



Queensland Government Capacity Expansion Program Independent Review Report

April 2025

Klok Advisory Pty Ltd
Level 33 Australia Square
264 George Street
Sydney NSW 2000

© Klok Advisory Pty Ltd 2025

Please note that in this report some tables may not add due to rounding.

Table of Contents

1.	Executive summary.....	2
2.	Terms of Reference.....	6
Part 1: Capacity Expansion Program		
3.	Governance and Oversight	8
4.	Project Management and Delivery	30
5.	Cost Escalations	45
6.	Stakeholder Engagement.....	53
7.	Lessons Learned.....	56
8.	Project Specific Commentary and Recommendations – Stage 1 Projects/Unawarded Projects	63
9.	Project Specific Commentary and Recommendations – Stage 2 Projects/Awarded Projects	108
10.	Hospital Car Park Program	121
Part 2: Sustaining Capital Program		
11.	Sustaining Capital Program.....	124
Part 3: Report Mechanics		
12.	Table of Recommendations	132
13.	Review Engagements and Interviewees	135
14.	Glossary and Abbreviations	136
15.	Gratitude and Thanks	137

1. Executive summary

The Capacity Expansion Program (CEP) was initially announced in 2022 as a \$9.785 billion program but has experienced well documented project delays and cost overruns. After a limited amount of new or expansion capital allocated to Health over prior years, CEP was a laudable effort to add clinical service delivery capacity across Queensland Health aligned with the Health and Hospitals Plan 2022-23. However, the CEP's execution has proven to be lacking on a range of fronts.

Poor execution of CEP is evident in that:

- CEP projects were planned in around 6 weeks in 2022 – despite good teams being put together to undertake the initial planning, it is impossible to follow best health infrastructure planning practices in such a short period of time and the cost overruns arising from “support services” additional scope items, site conditions and required site infrastructure upgrades are directly attributable to this highly compressed planning process;
- CEP was launched in combination with creating Health Infrastructure Queensland (HIQ) – it would have been difficult to procure and execute the CEP even with a fully operational and highly skilled team already in place;
- The chosen procurement strategy was deeply flawed and ignored market realities, despite a range of internal and external advice being provided, leading to significant project cost blowouts. The initial project budgets were set inexplicably in isolation of the realities of market conditions – prevailing market conditions were well known at the time of the establishment of the project budgets;
- For projects awarded in September 2024, significant additional budget (an increase of more than 70%) was required to be provided to allow for these projects to move into construction;
- Project delivery strategies did not adequately contemplate staged delivery of the very large CEP projects – planning for these projects was structured to unrealistically attempt to deliver all scope in a single stage of development;
- For the new hospitals at Bundaberg and Toowoomba, the project scopes and budgets did not provide for full relocation onto the new sites (despite earlier business cases planning for full relocations), and while the extra operating costs and staffing implications of requiring the local health service to run two sites in these locations were documented, they did not sway the decision to move to single sites;
- The chosen contracting framework and risk allocations were not appropriate in the then prevailing market conditions and have been a major driver of project cost blowouts;
- Business cases were not completed ahead of Government approvals, with Project Validation Reports being developed in the months following the CEP announcement, and
- Project scopes were developed with intended high levels of standardisation and in isolation of consultation with local clinicians and health service executives and their local priorities, leading to poor acceptance of the chosen scopes on many projects.

The CEP was governed in a manner where project timelines dominated project delivery, planning and budgets, but this approach was futile. Project timelines have all been extended way beyond the initially announced delivery timeframes – and as with the initial budgets, it was the initial timeframes that were overly ambitious whereas current timeframes are more realistic. Recommendations on unawarded projects in this report also highlight that further elongations will be required as projects are delivered in a more orderly and staged manner. This will also smooth the capital requirements for the CEP and allow for consultation and engagement with clinicians and health service executives.

Lack of regular, predictable capital allocation to Health over preceding years meant a significant backlog of capacity expansion was required and had the CEP allocation be provided over a multi-year period following normal planning practices and procured in a manner reflective of prevailing market conditions the present malaise would have been avoided. A historical analysis of capital allocation to Queensland Health shows a significant period of time where new project capital was around \$250 million per annum or less, around one tenth of the allocation provided in the current financial year.

A highly skilled, experienced and appropriately resourced HIQ should be an ongoing feature of Queensland Health, and together with a refreshed culture, HIQ governance processes and practices need to be reformed. A number of specific recommendations on HIQ's future role, structure, governance and culture have been made.

Specific recommendations have been made in each section of the report, and for ease of future reference are summarised in a table on the last page of the report. For the CEP projects that were awarded in the days prior to the commencement of the caretaker period on 1 October 2024, the overall thrust is to continue to drive value with the contracted construction partners. The private sector partners have, collectively, resourced to deliver these projects notwithstanding the difficult start each project has endured. A balanced approach to risk allocations may also derive future savings on awarded projects.

Individual recommendations have been made for each of the presently unawarded projects. In each case continuing with the currently scoped and programmed projects is an exercise in futility. For the two major green fields projects at Bundaberg and Toowoomba, options to replan these projects to deliver wholistic replacements of the old sites and consolidate onto a new site have been presented.

Major cost drivers across the CEP have been identified and examined, and section 5 sets out an analysis of the major elements that have seen the CEP's current forecast grow to just short of \$17 billion against an initial budget of \$9.8 billion. These included site infrastructure requirements, site conditions, scope change, market conditions and the productivity and cost impacts arising from the previous BPICs regime.

Table 1 below provides a summary of CEP project financials.

Project name	\$ million	[A] Original Budget	[B] Current Budget	[B]-[A] Budget uplifts	[C] Current Forecast	[C]-[A] Variance to Original	[C]-[B] Variance to Current
New Toowoomba Hospital		1,300	1,300	-	1,980	680	680
New Coomera Hospital		1,300	1,300	-	2,254	954	954
New Bundaberg Hospital		1,200	1,200	-	2,306	1,106	1,106
Redcliffe Hospital Expansion		1,060	1,148	88	2,122	1,062	974
Ipswich Hospital Expansion Stage 2		710	1,066	356	925	215	(141)
Logan Hospital Expansion Stage 2		530	875	345	875	345	-
Townsville University Hospital Expansion		530	530	-	1,029	499	499
QEII Hospital Expansion		465	619	154	621	156	2
PA Hospital Expansion		345	748	398	761	411	13
Prince Charles Hospital Expansion		300	360	60	788	488	428
Cairns Hospital Expansion		250	71	-	447	197	376
Cairns Hospital Refurbishment		-	179	-	181	181	2
Mackay Hospital Expansion		250	250	-	520	270	270
Queensland Cancer Centre		1,180	1,180	-	1,800	620	620
Robina		-	-	-	-	-	-
Hervey Bay		-	94	94	94	94	-
Program contingency		360	80	(280)	80	(280)	-
Totals		9,785	11,000	1,215	16,783	6,817	5,783
Site infrastructure risks – see section 5.1.2					461		
Total including site infrastructure risks					17,244		
Awarded projects							
Ipswich Hospital Expansion Stage 2		710	1,066	356	925	215	(141)
Logan Hospital Expansion Stage 2		530	875	345	875	345	-
QEII Hospital Expansion		465	619	154	621	156	2
PA Hospital Expansion		350	748	398	761	411	13
Cairns Hospital Refurbishment		-	179	-	181	181	2
Hervey Bay		-	94	94	94	94	-
Totals		2,055	3,581	1,347	3,457	1,402	(124)

Table 1: CEP Project Budgets and Forecasts

The Review has assembled the data in Table 1 from a range of materials and project reporting artefacts. The Review is aware that HIQ does have a data portal and reporting system that draws information from a range of sources, but the table above was not readily available as a program reporting artefact. Different project artefacts provided to the Review demonstrate significant variances and differences in data provided for different purposes and reports. In particular, the financial reporting for projects to steering committees in many cases uses the current budget amounts rather than otherwise available project forecast costs, and different reports seemingly use different templates for what should be standardised project reporting. All of these factors present the opportunity for data quality issues and inaccurate presentation of information to governance forums regarding the actual state of project financials.

In addition, Queensland Treasury has provided the Review with some different initial and current budget allocations for the projects set out in Table 2. It is unclear to the Review why Treasury and Health presently have different budget allocations for these projects.

