitions of the contract.

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