Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Amanda Bock

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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 Rural and Regional of Health Infrastructure NSW (**HI**). My curriculum vitae is exhibited to this outline (Exhibit 16 in NSW Health Tranche 4 Consolidated Exhibit List).

3. In this role, I am responsible for the planning and delivery of the infrastructure projects within HI's Rural and Regional portfolio. The portfolio covers seven Local Health Districts across NSW as well as NSW Ambulance projects in rural and regional areas. It includes major hospital redevelopments in NSW regional centres and smaller redevelopments in rural towns across Southern, Northern and Western NSW. In my role, my responsibilities include:

    a. working with a range of multi-disciplinary teams and different clinical stakeholders to deliver projects from inception to post-completion

    b. planning and business case development

    c. oversight of the design and construction process, and

    d. building commissioning (ensuring we have validated that the contractor has the building systems, eg air conditioning up and running, and managing the overlay with operational commissioning (setting up the hospital for operation) and clinical occupation which is managed by the LHD).

4. As part of my role as Executive Director, I am the Lead for the Eurobodalla Regional Hospital Redevelopment (the **Project**) within the Southern NSW Local Health District (**SNSWLHD**).

5. This outline provides an overview of the governance and planning and procurement process for Eurobodalla Regional Hospital Redevelopment, in accordance with standard governance arrangements and processes across the HI capital program. I consider the Project supplies a convenient means of explaining the work of HI, and what I describe is typical of projects in the planning phase managed by HI. 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

6. The *Project Governance Arrangements* (***Arrangements***) for the Project, a copy of which is exhibited to this outline (Exhibit 1 in my Exhibit List) outlines its governance structure, and terms of reference for the various groups responsible for it. Those terms of reference allocate roles and responsibilities in relation to key project deliverables between HI, the LHD, the Ministry of Health (**MOH**), specifying which group is responsible for providing input into and/or noting and endorsing each of the documents and decisions during the planning and implementation stages of the Project.

7. The *Arrangements* are based on a standard template and are generally consistent across all HI projects, however, are modified as required to suit the scale, nature and stage of the project. The *Arrangements* provide the governance for project planning and procurement activities in accordance with the HI project delivery standards, which supports the planning and delivery of capital projects through guidance, tools and templates, and the *NSW Treasury Gateway Review Guidelines* TPG 22-12, a copy of which is exhibited to this outline (Exhibit 2 in my Exhibit List).

8. The following committees are generally convened for all projects:

    a. Executive Steering Committee (**ESC**): provides strategic direction and leadership and has ultimate decision-making and endorsement authority. Members are generally comprised of HI and LHD Executives, Directors, and Managers, as well as representatives from the MOH and NSW Treasury.

    b. Planning & Development Committee (Stage 1-2) (**PDC**): monitors and advises on planning aspects and oversees planning until a contractor is appointed. Members

are generally comprised of HI Directors, LHD representatives including the Chief Executive and clinical leaders, and a representative from the MOH. Invitations are generally extended to third party contractors such as project architects.

c. Project Control Group (**PCG**) (Stage 3): Monitors and advises on all delivery (construction and commissioning) aspects. Members are generally the HI Project Director, HI Director Delivery, LHD facilities manager, an LHD Executive, the chairs of the Executive User Group and Project User Group, and a MOH representative. Other stakeholders are invited, including third party contractors such as project architects, LHD communications representative and a consumer representative.

d. Project Planning Team (**PPT**) (Stage 1-2) and Project Delivery Team (**PDT**) (Stage 3): operational planning and implementation, manages interface of Project Working and Project User Groups, and co-ordinates consultation with users. For the Project Planning Team:

    i. For the Project Planning Team: members are generally HI Consultant Project Director, LHD General Manager, LHD Redevelopment Manager, LHD Executive, LHD Service Planning Representative, LHD Clinical Leaders in Nursing, Medical Services, Allied Health and Primary & Community Health, LHD Corporate Services Manager, LHD Assets General Manager. Other stakeholders are invited, including third party contractors such as project architects, communication representatives, consumer representatives and others.

    ii. For the Project Delivery Team: members are generally an LHD General Manager, an LHD Executive, clinical leaders and LHD non-clinical personnel are members with others invited such as HI Project Directors or Managers, architects, LHD communications representative and LHD change management representative.