\$m	[A]	[B]	[C]	[D]
Project name	Original Budget HIQ	Current Budget HIQ	Original Budget Treasury	Current Budget Treasury
Townsville University Hospital Expansion	530	530	530	550
PA Hospital Expansion	345	748	350	748
Prince Charles Hospital Expansion	360	360	300	360
Cairns Hospital Expansion*	250	71	250	250
Cairns Hospital Refurbishment*	-	179	-	-
Mackay Hospital Expansion	250	250	250	270
Robina	-	-	-	80
Hervey Bay **	-	40	40	94
Program Management	-	-	-	75
Program contingency	360	80	750	-
Transfer to Sustaining Capital Program	-	-	-	100

Table 2: Treasury project values compared with HIQ Values

* Treasury has advised the Review that the proposal to split the Cairns Hospital into two elements has not been approved by Government.

** HIQ reporting for Hervey Bay provided to the Review has the current budget for the project reported differently in different reports all dated after the announced increase of the budget to \$94 million.

Further, examples were provided to the Review where project financial data was redacted or withheld from governance forums due to supposed “commercial in confidence” reasons. Given these governance forums were constituted by senior Government executives it is difficult to comprehend this decision, especially as it drove a poor perception of transparency and trust between HIQ and, in particular, health service CEOs and executives.

The Review has also examined the hospital car park program and found that the present trajectory of those projects is forecasting widely disparate costs per car space, and all higher than seen in other Queensland projects and projects in other jurisdictions. Costs per space for CEP multi-deck car parks range from \$80,000 to nearly \$250,000 per space, whereas benchmark costs are in the range of \$40,000-65,000. Using the highest benchmark rate of \$65,000 per space would see carparks delivered at around 44% of the current CEP forecast rate, saving more than \$750 million. However, HIQ has inexplicitly already awarded contracts for three car park projects at these grossly inflated prices, reducing the potential savings by at least \$230 million and up to \$326 million. Accordingly, a thorough review of the designs and procurement strategy for car park projects needs to be undertaken to ensure value for money is achieved on the unawarded projects, targeting savings in excess of \$500 million or \$84,000 per space.

Following the release of the Queensland Audit Office's report into Health's 2023-24 financial statements during January 2025, Government requested that an assessment of the Sustaining Capital Program (SCP) be included in this Review. Commentary on the SCP appears in Part 2 of the Report.

It is clear that the long-held level of capital provided to Health for capital maintenance is insufficient, and this situation was exacerbated by the announcement of the Accelerated Infrastructure Delivery Program and the Building Regional and Remote Hospital Program in the 2022-23 budget, to be drawn from the Sustaining Capital Program budget. The overall Sustaining Capital Program budget has seen increases in the last two State budgets, but significant components of that SCP allocation are dedicated to these other programs, reducing the amount of capital available for capital maintenance and major medical equipment replacements.

The Review has also made a series of other recommendations relating to improving the way capital projects are planned and delivered in Queensland Health, observations from other jurisdictions and lessons that ought to be learned from the CEP.

Implementation of the various recommendations set out in this Review will put the CEP and SCP back on track, with refreshed organisational capability and governance ensuring the current predicament does not reoccur.

2. Terms of Reference

On 23 December 2024, the Queensland Government announced the creation of an independent review (**Review**) of the Capacity Expansion Program, with the following terms of reference:

The independent review will:

- i. **Evaluate Governance and Oversight**
 - Assess the governance structures and accountability mechanisms in place for CEP delivery.
 - Identify deficiencies in oversight that may have contributed to underperformance.
- ii. **Assess Project Management and Delivery**
 - Review project management practices, including planning, procurement, risk management, and contract administration.
 - Identify factors leading to delays, cost escalations, and other performance issues.
- iii. **Examine Cost Escalations**
 - Investigate the root causes of budget overruns, including potential deficiencies in project planning, communication of project issues, scope changes, external economic pressures, and inefficiencies.
 - Assess the accuracy and robustness of reference designs, cost estimation and forecasting processes.
 - Consider the impact of the Best Practice Industry Conditions (BPICs) policy on cost and project timelines.
- iv. **Analyse Stakeholder Engagement**
 - Review the effectiveness of engagement with key stakeholders, contractors and industry advisors.
 - Assess how stakeholder input has been incorporated into the Program's planning and delivery – including how consistent external advice on programme frailties was considered and communicated.
- v. **Identify Lessons Learned**
 - Highlight key lessons from the CEP and comparable infrastructure programs, with particular reference to successful programs in other Australian jurisdictions.
 - Provide practical recommendations to enhance governance, management, and delivery of future health infrastructure programs.

This report adopts the structure of the Terms of Reference as chapter headings and additionally provides commentary and recommendations for each of the current CEP projects plus commentary regarding the car park program.

In addition, on 16 January 2025, the Queensland Government expanded the Terms of Reference to include an assessment of the Sustaining Capital Program. The Review's assessment of that program appears in Part 2 of this report.

Part 1: Capacity Expansion Program

3. Governance and Oversight

3.1 Queensland Government Infrastructure Governance

3.1.1 Health infrastructure governance in the context of whole of government infrastructure governance

The planning and delivery of health infrastructure projects in Queensland is to be undertaken within the context of whole-of-government policy and process as per the **Queensland Government Project Assessment Framework (PAF)**, **Capital Works Management Framework (CWMF)**, and **Queensland Government Gateway Review** (assurance) process.

Health service planning, assessment and prioritisation processes occur within Queensland Health as detailed within the **Capital Infrastructure Requirements (CIR)** and must be consistent with the Government’s capital works management and PAF process.

Where the PAF provides the overarching framework and strategic assessment of projects to ensure they align with Government priorities and deliver value for money, the CWMF provides detailed guidance for the practical aspects of managing and delivering infrastructure projects, while the CIR offers detailed guidelines specific to health infrastructure projects.

Table 3 below highlights the key governance frameworks for health infrastructure project assessment and delivery in Queensland

Remit	Governance framework / mechanism	Definition
Whole of QLD Government	Project Assessment Framework (PAF)	A structured approach for assessing projects at critical stages throughout their lifecycle. It emphasises evaluation, decision-making, and alignment with Government priorities to ensure projects deliver value for money
	Capital Works Management Framework (CWMF)	Focuses on the planning, delivery, and management of Government building and infrastructure projects. It provides detailed guidance on procurement, contracts, cost planning, and project governance.
	Queensland Government Gateway Review	Conducted by a small team of independent experts who provide an unbiased assessment of the project's progress and quality
Health-specific projects	Capital Infrastructure Requirements (CIR)	Guidelines established by Queensland Health to ensure a consistent and standardized approach to planning, designing, and managing health capital infrastructure projects

Table 3: Governance requirements

Service planning, assessment and prioritisation processes occur within Queensland Health before the decision is made to proceed with a capital solution. Once this decision is made then the steps in the capital delivery process must be consistent with the Government’s capital works management and PAF process.

Figure 1 illustrates the sequence of the gateway review and PAF processes in parallel with statewide, Hospital and Health Service (HHS) and facility level health service planning and infrastructure design processes.

