Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Bruno Zinghini

Name:	Bruno Zinghini
Professional address:	1 Reserve Road St. Leonards NSW
Occupation:	Executive Director Western Region, Health Infrastructure

1. This is an outline of evidence that it is anticipated that I will give to the Special Commission of Inquiry into Healthcare Funding.

A. INTRODUCTION

2. I am the Executive Director, Western Region of Health Infrastructure (**HI**). My curriculum vitae is exhibited to this statement (Exhibit 15 in NSW Health Tranche 4 Consolidated Exhibit List).

3. In this role, I oversee HI's Western Region, which includes some of Australia's largest and most complex health capital projects. That portfolio covers three Local Health Districts (**LHDs**) across NSW as well as NSW Ambulance projects in metropolitan locations, and projects with HealthShare NSW and NSW Health Pathology.

4. My role is to ensure health infrastructure is delivered successfully in close partnership with LHDs and other NSW Health partners. I oversee the delivery of infrastructure projects, from inception to handover, including planning, procurement and delivery of the project. I have been in this role for 5 years and 6 months.

5. As part of my role as Executive Director Western Region, I was the Executive Lead for the Campbelltown Hospital Redevelopment Stage 2 (the **Project**) in South Western Sydney Local Health District (**SWSLHD**). I held that role as it is a project that falls within my geographical portfolio.

6. This outline provides an overview of the governance and planning, procurement and delivery process for the Project in accordance with standard governance arrangements and processes across the HI capital program. I consider that the Project gives a good overview of the general role of HI and the governance arrangements in capital project delivery. It is an example of a typical project that has gone through the full planning and delivery phases of HI processes. There are many documents in the lifetime of a project

which are commercial in confidence. Some exhibits contain redactions of personal information and/or confidential information.

B. HEALTH INFRASTRUCTURE PROJECT GOVERNANCE ARRANGEMENTS

7. The *Project Governance Arrangements* for the Project dated March 2018 (Exhibit 1 in my Exhibit List) outline the governance structure and terms of reference for the various groups responsible for the Project. Those terms of reference allocate roles and responsibilities in relation to key project deliverables between HI, the LHD or health entity and the Ministry of Health (**MOH**). This includes strategic oversight of the project through the Executive Steering Committee (**ESC**) and structured committees and groups which are responsible for the input, oversight and review of the documents and deliverables during the planning and implementation stages of the Project.

8. Project governance arrangements are generally consistent across all HI projects and provide mechanisms for project planning, Business Case development and procurement activities in accordance with *NSW Government Business Case Guidelines* and *NSW Health Facility Planning Process* (which was known as *NSW Health Process of Facility Planning PD2010_035* (**PoFP**)), and HI standards and guidelines for major capital projects. Copies of the PoFP and the *Business Case Guidelines*, as at the time that Project was planned, are exhibited to this outline (Exhibits 2 and 3 respectively in my Exhibit List).

9. Project governance committees and groups are convened for all projects. The *Project Governance Arrangements* formed part of the Final Business Case (**FBC**) for the Project, with governance committees and groups membership updated as required during the Project as each iteration was approved by ESC.

10. The *Project Governance Arrangements* for the Project included the following committees and groups, which reflect the standard governance arrangements on HI projects:

    a. ESC:

        i. The ESC provided strategic direction and leadership on all Project activities, including monitoring achievement of deliverables (including adherence to Project scope) and endorsing deliverables prior to submission to HI, MOH or NSW Treasury in the case of Gateway review documentation. The ESC was the ultimate decision-making authority within the Project's governance structure.

ii. Membership of the ESC included the HI Chief Executive as the Chair, the LHD Chief Executive and a MOH representative. Quorum was the HI Chief Executive and LHD Chief Executive.

b. Planning and Development Committee (**PDC**) (during the Planning stage):

i. During Stage 1 and 2 of the PoFP and Parts 0-3 of the HI Project Framework, the PDC was responsible for monitoring and advising on all aspects of the Project, monitoring the achievement of Project deliverables by relevant stakeholders in accordance with their designated responsibilities as outlined in the PoFP (including adherence to Project scope and parameters, making decisions consistent with their level of delegation, providing direction and advice to other governance structures), and they endorsed Project deliverables prior to submission to the ESC.