e. Executive User Group (**EUG**): Oversees Project User Group process, aligns design briefs with boarder plans, policies and parameters. Members are generally an LHD Executive, an LHD Service Planning, and clinical leaders from nursing, allied health, medical services, community health, nursing, physiotherapy, and occupational therapy and non-clinical personnel. Others are invited such as the LHD change management representative, a MOH representative, HI Directors and other third party contractors.

f. Project User Group (**PUG**): Provides clinical and operational planning input and feedback on health service delivery and develops functional briefs for planning units. Members are generally an LHD Executive, LHD clinical leaders, and non-clinical personnel. Other stakeholders are invited, including third party contractors and consumer representatives.

g. Project Working Groups (**PWGs**) (established as required): develops and monitors key strategies and activities. Membership generally include LHD Executive, clinical leaders, and non-clinical personnel. Invitations are sent to HI consultant project manager, a General Manager of health service or facility, and an LHD change management representative, and a consumer representative.

h. Clinical Reference Groups (**CRGs**) (established as required): provides expert clinical advice on clinical or health service delivery and resolves clinical issues raised by Project User Group. Membership is comprised of LHD executive and clinical representatives, and other LHD non-clinical personnel. Invitations are extended to the LHD Change Management representative, a MOH representative, HI and other third party contractor representatives.

9. The specific membership of each of the governance groups for the Project are set out in the *Arrangements*, together with their key project deliverables.

10. The membership of governance committees (and the committees) changes as appropriate during the project duration in response to the project stage. The version provided is current at time of provision of this statement.

11. The governance hierarchy provides the key framework for decision making on the project however there are numerous other stakeholder interactions including local stakeholders including Councils, community groups, community members, Local Health Advisory Committees, and Local Aboriginal Advisory Committees.

12. There is one additional element of the NSW Health capital governance framework that is not included in the Project Governance Arrangements documentation and that is the Capital Strategy Group, which is chaired by the Deputy Secretary, Health System Strategy and Planning Division (**CSG**). 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*. The Project has followed this standard framework and one request for Executive Contingency release was submitted to the CSG in December 2023.

13. The development of an HI project is aligned to the NSW Health Facility Planning Process (**FPP**), which at the time of the Project was the *GL2020_018 NSW Health Facility Planning Process Guideline*, a copy of which is exhibited to this outline (Exhibit 3 in my Exhibit List). The FPP provides a framework for capital projects over $10 million dollars. A summary of the stages of the FPP and their objectives is set out below:

    a. Stage 0: Principles, Planning & Prioritisation: to identify proposals aligned with local service needs, system-wide objectives and Government policy using a collaborative approach to create stronger linkages between early strategic planning, options analysis (including non-capital solutions), decision making and the existing process of facility planning (Stages 1-4). Stage 0 reflects the *NSW Health Investment and Prioritisation Framework* and users should refer to the framework for background and guidance. Stage 0 uses a collaborative planning approach involving LHDs and SHNs, MOH, HI, Shared Services, Pillars and Statewide Health Services.

    b. Stage 1: Services & Facilities Needs Analysis: analyse options of maximise benefits and meet service needs. HI leads service delivery planning, options analysis, cost benefit analysis and estimates, risk management, and Investment Decision Document (**IDD**) in partnership with Local Health District or Specialty Network Prepares Gateway / Health Check reviews, while LHDS and SHNs lead the Services & Facilities Needs Analysis and prepare the Financial Impact Statement and the supporting project and organisation strategies, including communications and consultation, change management and workforce development. The MOH endorses the IDD and the short-list of preferred options.

    c. Stage 2 Project Definition: develop an evidence base that proves the preferred option best meets the service need and maximises benefits at optimal cost. HI leads options analysis, cost benefit analysis, procurement strategy, parameter refinement, risk management, planning submission and the Final Business Case in partnership with Local Health District or Specialty Network and prepares Gateway / Health Check Reviews. LHDs and SHNs inform and refine the Project Definition, prepare the Financial Impact Statement and supporting project and organisation strategies and plans, including operational commissioning, facilities management, communications and consultation, change management and workforce development. The MOH endorses the Final Business Case and the preferred option.