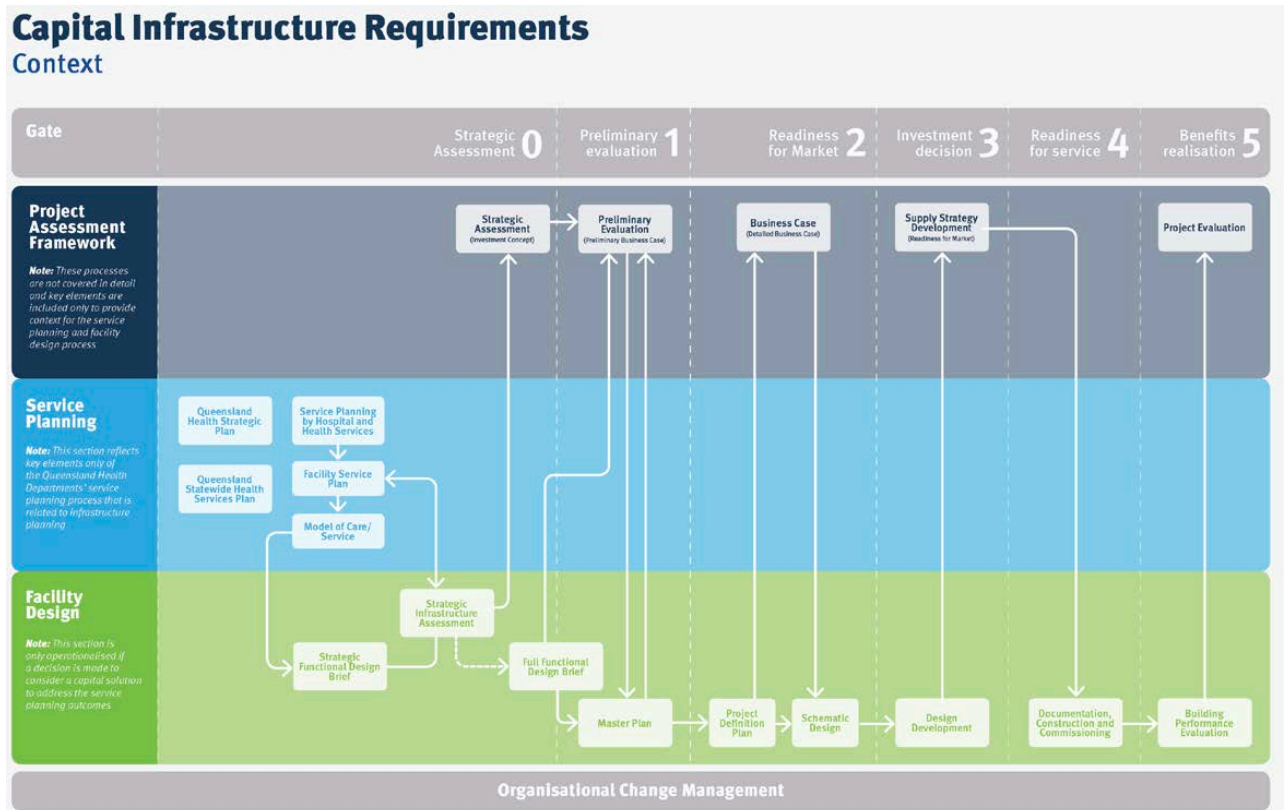


Figure 1: Queensland Health Capital Infrastructure Requirements

For the purposes of this Review, the PAF is the relevant measure as to whether the appropriate steps were taken to assess and evaluate the CEP’s viability and value for money.

The Queensland Project Assessment Framework (PAF) provides specific guidance and obligations on capital project proponents to establish processes and practices to appropriately plan, deliver and govern capital projects.

3.2 Queensland Project Assessment Framework (PAF)

3.2.1 Overview

The Queensland Project Assessment Framework (PAF) provides specific guidance and obligations on capital project proponents to establish processes and practices to appropriately plan, deliver and govern capital projects.

This PAF assists in meeting key legislative obligations, including:

Financial and Performance Management Standard 2019 and Financial Accountability Act 2009

The Financial and Performance Management Standard 2019 (FPMS) provides a framework for a department's accountable officer or a statutory body to achieve reasonable value for money by establishing and maintaining systems, practices and controls for the efficient, effective and economical financial and performance management of the department or statutory body. These standards are issued by the Treasurer under the Financial Accountability Act 2009. The FPMS states that departments and statutory bodies must have regard to the PAF in preparing evaluations concerning the acquisition, maintenance or improvement of assets.¹

The PAF is used across Government to ensure a common, rigorous approach to assessing projects at critical stages in their lifecycle, from the initial assessment of the service required, through to delivery.

At each stage of a project, the project's progress and quality is assessed to ensure that the project (and associated investment) meets strategic objectives and achieves value for money. Once a project 'clears' a particular stage, it can progress to the next. The Treasury Commercial Group manages the PAF and works with agencies to ensure consistent application.

3.2.2 Structure

The PAF is structured to provide guidance at each of the following stages:

Pre-project stage:

1. Strategic Assessment of Service Requirement

Six generic project stages:

2. Preliminary Evaluation
3. Business Case Development
4. Supply Strategy Development
5. Source Supplier(s)
6. Establish Service Capability
7. Deliver Service

Post project stages:

8. Benefits Realisation

For the purposes of this Review, a high-level assessment has been conducted on the following key stages of the PAF:

2. Preliminary Evaluation
3. Business Case Development
4. Supply Strategy Development
5. Source Supplier(s)

¹ Sourced from <https://www.treasury.qld.gov.au/programs-and-policies/project-assessment-framework/> accessed on 22 January 2025

3.2.3 Project Stage 2: Preliminary Evaluation

The purpose of the preliminary evaluation stage is to provide sufficient information to Government decision makers as to whether to proceed further with the project by investing in developing a business case.

Some of the key steps and requirements at this stage are as follows:

- Define the **options and associated benefits** for evaluation
- Conduct a preliminary evaluation of the **costs, risks and benefits** associated with the identified project options
- Consider **procurement strategies** (traditional delivery or potential PPP project)
- Establish initial project organisation and **governance arrangements**
- Develop a **detailed plan and budget** for progressing to the business development stage
- **Seek approval** to progress to the business case development stage

Table 4 provides a high-level review of the key process steps recommended in this stage 2 of the PAF:

Stage 2 – Key Process Step	Activities	CEP Review Assessment
Define the options and associated benefits for evaluation	Develop a benefits management plan	<i>Developed as part of the PVR</i>
	Develop a profile for each benefit	<i>Developed as part of the PVR</i>
	Develop measures and quantify benefit opportunities	<i>Developed as part of the PVR</i>
Conduct a preliminary evaluation of the costs, risks and benefits associated with the identified project options	Risk analysis	<i>Developed as part of the PVR</i>
	Financial and economic analyses	<i>Developed as part of the PVR</i>
	Market sounding	<i>Developed as part of the PVR</i>
	Consideration of legislative approval issues eg environmental, planning, cultural heritage and native title	<i>Developed as part of the PVR</i>
	Consideration of whole-of-Government policy issues eg employee, employment and skills development issues	<i>Developed as part of the PVR</i>
	Consideration of regulatory issues and impacts	<i>Developed as part of the PVR</i>
	Conduct a public interest assessment for options that have a direct impact on the community	<i>Developed as part of the PVR</i>
Consider procurement strategies	Consider private sector involvement eg PPP	<i>Developed as part of the PVR</i>
	Appropriate risk allocation under traditional delivery model	<i>Developed as part of the PVR</i>
Establish initial project organisation and governance arrangements	Develop initial project organisation and governance arrangements	<i>Developed as part of the PVR</i>
	Minister or CEO for the agency has key approval powers for the project	<i>Developed as part of the PVR</i>
	Governance of the project is responsibility of a senior management group in the agency, eg making recommendations to the Minister on policy or management issues requiring high-level approval	<i>Developed as part of the PVR</i>
Develop a detailed plan and budget for progressing to the	Develop a detailed plan and budget to fully develop a business case	<i>Developed as part of the PVR</i>

Stage 2 – Key Process Step	Activities	CEP Review Assessment
business development stage		
Seek approval to progress to the business case development stage	Develop a submission to the appropriate decision makers eg Cabinet Budget Review Committee	<i>CEP project announcement led to funding announcements including the funding to subsequently develop PVRs</i>

Table 4: Assessment of PAF Stage 2 Compliance

As can be seen from the above table, these requirements were fulfilled as part of development of the Project Validation Reports (PVR) for all of the CEP projects – PVRs have been developed for all projects except for the Queensland Cancer Centre.

However the timing of meeting these requirements is problematic. PVRs were developed after the projects were announced and budget funding was allocated. The PAF requires these elements to be developed prior to announcements and funding allocations, and before business cases are prepared.

3.2.4 Project Stage 3: Business Case Development

The purpose of the business case development stage is to undertake a more **detailed comparative analysis of the shortlisted project options** and delivery models identified during the preliminary evaluation stage, with the view to identifying the option most likely to achieve the service requirement and provide the best value for money outcome.

Some of the key steps and requirements at this stage are as follows:

- Conduct a detailed comparative evaluation of the options and delivery models
- Develop a project **implementation plan** for the preferred option, which includes:
 - **Scope, breakdown of tasks** and arrangements
 - **Human resources** requirements and **governance** arrangements
 - **Risk, benefits, stakeholders, change and quality** management plans
 - **Funding** framework
- Seek approval to proceed

Table 5 provides a high-level review of the key process steps recommended in this stage 3 of the PAF:

Stage 3 – Key Process Step	Activities	CEP Review Assessment
Conduct a detailed comparative evaluation of the options and delivery models	<ul style="list-style-type: none"> • Detailed risk analyses • Detailed financial and economic analyses • Market sounding • Legislative requirements • Whole-of-Government policy issues • Regulatory issues • Public interest issues • Procurement and delivery strategies 	<i>Developed as part of the PVR, but procurement strategies were curtailed as result of prior project announcements. PPPs and other procurement strategies were not thoroughly considered.</i>

Stage 3 – Key Process Step	Activities	CEP Review Assessment
	<ul style="list-style-type: none"> Recommend a preferred option and delivery model 	
Develop a project implementation plan for the preferred option	Define scope, breakdown of tasks and reporting arrangements	<i>Developed as part of the PVR</i>
	Define: <ul style="list-style-type: none"> Human resources requirements (roles, advisors, specialist skills and expertise required and estimated salary requirements) and, Governance arrangements (roles and responsibilities, accountabilities and reporting structure) 	<i>Developed as part of the PVR</i>
	Develop risk, benefits, stakeholders, change and quality management plans	<i>Developed as part of the PVR</i>
	Define the operating model to apply following handover from final project stage to new service delivery	<i>Developed as part of the PVR</i>
	<ul style="list-style-type: none"> Define the funding framework for the preferred option including: <ul style="list-style-type: none"> Timing Mechanisms Sources for cash flows Consequent impact on agency budgets 	<i>Developed as part of the PVR</i>
Seek approval to proceed	<ul style="list-style-type: none"> Develop a submission to the appropriate decision makers seeking: <ul style="list-style-type: none"> funding approval for project delivery approval to proceed allocation of appropriate resources 	<i>Developed as part of the PVR</i>

Table 5: Assessment of PAF Stage 3 Compliance

As can be seen from the above table, these requirements were fulfilled as part of development of the Project Validation Reports (PVR) for all of the CEP projects – PVRs have been developed for all projects except for the Queensland Cancer Centre.