c. Project Control Group (**PCG**) (during Delivery stage):

i. On completion of the Stage 2 of the PoFP and Part 3 of the HI Project Delivery Framework, the PDC was replaced by the PCG. The PCG took on the responsibility of managing the key deliverables and key activities for the Project scope as defined by the FBC through Stage 3 of the PoFP and Parts 4-9 of the Health Infrastructure Project Delivery Framework. During implementation, the PCG was responsible for overseeing construction and commissioning, providing direction and advice to other governance structures, monitoring and reporting to the ESC on project progress and making decisions consistent with their level of delegation.

d. Project Planning Team (**PPT**) (during Planning stage):

i. The PPT was responsible for early planning for operational planning and implementation to facilitate the achievement of Project objectives as defined the FBC. The role of the PPT included interfacing with Project Working Groups (**PWGs**), Project User Groups (**PUGs**), and monitoring and/or implementing key operational and clinical strategies which support the PoFP including risk management, change management (including operational policies and models of care), communications, operation and commissioning (including non-clinical support services, systems and equipment).

ii. The PPT was responsible for the consideration and coordination of the consultation processes and engagement with users. The PPT reviewed key activities and provided advice to the PWGs, the Executive User Group (**EUG**), PUGs and PDC/PCG on clinical and non-clinical issues in order to facilitate, co-ordinate, and guide the Project as required.

e. Project Delivery Team (**PDT**) (Delivery stage):

i. The PDT was responsible for operational planning and implementation to facilitate the achievement of the Project's objectives as defined the FBC during the delivery stage. The role of the PDT included the interface with PWGs, PUGs, and monitoring and/or implementing key strategies which support the PoFP including risk management, change management (including operational policies and models of care), communications, operation and commissioning (including non-clinical support services, systems and equipment).

ii. The PDT was also responsible for the consideration and coordination of the consultation processes and engagement with users. The PDT reviewed key activities and provided advice to the PWGs, PUGs and PDC/PCG on clinical and non-clinical issues in order to facilitate, co-ordinate, guide and advise the Project as required.

f. PWGs:

i. PWGs reported to the PPT and PDT, (depending on the stage of the Project) and had responsibility for developing and monitoring key Project activities including communications and consultation, change management, overarching operational policy development, capital and recurrent cost estimates and economic appraisals. PWGs were convened as required to coordinate, monitor and implement planning strategies to achieve project objectives and timeframes. PWGs were also responsible for planning requirements with whole-of-organisation impacts.

ii. Generally, the type and number of PWGs developed depends on the needs of a project, including whether a project has complex issues that require resolution or co-ordination across clinical or functional areas within the facility or LHD. Typical PWGs include:

1. Furniture, Fittings and Equipment Control Group;
2. Communications and Consultation;
3. Change Management;
4. ICT Strategy;
5. Commissioning and Operational Planning;
6. Systems and Equipment – Major Medical; and
7. Move Logistics and Decant.

g. Clinical Reference Group (**CRG**):

i. A CRG was chaired by the General Manager of Campbelltown Hospital and convened as required to provide expert clinical advice on clinical and health service delivery matters to the PDC/PCG or PPT. This group was responsible for the resolution of clinical issues escalated from the PUGs.

h. Project Communications and Engagement Working Group (**CEWG**):

i. The CEWG carried out interagency, stakeholder and community consultation throughout the planning, design and delivery stages of the Project. It provided advice to the PPT and PDT on matters such as:

1. Stakeholder and community strategy, activities, risks and issues;
2. Transport for NSW coordination and interface;
3. Department of Planning, Housing and Infrastructure coordination and interface; and
4. Coordination and interface with other NSW and Local Government agencies, utility authorities and non-government stakeholders such Universities.