d. Stage 3 Implementation: develop an approach to market and delivery scope that will realise the intended benefits of the project. HI prepares the procurement strategy, the go to market approach, and construction / commissioning, as well as any tender documents and Gateway or Health Check Reviews. LHDs and SHNs finalise supporting strategies and plans (prepared in preceding stages), as well as finalising a move logistics and decant plan. The MOH endorses any variations.

e. Stage 4 Evaluation: seeks to understand how well the intended benefits and outcomes have been realised and what can be learned from the project or program. HI prepares prioritisation, strategy, evaluation and closing the loop phases, as well as the Evaluation and Next Steps Report and any Gateway or Health Check Reviews. LHDs and SHNs support the prioritisation and strategic analysis and provides inputs to support the evaluation. The MOH endorses any findings, recommended learnings or changes from the evaluation.

14. 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.* HI is required to lodge a State Significant Development Application (**SSDA**) to the Department of Planning, Housing and Infrastructure (**DPHI**) to seek 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.

C. EUROBODALLA REGIONAL HOSPITAL REDEVELOPMENT

Background to the redevelopment

15. The new hospital site is located at Princes Highway, Moruya. It has an approximate area of 21.94 hectares and comprised of vacant greenfield land.

16. The new Eurobodalla Regional Hospital will include the following:

a. an Emergency Department

b. eight-bed Intensive Care/Close Observation Unit

c. increased capacity for chemotherapy

d. increased access to renal dialysis

e. surgical and operating theatres and a day stay surgical unit

f. an expanded medical imaging department, including MRI service

g. ambulatory care for community and outpatient services

h. paediatric and maternity beds and a special care nursery

i. mental health beds for short-term admission

j. enhanced education and training facilities including a simulation lab

k. rehabilitation and palliative care in-patient units

l. pathology department

m. pharmacy department

n. front of house including retail, and

o. back of house including a mortuary.

17. The Project's capital cost estimate was developed by the cost manager, Genus Advisory in accordance with HI cost planning standards. The capital costs included a base cost comprised of building works, land acquisition, preliminaries, margin, professional fees, HI management fees, LHD costs, furniture, fittings and equipment and ICT, escalation allowances, and contingencies. These cost planning standards are typical of a HI project, noting some sites do not require allocation for "land acquisition".

Clinical Services Planning

18. A clinical services plan outlines the current and future health needs of the population, future strategies for the delivery of clinical services to best meet those needs and determined the requirements and role of the new hospital. Typically, before HI becomes involved in the process, clinical services planning has already been undertaken by the LHD. The CSP informed the scope of the Project. HI does not have any involvement in the preparation or approval of a clinical service plan. However, a clinical service plan provides HI with significant guidance as to the scope of a project and its intended goals.

19. The first stage in the development of a new hospital is clinical services planning by a Local Health District which informs the scope of the project. SNSWLHD undertook clinical services planning for the Project in 2018-2019. The *Eurobodalla Regional*

Hospital Clinical Services Plan (**CSP**) developed by SNSWLHD and identified a need to consolidate existing services, reduce duplication and increase the provision of care to meet the needs of the Eurobodalla population up to 2031. A copy of the CSP fact sheet is exhibited to this outline (Exhibit 4 in my Exhibit List).

20. The CSP was submitted for review in 2019 and endorsed by MOH in May 2020.

Stage 1: Services and Facilities Needs Analysis

21. The Project formally commenced once its capital budget was allocated in the NSW Budget papers. At this stage of the process, HI led planning, options analysis, cost-benefit analysis, risk management and developed an Investment Decision Document (**IDD**) in partnership with the LHD.

22. The first step in this Project was for HI to allocate its own resources to manage the Project. The HI team for the Project included myself, the Project Director, the Senior Project Director, and the Regional Director.

23. The HI team then worked to appoint a consultant project team to begin planning for the redevelopment and contracted private sector professional services providers to implement the Project. The initial appointments to the consultant team, made after a competitive tender process, were a Project Manager (RP Infrastructure), an Architect (Conrad Gargett) and Cost Manager (Genus Advisory). This consultant team, LHD project resources and HI team (together, the **Project Team**) are responsible for preparing all documentation, reports, and other documentation required to complete the project. The Project governance is responsible for making key decisions or endorsements throughout the project lifecycle – usually informed by recommendations from the Project Team.