As with Stage 2, the timing of meeting these requirements is problematic. **PVRs were developed after the projects were announced and capital budget funding was allocated. The PAF requires these elements to be developed prior to announcements and funding allocations.**

Operating funding impacts were prepared in the PVRs using the project scope and Queensland Health’s modelling tools for clinical activity using the then-prevailing Queensland Weighted Activity Units derived from the clinical scope multiplied by the then-prevailing Queensland Efficient Price escalated to project completion years. As such, **the substantial incremental operating cost impact of the CEP was known once all of the PVRs were completed, but it is unclear whether the substantial extra operational costs arising from the delivery of the CEP was accurately established or considered by decision makers before the initial CEP announcement.**

Further, there was scant, if any, commentary in the PVRs describing how alternate project scopes or delivery mechanisms would provide different operating cost outcomes. Given the project scopes and capital budgets had already been announced, such alternate approaches were not adequately canvassed in the PVRs.

3.2.5 Project Stage 4: Supply Strategy Development

The purpose of the supply strategy development stage is to develop and/or refine a proposed procurement approach and undertake all preparations in readiness for internal sourcing or competitive offer (or tender) processes.

Some of the key steps and requirements at this stage are as follows:

- Establish processes to **ensure probity**
- Gather **demand and supply** information
- Develop **procurement specifications**
- Undertake **supply market analysis** and **market sounding**
- Develop a **procurement strategy**
- Develop **offer/tender documents**
- Refresh the **business case**
- **Seek approval** to proceed

Section 4.3 of this report sets out the processes and practices used by HIQ to develop and seek approval of the procurement strategy for the CEP.

Table 6 provides a high-level review of the key process steps recommended in this stage 4 of the PAF:

Stage 4 – Key Process Step	Activities	CEP Review Assessment
Establish processes to ensure probity	Develop a probity plan	<i>See section 4.4 of this report</i>
	Appoint a probity advisory	<i>See section 4.4 of this report</i>
	<ul style="list-style-type: none"> • Uphold probity principles in all procurement activities: <ul style="list-style-type: none"> - Transparency - Confidentiality - Conflicts of interest - Accountability 	<i>See section 4.4 of this report</i>
Gather demand and supply information	Review, verify and further develop demand and supply information collected at business case stage	<i>See sections 4.3, 4.4, 6.3 and 6.4 of this report</i>
Develop procurement specifications	Involve representative stakeholders in developing detailed specifications based on functional performance and technical requirements	<i>See section 4.4 of this report</i>
	Document agreed procurement specifications (including evaluation criteria)	<i>See section 4.4 of this report</i>
Undertake supply market analysis and market sounding	<ul style="list-style-type: none"> • Use primary and secondary sources to undertake research into market characteristics 	<i>See sections 4.4, 6.3 and 6.4 of this report</i>
	<ul style="list-style-type: none"> • Consult with suppliers in the market on a without prejudice basis to explore: <ul style="list-style-type: none"> - Supplier levels of interest - Technical or business feasibility - Evidence of value for money 	<i>See sections 4.3, 4.4, 6.3 and 6.4 of this report</i>
Develop a procurement strategy	<ul style="list-style-type: none"> • Identify total proposed expenditure and assess difficulty of supply • Evaluate procurement strategies and specify performance measures 	<i>See sections 4.3, 4.4, 6.3 and 6.4 of this report</i>

Stage 4 – Key Process Step	Activities	CEP Review Assessment
Develop offer/tender documents	<ul style="list-style-type: none"> • Prepare offer documentation, including: <ul style="list-style-type: none"> - Objectives and specifications - Format and lodgement instructions - Terms and conditions - Arrangements for communicating with suppliers 	<i>See section 4.4 of this report</i>
	<ul style="list-style-type: none"> • Form an evaluation committee and agree procedures • Document in an evaluation plan: <ul style="list-style-type: none"> - Roles and responsibilities for evaluators - The proposed evaluation process - Details on the evaluation method 	<i>See section 4.4 of this report</i>
Refresh the business case	<ul style="list-style-type: none"> • Update the project: <ul style="list-style-type: none"> - Implementation plan - Risk and issues registers - Benefits management plan - Learnings register 	<i>See section 4.4 of this report</i>
Seek approval to proceed	<ul style="list-style-type: none"> • Develop a submission to the appropriate decision maker seeking approval to proceed to the Source supplier/s stage 	<i>See section 4.4 of this report</i>

Table 6: Assessment of PAF Stage 4 Compliance

Overall, the Review finds that stage 4 was broadly complied with, however the elements of appropriately considering the prevailing market conditions and shaping a procurement strategy that addressed those conditions may have been done but within a level of constraint that produced a poor outcome for Queensland.

Importantly, it appears that the process-based and probity elements have been complied with in the manner in which HIQ procured Managing Contractors.

3.2.6 Project Stage 5: Source Supplier(s)

The purpose of the supply strategy development stage is to apply procurement policies to rigorous offer (or tender) processes and associated evaluation activities.

Some of the key steps and requirements at this stage are as follows:

- **Evaluate** offers (or tenders)
- Conduct a **supplier appraisal**
- Undertake **financial appraisal**
- Develop **evaluation report**
- Negotiate and finalise the **service contract**
- Refresh the **business case**
- **Seek approval** to proceed

Table 6 provides a high-level review of the key process steps recommended in this stage 5 of the PAF:

Stage 5 – Key Process Step	Activities	CEP Review Assessment
Evaluate offers (or tenders)	If a large number of responses are received, it may be desirable to use screening and shortlisting processes to focus on the most credible candidates for the detailed evaluation	<i>See section 4.4 of this report</i>
	Detailed evaluation: <ul style="list-style-type: none"> - For larger and/or more complex projects, evaluation moderation may be held once all evaluators have completed their assessment. This allows for discussion on all ratings and comments, with the view of agreeing a consolidated rating for each supplier 	<i>See section 4.4 of this report</i>
	Comparative evaluation: <ul style="list-style-type: none"> - Using the results from the detailed evaluation to develop rank order of merit and identify a preferred offer 	<i>n/a</i>
	Large complex projects may require a multi-stage tendering process (eg expression of interest, indicative bid and final binding offer)	<i>See section 4.4 of this report</i>
	Evaluation processes must be able to withstand scrutiny and appropriate probity arrangements should be in place. The agency may retain the services of a probity advisor to observe supplier interactions to ensure that the type of information provided to would not advantage one supplier over competitors	<i>See section 4.4 of this report</i>
	Activate evaluation committee arrangements	<i>See section 4.4 of this report</i>
Conduct a supplier appraisal	Consider viability of the proposed supply arrangements	<i>See section 4.4 of this report</i>
	Consider capability and capacity of supplier	<i>See section 4.4 of this report</i>
	For approaches involving multi-supplier arrangements, consider supply chains, value chains and structure	<i>See section 4.4 of this report</i>