i. EUG:

i. The EUG was responsible for overseeing the PUG process. This included resolving issues escalated from PUGs, ensuring consistency

across each PUG, and alignment with design briefs with the CSP, as well as local, area and statewide LHD and Facility operational policies and other Project parameters. The EUG was also responsible for endorsing design briefs and design documents prior to submission to the PPT or PDT for endorsement.

j. PUGs:

i. PUGs reported to the EUG as required and referred clinical matters for resolution to the CRG. PUGs were responsible for developing the functional briefs for health planning units (**HPUs**). One key requirement was for them was to ensure briefs are aligned with the endorsed CSP and local, area and statewide operational policies and other Project parameters.

ii. The PUGs generate and provide clinical and operational planning input, provide feedback on health service delivery matters and non-clinical factors as they impact the design and operational implementation. The PUGs consider and moderate the interests of the broader workforce and work collaboratively to ensure that the facility user requirements both in the short and long term are accurately reflected in the project brief and design documentation.

11. The *Project Governance Arrangements* do not refer to the Capital Strategy Group (**CSG**), which is chaired by the Deputy Secretary, Health System Strategy and Planning Division. The CSG has portfolio level oversight of the capital program and a focus on portfolio-wide contingency management in accordance with the *NSW Health Capital Contingency Management Framework*.

12. During the life of the Project, three relevant proposals were submitted to the CSG and approved, resulting in approximately $25.4M of Executive Contingency being released into the Project. It is anticipated that at financial close of the project (the end of FY23/24), once all final Project costs are closed out, approximately $6M of the $8.5M of Executive Contingency remaining in the Project will be returned to the Centralised Contingency Pool.

C. CAMPBELLTOWN HOSPITAL REDEVELOPMENT STAGE 2 OVERVIEW

Background to the redevelopment

13. Prior to the 2015 NSW election, the then NSW Government announced that it would commit $300 million to commence a Stage 2 Redevelopment of Campbelltown Hospital, following on from the $134 million Stage 1 Redevelopment which was completed in January 2016.

14. In December 2016, MOH requested SWSLHD undertake clinical service planning, to inform the Stage 2 Redevelopment.

15. In May 2017, SWSLHD approved the Project as its number one capital works priority for the next 10 years. SWSLHD presented an investment decision submission to MOH concerning the Project. The outcome was that the NSW Government committed $632 million to the Project in the NSW State Budget for 2017/2018. HI did not have a role in this process.

16. *GL2021-018 NSW Health Facility Planning Process Guideline* (**FPP**) outlines the current requirements of each stage of the facility planning process (Exhibit 142 in NSW Health Tranche 4 Consolidated Exhibit List). At the time the Campbelltown Hospital Redevelopment Stage 2 commenced, the facility planning process was known as PoFP, as set out in paragraph 8 above.

17. The Project followed the stages as set out in the PoFP which were in force as at the time the Project commenced. The most significant differences between the FPP and the PoFP is that the FPP introduced a MOH-led 'Stage 0' and HI's project delivery standard of 'Pre 0'. The Project from HI's perspective therefore commenced at Stage 1.

Stage 1: Services & Facilities Needs Analysis

18. During Stage 1 of the Project, it was the responsibility of HI to lead service delivery planning, options analysis, cost-benefit analysis and risk management. The key milestone for Stage 1 of the Project was the preparation of a Masterplan and feasibility development.

19. From HI's perspective, the Project formally commenced once capital budget was allocated in the NSW Budget papers. By the time HI became involved, the development of the clinical services plan had already been undertaken by SWSLHD, in coordination with community feedback. HI does not have any involvement in the preparation or approval of the clinical services plan. However, the clinical services plan provided HI with significant guidance as to the scope of the Project and its intended goals.

20. The relevant services plans prepared by SWSLHD were the *Abridged Clinical Services Plan for Macarthur to 2031* (**CSP**), and the *Enhanced Paediatric Capacity Plan 2031*. The CSP provided a high-level review of changes to the scope of project planning to 2031, a snapshot for the Macarthur region over the 2016 to 2031 period, and examined the drivers for change and lack of clinical capacity at Campbelltown Hospital. The CSP also identified the need for a substantial enhancement of paediatric services, expansion of the range of surgical, medical, maternity and diagnostic services, and integration and expansion of mental health services.