24. The first deliverable of the Project Team was a campus masterplan based on the CSP, which was then used to develop a Concept Design, A copy of the *Masterplan Report* is exhibited to this outline (Exhibit 5 in my Exhibit List).

25. The masterplanning process typically involves the development of a campus plan identifying the location of key elements of a hospital, including clinical or acute services buildings and ancillary or support services. It may also show how a site could be further developed in the future if expansion is required. Part of the masterplan process involves site selection when a project involves a ‘greenfield’ or new site.

26. In November 2019, the Project Team commenced an investigation into potential site locations for a new hospital. Through the PDC and ESC it was determined that the existing Batemans Bay hospital site could not accommodate a new hospital at the size and scale that would be required for the new hospital.

27. The Project Team considered developing the existing Moruya Hospital site as a new hospital, however, given the site constraints and its location in a flood zone, recommendation was made to the PDC and ESC that a new site would be most appropriate, ideally in close proximity to both Batemans Bay and Moruya.

28. Generally the site selection group will include representatives from the LHD, clinical staff, community consultative committee representatives, Transport for NSW (to provide roads and other transport information) and HI. That working group will then develop a site selection criteria, which typically considers proximity to the township, accessibility via road, proximity to or access restrictions relating to flood zones, proximity to bushfire zones, access to airport, quality of existing infrastructure.

29. Following the formation of the site selection working group in this Project (which I was a member of) and the establishment of the site selection criteria, they engaged a consultant real estate professional group to identify potential sites around Moruya that met the key criteria requirements. Six potential sites were identified through this process. No sites were identified that met the criteria, within a 5km radius of Bateman's Bay town centre.

30. Community consultation undertaken by HI and SNSWLHD regarding site selection took place in June and July 2020 by way of community meetings – both general and with targeted groups including Eurobodalla Shire Council. The community feedback was that Moruya was generally supported as the preferred site location. Dedicated Aboriginal consultation also took place to determine if there were any significant cultural issues that should be considered in the site selection process.

31. Following further due diligence including flood mapping, town planning considerations, and a Multi-Criteria Analysis, a preferred site was agreed by the site selection working group and endorsed by the ESC in November 2020. The acquisition process then commenced.

32. Once the preferred site was selected, the Project Team commenced the master planning and the *Masterplan Report Summary* was endorsed by the ESC in May 2021 and publicly released in December 2021.

33. Following masterplanning, the *Functional Design Brief*, a copy of which is exhibited to this outline (Exhibit 6 in my Exhibit List), were developed by the Project Manager for each department to meet the needs of the service projections outlined in the CSP. This included documenting the functional relationships and operational requirements for each department. Extensive consultation was undertaken with stakeholders from the EUGs and PUGs to document individual service and workforce requirements.

34. Generally, the functional design brief is the first definition of the new building, as it describes the full range of services to be provided, how they will operate, as well as the functional and design requirements.

35. A Concept Design is a 'high-level' design that shows the relationships between the clinical functions, services, buildings and other facilities both horizontally and vertically, was developed by the Project Team and informed by the clinical service plan, the preferred Project option and Master Plan including *Functional Design Brief*.

36. Throughout this Stage of the Project, the Project Team consulted with PUGs and a *Concept Plan Report* was endorsed by the ESC in October 2021, a copy of which is exhibited to this outline (Exhibit 7 in my Exhibit List).

37. There are several deliverables developed by the Project Team in parallel with the design development noted above. The deliverables are captured in an IDD. In 2017, the MOH, NSW Treasury and HI agreed on the establishment of the IDD as a streamlined approach for NSW Health to accelerate development of key capital project analyses and scope, and subsequently, the submission for a capital budget approval to NSW Treasury. Approval of the IDD generally allows for commencement of early and enabling works packages in parallel with the progression of planning to the business case phase. However, approval of the final business case remains a prerequisite for the tendering and award of the main works package.

38. HI submitted the IDD to NSW Health in November 2021 with the recommended option of a greenfield development at Moruya, closure of Batemans Bay and Moruya Hospital, as well as land acquisition and urgent upgrade to Moruya Emergency Department and Close Observation Unit. The development of design deliverables as noted above enabled preliminary capital and recurrent cost information to be included in the IDD.