Stage 5 – Key Process Step	Activities	CEP Review Assessment
Undertake financial appraisal	Conduct basic checks of supplier’s financial and economic standing eg appropriate bank statements, audited statements of accounts, quarterly and annual reports	<i>See section 4.4 of this report</i>
	Consider financial information such as profit and loss, cash flows and balance sheets	<i>See section 4.4 of this report</i>
	Evaluation committee may check for further financial warning signs such as major reductions in staffing, larger increases in creditors than debtors, late filing of accounts, changing auditors and bankers	<i>See section 4.4 of this report</i>
Develop evaluation report	Describe critical issues and justification used to select the preferred supplier	<i>See section 4.4 of this report</i>
	Provide a summary of all offers received, briefly describing each offer and outlining its (and the supplier’s) strengths and weaknesses	<i>See section 4.4 of this report</i>
	Provide copies of individual evaluations completed for each offer received, as well as results of the comparative assessment	<i>See section 4.4 of this report</i>
Negotiate and finalise the service contract	Seek expert procurement and legal advice	<i>See section 4.4 of this report</i>
	An independent verifier can be used to provide advice on the quality of the technical solution and whether the proposed pricing reflects competitive costs for the standard of service provided.	<i>See section 4.4 of this report</i>
	For large projects involving significant procurement, the contract should establish the benefits, responsibilities and liabilities to accrue to those involved	<i>See section 4.4 of this report</i>
	Allocate risk through: <ul style="list-style-type: none"> • Service delivery specifications • Payment/pricing structure • Explicit contractual provisions 	<i>See section 4.4 of this report</i>
	The following criteria should be met before engaging in contract negotiations : <ul style="list-style-type: none"> • There’s a considered and soundly based prospect of improving value for money • It’s possible to justify the resource costs involved • The appropriate internal agency and project approvals have been obtained • Trained and experienced purchasing negotiators are available to conduct the negotiations 	<i>See section 4.4 of this report</i>
	There should be a clear audit trail to ensure the use of negotiation was justified and conducted in a fair manner eg justification, approvals, aim and methods used, a precise record of all exchanges (written and verbal)	<i>See section 4.4 of this report</i>

Stage 5 – Key Process Step	Activities	CEP Review Assessment
	The terms and conditions agreed between the negotiating parties should be subject to a final review and acceptance of legal provisions by agency legal and commercial advisors	<i>See section 4.4 of this report, and particularly noting that HIQ was not free to negotiate contract amendments without approvals from other parts of Government</i>
	Upon acceptance of the negotiated contract by agency advisors, it is appropriate to prepare a report on the outcomes of the negotiations and recommend that the contract be executed by an appropriately authorised officer of the State of Queensland. Execution of major contracts may require prior ministerial or Executive Council approval.	<i>See section 4.4 of this report</i>
	Prepare a long-term contract management strategy and plan including: <ul style="list-style-type: none"> - Performance measurement and monitoring - Optimisation of project costs - Risks and issues - Exit strategies 	<i>Partially compliant. See section 4.4 of this report</i>
Refresh the business case	<ul style="list-style-type: none"> • Update the project: <ul style="list-style-type: none"> - Implementation plan - Risk and issues registers - Benefits management plan - Learnings register 	<i>PVRs were developed in parallel with procurement processes and were not updated with procurement outcomes</i>
Seek approval to proceed	<ul style="list-style-type: none"> • Develop a submission to the appropriate decision maker seeking approval to proceed to the Establish service capability stage 	<i>See section 4.4 of this report</i>

Table 7: Assessment of PAF Stage 5 Compliance

Overall, HIQ followed the process and probity obligations in stage 5 of the PAF.

3.3 Queensland Government Business Case Development Framework

The Queensland Government’s Business Case Development Framework (BCDF) exists to ensure “a consistent and rigorous approach to proposal development, enabling decision-makers to compare investment opportunities”². The Framework operates across multiple stages:

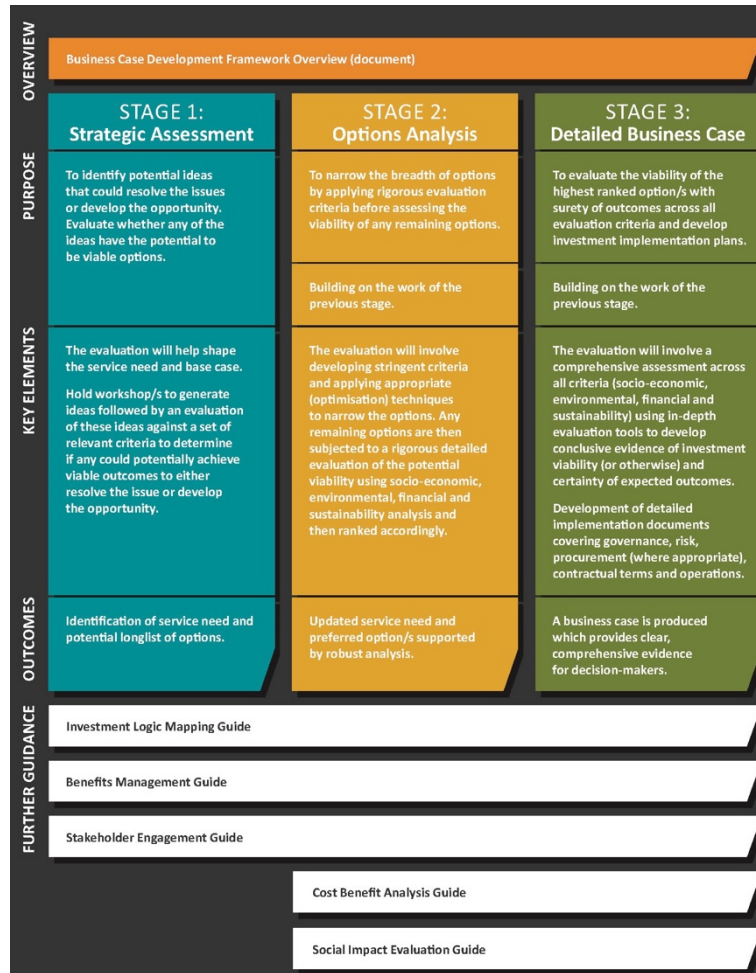


Figure 2: Business Case Development Framework³

As noted in the previous section, **HIQ did not complete the required business cases for CEP projects ahead of the investment decision to proceed with the CEP.**

Instead, HIQ commissioned capable health capital planning consultants to develop Project Validation Reports (PVRs) for all CEP projects (with the exception of the Queensland Cancer Centre) after the investment decision had been made and funding announced. The PVRs are comprehensive and cover all the requirements set out in the BCDF.

² <https://www.statedevelopment.qld.gov.au/infrastructure/governance-and-resources/business-case-development-framework>, accessed 22 January 2025

³ Source: Business Case Development Framework Overview version 3.1, page 2

3.4 Governance structures and accountability mechanisms

Health Infrastructure Queensland (HIQ) is the division of Queensland Health responsible for leading the planning, design, procurement and delivery of Queensland’s capital infrastructure. It was originally established in 2022 as the Health Capital Division before being renamed as HIQ in June 2024. It was created to manage and deliver health infrastructure projects across the State, ensuring that healthcare facilities meet the needs of Queensland's growing population.

In addition to the general Queensland Government accountability frameworks set out in the sections above, Queensland Health and HIQ established the following governance structures and mechanisms to oversee capital projects and the CEP.



Figure 3: Portfolio Governance, Risk & Assurance Model

HIQ’s role within the wider Queensland Health remit is two-fold:

1. Plan and deliver flexible, future-fit infrastructure that enables sustainable and equitable world-class healthcare for all Queenslanders, and
2. Partner across the ecosystem to innovate and design People-centre infrastructure that supports Hospital and Health Services to meet local needs.

Health System infrastructure responsibilities

Health Infrastructure Queensland <ul style="list-style-type: none"> • Planning, detailed design and delivery • Governance, Risk and Compliance • Program Performance, • Infrastructure Investment Development • Design, Innovation and Assurance
Clinical Planning and Service Strategy <ul style="list-style-type: none"> • Workforce Strategy • Business Case pipeline • Strategic and detailed models of care development, and service staging
Corporate Services Division <ul style="list-style-type: none"> • System procurement for FFE
eHealth Queensland <ul style="list-style-type: none"> • ICT design, infrastructure and systems
Healthcare Purchasing and System Performance <ul style="list-style-type: none"> • Phasing of commissioning inline with OPEX funding.
Hospital and Health Service <ul style="list-style-type: none"> • Timely local staff, community and consumer stakeholder engagement in relation to design, clinical service offerings and operational changes, including clinical and non-clinical HHS stakeholder engagement and union consultation as required • Operational commissioning planning and execution • Clinical and operational change management
Other agencies <ul style="list-style-type: none"> • Department of Housing, Local Government, Planning and Public Works: Contractor models such as BPPs and BPICs, QBuild, MID process and approvals • Department of the Premier and Cabinet: Governor in Council approval process • Queensland Treasury: Project Commencement Approval policy, State Budget and MYFER • Department of State Development and Infrastructure: State infrastructure strategy and pipeline reporting.