21. Once capital budget was allocated to HI for formal commencement of the Project, under HI's delivery model, support for planning a project is procured through a competitive tender process, and includes project management, architectural and cost management services, together with other specialist consultants (such as engineers). For the Project, this tender process commenced in mid-2017. The following capital consultants were engaged:

    a. Root Partnerships (Project Manager), supported by Carramar Consulting (Health Facility Planning);

    b. Billard Leece Partnerships (Architect);

    c. AECOM (Quantity Surveyor and Cost Manager); and

    d. Other key planning and design consultants for engineering tenders followed.

22. Once the capital consultants are engaged, the ESC for the Project was established. Version 3 of the *Project Governance Arrangements* also included a HI Director as a member and Chair.

23. Once the ESC was established, the *Project Governance Arrangements* were prepared. As I set out above, the *Project Governance Arrangements* are a standard HI document used across HI capital projects. The role of the ESC in the development of the *Project Governance Arrangements* was to ensure that the standard requirements are in place for the Project and confirm the relevant members and invitees to each of the governance groups and committees.

24. The *Project Governance Arrangements* groups and committees memberships were updated as the Project moves through each development stage.

25. The next step was the preparation of the Project Masterplan. The *Campbelltown Hospital Redevelopment Stage 2 Masterplan Report* was prepared by architects Billard Leece Partnership in January 2018. A copy of the *Masterplan Report* is exhibited to this outline (Exhibit 4 in my Exhibit List). The purpose of the Masterplan was to set the strategic vision of the Project and use of the campus.

26. The methodology for the preparation of the Masterplan required:

    a. a review of current documentation including site plans, service plans and other relevant documents;

    b. review and consultation with Campbelltown Hospital, SWSLHD and HI regarding health service planning assumptions; and

    c. the development and testing of options for funded and future stages of the Project.

27. All options for the potential Masterplan were presented to Campbelltown Hospital executive leadership, SWSLHD and HI, and endorsed via project governance. An assessment of the options was pursuant to weighted assessment criteria, ranging from maximising the range of services uplift (highest weighting) to earliest delivery of the project outcomes (lowest weighting). The options evaluated are set out in the *Value Management Study* report (referred to at paragraph 33 below).

28. The development of the Masterplan was undertaken in consultation with representatives from the following:

    a. Campbelltown Hospital;

    b. SWSLHD;

    c. HI;

    d. NSW Health;

    e. Root Partnerships (project manager);

    f. Billard Leece Partnership (architect); and

    g. AECOM (quantity surveyor and cost manager).

29. Part of the Masterplan process involves site selection or, in the case of this Project, site investigation. A site investigation and a structural assessment concluded that the

facilities at Campbelltown Hospital, originally opened in 1977 and progressively developed, were well maintained and in generally good condition.

30. The final action item for stage 1 of the Project was the preparation of the Concept Design. The Concept Design aligned with the endorsed Masterplan and set out the details of a substantial new build, which existing high value assets were to be retained and/or repurposed, and how services were to be consolidated in fewer buildings so that redundant or not fit-for-purpose buildings could be removed.

Stage 2: Project Definition

31. At this stage of the process, HI was responsible for leading options analysis, procurement strategy, risk management, submission to the Department of Planning, Housing and Infrastructure and developing the FBC in partnership with the LHD.

32. This stage largely involves the development of a number of documents, which was reflected in the *Project Governance Arrangements.* Each document was prepared by an expert consultant, in consultation with representatives as set out in paragraph 28 via the *Project Governance Arrangements* groups and committees. Documents were then endorsed via project governance as part of the FBC as final versions, for final approval of the Project's scope. All documents were then monitored and updated via project governance in accordance with the *Project Governance Arrangements*.