Stage 2: Project Definition

39. The Project Definition Stage includes the further development of the preferred Project option and preparation of the Final Business Case. HI's specific role in Stage 2 includes refining options analysis, cost benefit analysis, procurement strategy, parameter refinement, risk management, and the development of the Final Business Case in partnership with the LHD, as well as preparing Gateway and Health Check Reviews.

40. A *Schematic Design Report*, a copy of which is exhibited to this outline (Exhibit 8 in my Exhibit List), was completed by the Project Team and informed by the CSP, the preferred Project option, *Master Plan*, *Functional Design Brief*, *Schedule of Accommodation*, and the preferred *Concept Design*.

41. Generally, a schematic design is 'department focused' and includes plans for how rooms and services will relate to each other within a defined service for example intensive care unit and the Schematic Design Report provides a summary of all the activities and inputs to the schematic design phase including technical and engineering requirements.

42. As part of the schematic design phase for this Project, clinical departments were further defined including circulation, travel and engineering, as well as engineering spatial requirements for mechanical, electrical, hydraulic, fire and statutory building compliance requirements were defined and implemented into the preferred option design.

43. The *Schematic Design Report* was endorsed by the PDC in June 2022 and noted by the ESC in July 2022 (in accordance with the agreed governance).

44. The Final Business Case for the Project was completed in November 2022 and approved in August 2023 by MOH with a preferred option with a capital cost of $260m.

Stage 3: Implementation

45. The objective of the Implementation Stage is to develop an approach to market and delivery scope that will realise the intended benefits of a project. A key output is the preparation of tender documents by the Project Team and delivery (construction) of the project. The Project is currently in this stage.

46. Following consultation by the Project Team with the industry an Early Contractor Involvement (**ECI**) procurement pathway was determined to be the most appropriate given the location of the project, the heightened construction market activity and cost escalation being experienced at the time. This method (in lieu of a Design & Construct

style contract) better allocated the risk between the Principal and the potential contractor in a volatile market.

47. A tender was released in November 2022 and closed in December 2022. Two tenderers, Adco Constructions and Multiplex Constructions, who were pre-qualified by HI were invited to tender. There was no interest from other HI pre-qualified tenderers to tender for the Project.

48. Following the tender assessment, a contract was awarded to Multiplex Constructions in April 2023 to undertake the ECI planning phase of the project.

49. An ECI procurement is a method of construction contracting that allows a builder to become involved, and potentially start early works, before the design has been completed. The builder is also involved in finalising the design of the project whilst seeking subcontractor pricing and at the end of the process provide an 'offer' to enter into a contract to construct the building.

50. A key deliverable of the ECI contract was for Multiplex Constructions to complete Design Development during the ECI Planning Phase and maintain an open book approach to cost management leading towards a Main Works Offer (**MWO**). The MWO was to be based on the final developed design documentation. A final MWO was received in December 2023 and is under assessment. The MWO is the contractors lump sum price to construct the building in accordance the contract, along with the deliverables under the ECI contract.

D. CONSULTATION PROCESS

51. Consultation on the Project has been undertaken with various stakeholders through the project planning and design process including:

    a. Government Architect NSW

    b. Eurobodalla Shire Council

    c. Transport for NSW

    d. Local Aboriginal Community and Cobowra Local Aboriginal Land Council

    e. Department of Planning and Environment (which became the Department of Planning, Housing and Infrastructure since January 2024)

f. Heritage NSW

g. NBN Corporation

h. Essential Energy

i. Telstra

j. Environmental Protection Authority

k. Ambulance Service of NSW

l. Fire and Rescue NSW and the Rural Fire Service, and

m. State Emergency Services

52. Consultation was also undertaken with hospital patients, staff, visitors, local residents, community groups, community members, business owners and representatives of local Aboriginal and Torres Strait Islander community and stakeholder groups.

53. The consultation process was conducted via meetings, correspondence and activities with various stakeholders including hospital staff and the community to understand stakeholder and community needs and ensure a balanced outcome with the hospital plans.

54. Consultation also involved a range of activities including developing a project website, issuing online surveys project newsletters and communication materials, and conducting events and information sessions,.

55. Consultation was undertaken by HI, SNSWLHD, the consultant project team and other specialist consultants as required during the development of the project. At each project phase the key issues are identified and feedback incorporated into the next phase of the development of the Project.