Figure 4: HIQ's responsibilities within the Queensland Health ecosystem

3.4.1 Capital Board of Management

The Capital Board of Management Board (**CBoM**) oversees the development and execution of Queensland Health's capital strategy to ensure optimal and sustainable capital investment across Queensland Health in line with health needs and Queensland Government priorities. The Board was established to provide governance of HIQ in approving its strategies and policy approaches, and maintain oversight of HIQ performance, including operational financial, risk management and engagement with stakeholders. This oversight is inclusive of the performance of the HIQ Deputy Director-General.

The CBoM provides advice to the Director-General, who provides decision making within their delegations. The Board provides governance oversight of HIQ and is also responsible for providing advice and direction to the HIQ Deputy Director-General in relation to matters set out in the CBoM terms of reference.

Board members are collectively accountable for advice provided to the Director-General. The CBoM does not replace or diminish any member's individual delegations, responsibilities and accountabilities for managing their respective portfolios.

Board Members:

- Director-General, Queensland Health (Chair)
- Chief Health Officer, Queensland Health
- Deputy Director-General, Strategy, Policy and Reform Division
- Deputy Director-General, Clinical Planning and Service Strategy Division
- Deputy Director-General, eHealth Queensland
- Chief Executive, Darling Downs Hospital and Health Service
- Chief Executive, Townsville Hospital and Health Service
- Chief Executive, Cairns and Hinterland Hospital and Health Service

Representatives from the Departments of Premier & Cabinet, Treasury and State Development, Infrastructure and Planning attend CBoM as observers.

3.4.2 Investment Assurance Committee

The Investment Assurance Committee (**IAC**) was established to provide assurance to the Health Capital Board of Management and the Director-General for built infrastructure projects greater than \$5 million which meet the whole of Government assurance requirements throughout their development lifecycle.

The primary function of the IAC is to provide effective assurance for projects and programs within the Queensland Health capital program reporting to CBoM. This provides an indication of the readiness for the project to progress to the next investment stage with a level of certainty that the project will achieve the planned benefits. As projects progress through the gate stages, the IAC will call upon the accountable Division within the Department of Health to provide assurance that risks have been properly assessed and managed.

The IAC functions under the authority and delegations of the Director-General and reflects the Director-General's responsibilities to provide strategic leadership and direction for the Queensland public health system under section 45 of the *Hospital and Health Board Act 2011*.

IAC members are collectively accountable for advice provided to the Director-General. Membership of the committee does not replace or reduce any member's individual responsibilities for managing their respective division and branches, as well as exercising their delegated functions.

Members:

- External independent chair
- Deputy Director General, Healthcare Purchasing and System Performance
- Deputy Director General, Clinical Planning and Service Strategy
- Chief Digital Strategy Officer, eHealth Queensland
- Executive Director, Governance, Assurance and Information Management
- Nominated Hospital and Health Services' Chief Executive Forum (HHS CE) representative (x2)
- Nominated Queensland Clinical Senate representative
- Nominated Queensland Treasury representative
- Nominated Department of the Premier and Cabinet representative
- Nominated Department of State Development, Infrastructure, Local Government and Planning representative
- Nominated First Nations Representative
- Observer, Executive Director, Strategy, Reform and Assets, HIQ

The IAC has reviewed CEP projects at various points along their development, but it appears from Review interviews that IAC was provided with a huge volume of detailed data and project reports to consider and provide assurance over. With the exception of the independent chair, other IAC members have limited infrastructure project delivery and construction sector experience. This has limited the level of assurance that could reasonably be expected from this group, and some interviewees expressed a view that IAC was being used as a vehicle to "rubber stamp" approvals rather than performing the intended (and required) assurance function. Examples were provided to the Review where approval papers were presented to IAC to progress through gate 3 to contracting a Managing Contractor (**MC**) but the MC contract had already been executed. **This is patently poor governance practice and culture.**

In other jurisdictions, the equivalent of Infrastructure Queensland/Department of State Development, Infrastructure and Planning would commission entirely independent assurance reviews at each gate. Each gateway review report would then be provided to the agency and to the infrastructure oversight agency, and ultimately to a cabinet subcommittee.

Recommendation 1: The Health Investment Assurance Committee should be disbanded and the Department of State Development, Infrastructure and Planning should institute appropriate assurance gateway reviews, using entirely independent and experienced reviewers to assess the readiness of future projects to progress through project approval gates.

3.4.3 Program Steering Group (PSG)

The purpose of the Program Steering Group is to deliver on the strategic direction set for all aspects of the CEP, monitor progress towards Program outcomes and benefits, make decisions on issues impacting the Program within the time, cost and scope parameters approved as part of the Queensland Health budget. Meetings are supposed to be held monthly for one hour. The PSG is also responsible for the oversight of Program contingency.

Members:

- Deputy Director General, HIQ
- Executive Program Director, Program Branch, HIQ
- Executive Director, Infrastructure Planning and Delivery Branch, HIQ (x4)
- Senior Director, Program Branch, HIQ
- Director, Assurance Services, Operations Branch, HIQ
- Negotiation Lead, Capacity Expansion Program, Program Branch, HIQ
- Senior Contractors Administrator, HIQ
- Program and Technical Lead, Program Branch HIQ
- Senior Project Officer, Program Branch, Health Infrastructure Queensland

3.4.4 Project Steering Committees (PSCs)

The PSC is the peak governance forum for each project, charged with overall project governance responsibility. The PSC should receive accurate and clear reporting on the project and matters that cannot be resolved through the subsidiary Project Control Group (see below) are escalated to the PSC.

The PSC is also the forum that governs the allocation and distribution of the project's contingency.

Interviews conducted by the Review highlight a disparity in the quality of reporting provided to PSCs and a further disparity in the manner and tone with which this important governance forum has been conducted. The Review has heard from interviewees that project financial data was redacted or withheld from governance forums due to supposed "commercial in confidence" reasons. Given these governance forums were constituted by senior Government executives it is difficult to comprehend this decision, especially as it drove a **poor perception of transparency and trust between HIQ and, in particular, health service CEOs and executives.**

3.4.5 Project Control Groups (PCGs)

Sitting beneath the PSC is the Project Control Group – the primary working governance forum for the project. This governance forum is where the bulk of project matters are canvassed between HIQ, HSSs, project managers, MCs and their design consultants.

PCGs have been created in accordance with the required governance frameworks and with terms of reference and membership. Evidence presented to the Review illustrates that whilst PCGs have been held they have had various levels of efficacy and usefulness.

Good quality project managers and project management practices, coupled with the right collaborative cultures from all PCG members, would see PCGs able to drive each project at the appropriate level of momentum. Where matters cannot be resolved at the PCG, they can be escalated to the PSC.

3.5 Deficiencies in oversight

The CBoM has, from insights provided by members of the committee, had various levels of effectiveness in providing oversight to the CEP. Whilst meetings have been scheduled, they have periodically been either cancelled or otherwise not taken place, with papers circulated for approval without the opportunity for the Committee to meet and make the requisite enquiries of HIQ and project teams. Evidence was also provided to the Review that the HIQ secretariat did not always provide the Committee with papers that HHSs wanted presented to the Committee and HHS CEOs felt ignored when they raised concerns about matters being presented to the Committee.

The CBoM was constituted by Government executives with very busy roles and capital project and program oversight was an additional task in already hectic schedules. Clearly, future CBoM governance can be improved by the proposed Advisory Board for HIQ (see Recommendation 6) where industry and deeply experienced infrastructure sector individuals can provide a level of oversight and advice to the CBoM. CBoM can then meet less frequently and benefit from independent, experienced and clear advice.

The governance and oversight deficiencies in the Investment Assurance Committee are highlighted above, and Recommendation 1 provides for the replacement of that committee with independent gateway assurance reviews.

The Review has heard a wide range of experiences with HIQ's management of PGCs and PSCs. In some projects these forums seem to have operated with governance structures and practices that were less than desirable, including:

- Financial reporting being either redacted or removed from PSC and PGC reports provided outside of HIQ – repeated evidence has been provided to the Review that HHS CEOs and executives attending these governance forums had no visibility of the financial status of their projects;
- Financial and other project data being inconsistent between reports – the Review has been provided with examples of inconsistent and incoherent data within PSC and PCG papers and in papers going between PCG and PSC;
- Approved PGC recommendations being changed by HIQ before being presented to PSC, and
- Some project leaders “going through the motions” of running these governance forums rather than using them for their intended purposes and in accordance with their terms of reference.