33. The following documents were prepared between 2017 and 2018 as part of the Project:

    a. The Australian Centre for Value Management was commissioned to facilitate and report on a Value Management Study workshop held in November 2017. This brought together representatives from HI (including myself), SWSLHD, Campbelltown and Camden Hospitals, MOH, community representatives, stakeholder groups and the Project team for a workshop to review the four shortlisted options which were all within the $632m available budget. The workshop started with an overview presentation on key background information. As part of the workshop, participants evaluated the performance of each option against the weighted criteria, with a view to recommending which option should be supported to inform the basis of a business case. A *Value Management Study Report* was prepared by HI in November 2017, a copy of which is exhibited to this outline (Exhibit 5 in my Exhibit List). The workshop members came to an independent and unanimous regarding the preferred option, which formed the basis of the FBC.

b. A *Schedule of Accommodation* was prepared by Root Partnerships and Carramar Consulting through consultation with PUGs including representatives from SWSLHD and HI in April 2018.

c. A *Functional Design Brief* was prepared by Carramar Consulting in March 2018, a copy of which is exhibited to this outline (Exhibit 6 in my Exhibit List).

d. A *Cost Plan Review for Business Case* was prepared by AECOM in May 2018, a copy of which is exhibited to this outline (Exhibit 7 in my Exhibit List). It identified potential savings, risks and contingencies, fees and costs for each aspect of the Project.

e. A *Concept Design Report* was prepared by Billard Leece Partnership in April 2018, a copy of which is exhibited to this outline (Exhibit 8 in my Exhibit List). The Project design team were commissioned in September 2017 to complete the design. Generally, the Concept Design defines the scope, identifies the location of building works, describes key clinical relationships and looks at staging in order to ensure the existing facility can continue to function throughout the redevelopment of the site, and provides further detail to the Masterplan.

f. A *Project Resource Schedule*, prepared in May 2018, specifically identified the LHD resources dedicated to the Project and the schedule of each phase of the Project from planning, implementation and post occupancy. A copy of the *Project Resource Schedule* is exhibited to this outline (Exhibit 9 in my Exhibit List).

g. A *Workforce Plan* which was prepared by HI on behalf of SWSLHD in March 2018. The *Plan* was developed as a high-level strategy to address key issues and identify a framework to meet Project needs – specifically, to support the operational readiness of the Hospital. A copy of the *Workforce Plan* is exhibited to this outline (Exhibit 10 in my Exhibit List).

h. A *Risk Management Plan* dated March 2018, a copy of which is exhibited to this outline (Exhibit 11 in my Exhibit List).

i. A *Benefits Realisation Plan* dated March 2018, a copy of which is exhibited to this outline (Exhibit 12 in my Exhibit List).

j. A *Change Management Strategy 2018 – 2023* dated May 2018, a copy of which is exhibited to this outline (Exhibit 13 in my Exhibit List).

k. A *Project Communications and Engagement Plan* dated March 2017, a copy of which is exhibited to this outline (Exhibit 14 in my Exhibit List).

l. An *Aboriginal Health Impact Statement*, which was developed in accordance with the *PD2007_082 Aboriginal Health Impact Statement Policy*.

m. A *Delivery and Procurement Strategy* dated March 2018, a copy of which is exhibited to this outline (Exhibit 15 in my Exhibit List).

n. An *ICT Strategy* dated December 2017, a copy of which is exhibited to this outline (Exhibit 16 in my Exhibit List).

o. A *Campbelltown Hospital Redevelopment Master Program* – this document sets out a detailed schedule of the specific dates for each phase of the Project. A copy of is exhibited to this outline (Exhibit 17 in my Exhibit List).

p. A *Furniture, Fittings and Equipment/Major Medical Equipment Project Plan* dated March 2018, a copy of which is exhibited to this outline (Exhibit 18 in my Exhibit List).

q. A *Phase 1 – Planning – Project Management Plan* dated April 2018, a copy of which is exhibited to this outline (Exhibit 19 in my Exhibit List).

r. A Cost Benefit Analysis prepared by Ernst & Young for HI, May 2018 to accompany the Final Business Case, a copy of which is exhibited to this outline (Exhibit 20 in my Exhibit List).

s. A *Financial Impact Statement* (**FIS**) is prepared by SWSLHD to provide recurrent cost estimates of the project. The financial analysis of the preferred option was prepared by SWSLHD on the basis of the activity based funding aligning with the growth in recurrent costs. The purpose of the FIS is to compare the recurrent implication of each of the options for the purpose of the FBC. The final operational budget is negotiated between the SWSLHD and MOH prior to operation of the facility.