56. Some of the key issues raised during the consultation process included Connecting with Country, traffic, parking and noise. The *Consultation Outcomes Report*, prepared on behalf of HI by Ethos Urban, outlines the communication and stakeholder engagement undertaken and feedback received, a copy of which is exhibited to this outline (Exhibit 9 in my Exhibit List).

57. In particular, the NSW Government Architect's *Connecting with Country Framework*, a copy of which is exhibited to this outline (Exhibit 10 in my Exhibit List) has been utilised throughout the inception, design and delivery of the project. The Project is a pilot project for this *Framework*. It includes:

    a. identifying the Aboriginal knowledge holders early in the project to have comprehensive and meaningful influence throughout the Project

    b. drawing upon available research to gain understanding of local history and culture

    c. including appropriate space and facilities for cultural proceedings as identified by the community

    d. creating an opportunity for outside interaction by both Aboriginal and non-Aboriginal people to provide educational opportunities

    e. creating an ongoing line of communication between the Project group and design consultants to ensure that feedback is incorporated into the Project

    f. incorporating traditional local land and water management techniques into an ecologically sustainable design

    g. considering the original use of the site and community needs

    h. including cultural practices in the process of the Project, and

    i. seeking Aboriginal-owned businesses to partner with throughout the Project and after.

58. The Project architects, Conrad Gargett, partnered with cultural engagement organisation Yerrabingin to work with the local Aboriginal community and organisations to incorporate feedback throughout the project. The Project Team conducted community consultation both onsite and offsite, through design jams (an afternoon of design and consultation with the local Aboriginal community), a walk on country and presentations to relevant stakeholders. A Connecting with Country Working Group established under Terms of Reference was also established, with members of the local Aboriginal community, SNSWLHD and Project Team. A number of key themes were established as a result of this collaboration, including incorporating principles of Connecting to Country through the design and operational practices, as well as landscape and building elements.

59. The location of the helipad underwent significant research and development to ascertain the best location to ensure it met the requirements of the hospital whilst also minimising impacts on the surrounding area. With consideration of the site constraints, aviation requirements and feedback from consultation with Moruya Airport, Council and the community, the Project Team with an Aviation consultant developed seven helipad options on the site for assessment. Following the helipad option development, a Helipad Clinical Project Working Group was established with representation from clinicians across the SNSWLHD, NSW Ambulance and Air Ambulance and they assessed each of the options from a clinical perspective. Two meetings were held by the Helipad Clinical Project Working Group to evaluate each of the options and determine the preferred helipad location to the north of the main hospital building.

60. The design process also involved extensive consultation with the NSW Government Architect. As part of this process, the Architect presented to the State Design Review Panel six times. Details of these meetings and feedback and responses received and implemented by Conrad Gargett are outlined in the *Design Report,* which forms part of the EIS, a copy of which is exhibited to this outline (Exhibit 11 in my Exhibit List).

E. CURRENT STATE OF THE PROJECT

61. Project timeframes have moved due to a number of challenges, including delays in statutory approval for the Project. Works on site were initially expected to commence in 2023 and to be completed in 2025.

62. As noted above, a health services facility of more than $30 million is classified as a State Significant Development and HI is required to lodge a SSDA with DPHI to seek approval for the construction and operation of the hospital which requires the development of an EIS. A recommendation is then made to the Minister for Planning, who is the approver for SSDAs.

63. The community were provided an opportunity to review the EIS documentation (as set out in section D above) and provide feedback to DPHI through the formal submission process. These submissions have been published online. DPHI is completing its assessment of the merits of the project and preparing an assessment report. Once the SSDA has been assessed and approved which I anticipate will occur in May 2024, the main works contractor will be appointed and construction of the new hospital can commence.

64. The construction industry continues to experience cost escalation which is impacting the delivery of capital projects across the HI portfolio. A Value Management process led by the Project Team is underway to ensure the project can be delivered within the allocated budget and to enable award of the Main Works contract. Any changes to the project scope as a result of the process will be approved through the project governance.

65. There were also challenges with sourcing a contractor to commence the early works portion of the project, delays in receiving a referral decision under the *Environment Protection and Biodiversity Conservation Act 1999* and delays in gaining an Aboriginal Heritage Impact Permit to commence the archaeological salvage process.

66. Works are expected to commence in 2024 and take 2-3 years to complete.