Recommendation 2: The renewed HIQ structure, leadership and culture should run PSCs and PCGs for their intended purpose and in the manner set out in their terms of reference, with all project information accurately presented in reports to these governance forums

3.6 Suggested Future HIQ Role and Revised Governance Structures

Health Infrastructure Queensland was stood up as part of the announcement of the CEP to play a system-wide role in leading high value high risk (HVHR) programs and projects across Queensland Health. HIQ's role within the wider Queensland Health remit is presently two-fold:

1. Plan and deliver flexible, future-fit infrastructure that enables sustainable and equitable world-class healthcare for all Queenslanders, and
2. Partner across the ecosystem to innovate and design People-centre infrastructure that supports Hospital and Health Services (HHSs) to meet local needs.

The delivery of significant health infrastructure projects and programs is an essential function within every State Government in Australia and should be a core capability sitting alongside other state-wide functions supporting the health service delivery businesses. The HHSs are specialists in delivering clinical care to their constituents and should be primarily focused on their core capability of delivering health care, not delivering infrastructure projects. Whilst a few of the HHSs do have strong capabilities in infrastructure project delivery from previous structures and regimes (particularly two of the large metropolitan Brisbane HHSs), the infrastructure capabilities and workforce availability tapers off the further from southeast Queensland one looks.

System-wide benefits from retaining core infrastructure project planning and delivery capabilities, regularised repeatability and appropriate standardisation of approaches for design and delivery of projects and a central repository of knowledge and lessons learned are essential. If as recommended elsewhere in this Review, Queensland Government implements a longer-term capital program for Health, then an ongoing career path for health infrastructure specialists will be a key attractor in securing the necessary skills within Government.

Further, having a central point of industry engagement simplifies industry's engagement with Government and makes Queensland Health easier to do business with when delivering projects – construction firms and consultants have a common and consistent approach to procurement, risk allocations and contract management. With substantial construction pipelines evident across Australia, Queensland Health needs to be (and remain) an attractive client to work for – construction and consulting firms have real choice where they deploy their resources, and an informed client function within Queensland Health best positions such a role for Queensland.

Localised delivery of maintenance and non HVHR projects can continue to be performed by HHSs, together with development and implementation of strategic asset management plans (SAMPs) that form part of an HHSs clinical service delivery planning and the more detailed asset management plans (AMPs) that sit underneath the SAMPs. HIQ should build capability to advise and support HHSs in developing SAMPs and AMPs, and provide a state-wide perspective and templates where appropriate. This central support function will be of particular use to rural and remote HHSs.

Where HHSs believe that they have the relevant capabilities to deliver non-HRV construction projects with a capital value less than \$20 million, a process to validate those skills and capabilities needs to be established to authorise an HHS to opt-in for localised project delivery. That opt-in could be approved for a specific project or a range of projects over a period of time, say 3 years.

Where a HHS is delivering a local infrastructure project, the HIQ project management structures, disciplines and reporting platforms should be used to allow transparency of capital expenditure and project performance across the State.

Accordingly, a lean centralised infrastructure delivery and strategic asset management function should continue within Queensland Health.

Recommendation 3: Health Infrastructure Queensland should continue to be an important part of QH but with a refreshed lean structure, clear role, appropriately skilled team and a new advisory board providing governance to assist QH to deliver major capex projects

3.6.1 HIQ's Role and Organisational Responsibilities

During the Review several interviewees highlighted that their understanding of the role which HIQ was responsible for on projects was confused. The Review has identified that roles and responsibilities did change during the delivery of projects, irrespective of the documented roles and responsibilities in governance documentation.

The current top level organisational structure for HIQ is set out below:

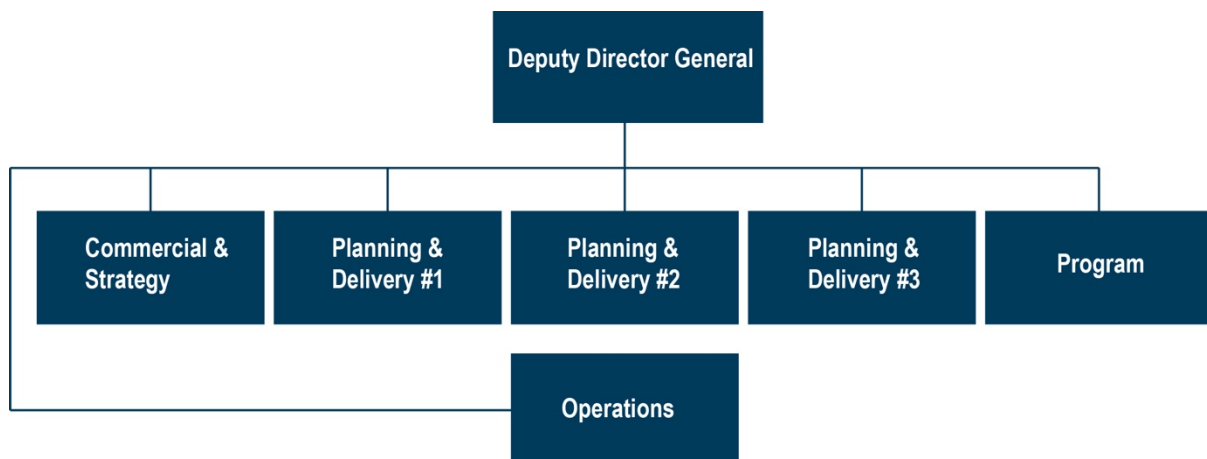


Figure 5: Current HIQ Organisational Structure

The future role for HIQ should be clearly defined to include:

- HVHR projects – full project cycle from planning to operational go live – with operational commissioning led by HHS under project governance;
- Planning and business case development for projects;
- Delivery of projects >\$20 million;
- Delivery of projects <\$20 million unless HHS opt in to deliver & have the requisite capability;
- State-wide programs such as CEP, AIDP and BRRHP – including appropriate program level reporting and data analytics to support program delivery;
- Strategic communications and stakeholder engagement for the capital program projects;
- Managing and promulgating Queensland Health standard design components;
- Establishing furniture, fixtures and equipment (FF&E) standards and providing procurement for capital projects;
- Operational commissioning standards and HHS support;
- Secretariat for the Sustaining Capital Program;
- State-wide asset management strategy, and
- Assisting HHSs with SAMP and AMP development and implementation.

This role should be clarified and documented in a statement of expectations and the organisation should operate under a service agreement-style structure with the Director General. **The size and scale of HIQ should be closely examined to ensure a lean organisation is delivering value for money for the State.**

3.6.2 Capabilities and experience for HIQ team

The role for HIQ set out in the previous section needs to be matched with a lean, capable and experienced team at HIQ, with an appropriate structure (see more on this below) and culture (see the next section).

The Queensland Public Service Commission's Leadership Competencies establish a framework for leading in a Government context. This should be supplemented with the development of a HIQ capability framework, focussing on the specific infrastructure and commercial competencies required to run large scale infrastructure delivery projects. An example of such a framework is that developed by the Construction Leadership Group and jointly auspiced under Infrastructure NSW and the Public Service Commission in NSW⁴ and is used across the infrastructure delivery agencies to ensure the right capabilities are used when defining role descriptions, evaluating remuneration levels, recruiting and managing performance of infrastructure delivery agency staff.

Such a framework is an essential element of infrastructure delivery agency creation, management and oversight, and allows the functions of such an agency to be appropriately defined within a Government leadership competency framework. This framework plus clarity of HIQ's role will lead to simplification of the understanding of the roles and responsibilities of the organisation and its leadership.

Recommendation 4: An infrastructure and construction project leadership capability framework should be developed for HIQ (and more broadly for Queensland infrastructure delivery agencies)

3.6.3 HIQ Culture

Along with the technical and infrastructure delivery capability capabilities outlined in the previous section, HIQ needs to establish an appropriate service-oriented culture. HIQ culture starts at the top and leaders across the HIQ structure need to be held accountable to behavioural and cultural standards as part of their performance management framework.

The right cultural and behavioural capabilities, together with technical capability, will provide the best possible outcome for Queensland, with highly collaborative, service oriented and transparent delivery of infrastructure projects.

Historical culture at HIQ has not been the kind of culture that is required going forward, and throughout the Review examples were provided of attitudes and behaviours that were not conducive to collaborative and partnering outcomes. Some examples of this behaviour were witnessed by the Reviewer first hand.

⁴ See: https://www.psc.nsw.gov.au/assets/psc/documents/AG014_210x297_Public-Service-Commission-Infrastructure-and-Construction-Project-Leadership-Capability-Set-final_.pdf

3.6.4 Future Structure for HIQ

To implement the roles and responsibilities set out above, a refreshed organisational structure beneath the Deputy Director General is required. New roles should be defined based on a capability, skills and experience matrix, with new role descriptions aligned to the new infrastructure delivery capability framework and cultural and behavioural expectations.