34. The FBC set out the baseline of Project scope, program and budget, attached relevant reports are monitored and any updates during the Project implementation that were approved via project governance. The FBC for the Project was completed in May 2018.

Stage 3: Implementation

35. Generally at this stage of a project, it is the responsibility of HI to prepare tender documents for construction contractors, prepare a procurement strategy, commission works in accordance with the contract scope for successful tenderers and ensure the completion of construction and involvement of relevant stakeholders.

36. Following the tender process for the Project, major contracts were awarded to the following contractors:

Contractor Name	Award Date	Contract Title
Brodyn Pty Ltd	29 November 2018	Enabling Works package 1
CPB Contractors Pty Ltd	14 August 2019	Main Works package
Brodyn Pty Ltd	26 November 2019	Refurbishment Works package 1
Taylor Construction Group Pty Ltd	24 December 2020	Refurbishment Works package 2
Taylor Construction Group Pty Ltd	23 September 2022	Refurbishment Works package 3
MOITS and Sons Pty Ltd	23 September 2022	Demolition Works package

37. Before construction began, HI prepared a *State Significant Development Application* (**SSDA**) – a health services facility of more than $30 million is classified as a State Significant Development under Schedule 1 of the *State Environmental Planning Policy (Planning Systems) Act* 2021 and HI is required to lodge a SSDA to the NSW Department of Planning, Housing and Infrastructure (at that time known as Department of Environment and Planning (**DPE**). The SSDA sought approval for the construction and operation of the Hospital. This requires the development of a comprehensive Environmental Impact Statement (**EIS**). A recommendation is then made to the Minister for Planning, who is the approver for the SSDA.

38. The community were provided an opportunity to review the EIS documentation and provide feedback to the DPE through the formal submission process. The SSDA was publicly exhibited for 28 days between 30 August 2018 and 26 September 2018. DPE received 11 submissions which were published online and no objections were received. An additional 6 submissions were received in response to the HI's response to submissions. The key issues raised included build form, urban design, parking, noise and vibration.

39. The DPE recommended the application be approved in its *Assessment Report* published in January 2019. The notification date for commencement of construction was 1 July 2019.

40. Construction on the Project commenced in early 2019. The COVID-19 pandemic caused challenges and meant that physical construction was required to stop for three months as the Project was in a Local Government Area of concern which was subject to heightened lockdown measures. During that period, HI worked with NSW Government, Infrastructure NSW, and representatives within the construction industry to seek ways to re-start works and permit construction to continue. This included pilot RAT testing of all workers attending the site.

41. Construction of the new Clinical Services Building was officially completed on 26 May 2022. The Clinical Services Building has been operational since June 2022. Existing buildings on the hospital campus were also refurbished as part of the Project, including a significant expansion of the hospital's Pathology Laboratory, Pharmacy, Clinical Information Department and Cancer Therapy Centre, and a new Dental Centre. These refurbishments are also complete. From HI's perspective, there are still some ongoing contract administration and fire compliance variation works which are on track to be finalised in mid-May 2024.

Stage 4: Evaluation

42. The evaluation stage seeks to understand how well the intended benefits and outcomes have been realised, whether the delivery of a project is meeting the identified services needs of the patients, Health entity and staff, and what can be learned from a project to inform HI's continuous improvement loop. It ensures that HI takes learnings, improvement opportunities, and examples of best practice into account in the planning, designing and implementation of subsequent projects.

43. Evaluation can be undertaken at whole-of-project level or in relation to specific elements of the project.

44. For this Project, a *Post Occupancy Evaluation Report, Clinical POE of Operating Theatres*, is currently underway. This is a program-level review and this site is one of the sites that were evaluated. The report is not complete as at date of this statement.

45. The Project was delivered on time, within budget, delivered as planned, and to my knowledge the feedback from the community regarding the delivery of the Project is quite positive.