This structure should include, as a minimum:

- A to-be-defined number of right-sized delivery units with appropriate spans of responsibility and lean but capable and experienced teams;
- A dedicated unit responsible for rural and remote projects and HHS support;
- An independent program management office responsible for ensuring transparent project and program reporting is available to the governance structures;
- Appropriately skilled procurement and project accounting functions to ensure an appropriate control environment is established and maintained;
- State-wide asset management and HHS SAMP and AMP development support functions, and
- Design leadership, major medical equipment (MME) and FF&E standards and procurement support.

Current HIQ Executive Directors can be assessed against the revised technical and behavioural requirements as part of renewed role descriptions and recruitment processes. The Review suggests that with a clear mandate, an appropriate governance structure and a refreshed approach to the market, HIQ will be a desirable and attractive place to work. Accordingly, leadership roles should be advertised and recruited in an open market process, with existing Executive Directors able to apply for the new roles and be assessed against external market candidates.

Team structures and (reduced) size of the overall organisation should be addressed following the appointment of a refreshed HIQ leadership structure.

The recruitment process for a permanent DDG should commence immediately, followed by recruitment processes for the newly defined leadership team roles led by the DDG. The office location for the rural and remote group should be considered, with an appropriate regional location preferred.

Recommendation 5: A revised structure for HIQ should be implemented, with all leadership roles advertised and filled through appropriate recruitment processes.

3.6.5 Reporting line for HIQ

HIQ should remain within Queensland Health reporting to the Director General, with an advisory board providing the DG and HIQ DDG with advice and input.

3.6.6 Suggested Governance Structure

The Review understands that the Director General is presently reviewing the governance structures that provide system-wide leadership of the Queensland health system. This includes the creation of a group to oversee the development and implementation of strategic clinical service planning and accompanying infrastructure requirements. The recommendations in this Report are additive to the governance reforms being implemented by the Director General.

To overcome and ameliorate the specific issues highlighted in this Report, an Advisory Board should be created for HIQ including external industry expertise, HHS representation and Queensland Health representation. The Chair of the Advisory Board should have direct access to the Minister for Health and Directors General of Health and Treasury, allowing for transparent and efficient escalation of issues.

The key skills required for this Advisory Board should be shaped around the oversight of a major infrastructure program and be modelled on other State Government infrastructure delivery agencies including the (previous) Health Infrastructure NSW Board and the Victorian Government's Infrastructure Delivery Agency (VIDA) Board.

Skills required on the Advisory Board include:

- Major infrastructure project delivery;
- Health infrastructure planning and delivery;
- Construction;
- Project and program management of high value high risk projects;
- Commercial and (Government) procurement;
- Stakeholder engagement and communications;
- Finance, audit and risk in the context of Government infrastructure programs, and
- First Nations engagement.

Given the nature of the CEP and hospital distribution throughout the State, appropriate levels of regional representation and understanding of the specific needs and challenges of delivering projects in a regional setting would be highly advantageous.

Recommendation 6: an Advisory Board for HIQ with appropriate external industry and HHS representation and regional representation should be created and roles filled with an appropriate skill mix

4. Project Management and Delivery

4.1 Queensland Health Project Lifecycle

Queensland Health has historically operated health capital projects using the following Project Lifecycle:

Project lifecycle: *The Queensland Health way*

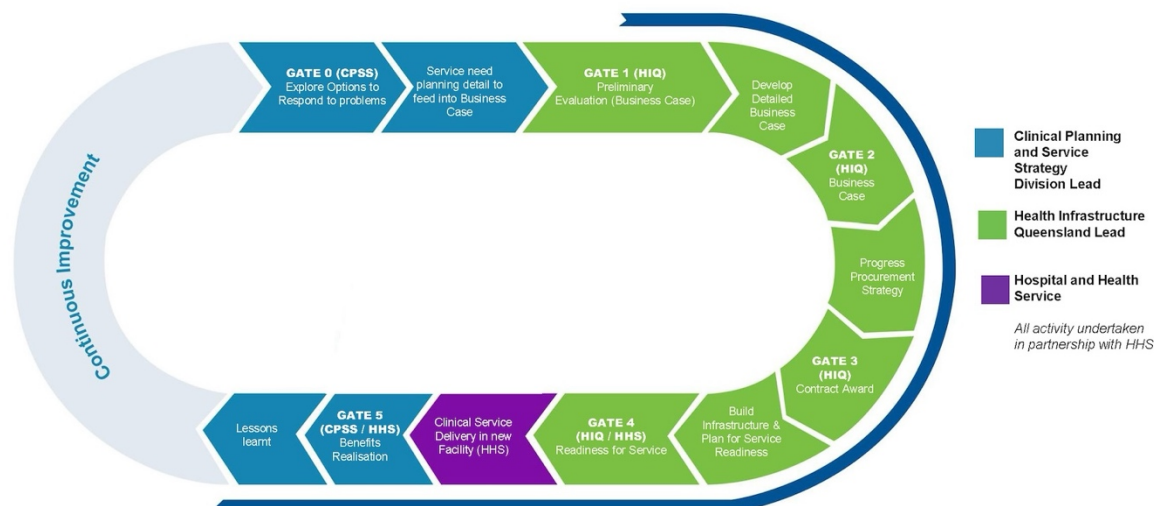


Figure 6: Queensland Health project delivery lifecycle/gates

This diagram illustrates the division of responsibilities with the Clinical Planning and Service Strategy (CPSS) Division being responsible for developing the clinical services plan for projects and considering Statewide and contemporary model of care requirements to be established or delivered as part of the project. This Statewide and centralised function, coupled with strong HHS engagement to agree the initial clinical scope, should result in clear and unambiguous clinical scope.

Where future capital projects are being contemplated, clinically-led prioritisation of projects should continue to be undertaken by this central Departmental function.

Once clinical scope is determined, the development of a functional design brief, schedule of accommodation, initial (or updated) masterplan, site investigations and initial block and stack should be undertaken by HIQ. This will require a change to move responsibility to HIQ for the masterplanning and site analysis functions that are presently sitting in the CPSS Division.

Figure 6 illustrates that at the completion of construction works, the HHS becomes responsible for Operational Commissioning. Under the current model, the HHS CEO becomes the Senior Responsible Officer for the project – a highly charged time in every hospital construction project where building works defect resolution, commissioning of building services, clinical cleans and MME plus FF&E installations are all being done in parallel with clinical operation commencement and patient transfers taking place.

This model also assumes every HHS has the capabilities and experience internally to take over and lead this crucial time in a project. Where an HHS has either several CEP or other infrastructure projects underway or has historically not had infrastructure projects requiring operational commissioning, these skills and resources may not be readily available within every HHS.

The Review thus suggests that project governance be amended to leave HIQ responsible for the overall project until successful completion, with HHSs leading operational commissioning as a work stream within the project. Where an HHS does not have the requisite skills and depth of team, HIQ's team can supplement the HHS resources and bring templates and capability to ensure smooth operational commissioning of the project.

Finally, the Lessons Learnt phase of the project is essential to continuously improve future capital project planning exercises – the lessons identified can be captured and instilled in the next projects. This process should be led by CPSS and the relevant HHS but will also require the close and extensive involvement of HIQ.

Recommendation 7: Responsibility for capital project masterplanning and site analysis should be moved from Clinical Planning and Service Strategy Division to HIQ, and HIQ should remain responsible for capital projects until successful completion. HHSs should lead operational commissioning with the support of HIQ.

4.2 Planning for the CEP

CEP projects were initially planned in around 6 weeks.

Whilst well renowned and highly capable health infrastructure consultants were engaged to undertake the initial planning exercise for CEP, the time provided to the teams was patently insufficient to provide a level of specificity such as fully worked-up scopes, considered budgets and appropriate construction timeframes. **It is impossible to follow best health infrastructure planning practices in such a short period of time and the cost overruns that have arisen from “support services” additional scope, site conditions and site infrastructure requirements are directly as a result of this highly compressed planning process.**

Projects in the CEP were incorporated based on clinical service prioritisation undertaken by the CPSS Division, with bed volumes and other clinical needs derived from central planning and demographic data. During the Review several HHSs noted that there are differences of opinion regarding some of the demographic data used to calculate the clinical needs and priorities. This is clearly suboptimal, and it is preferable if there was a standardised set of demographic assumptions used for planning.

These clinical volumes were then translated into high level schedules of accommodation which were subsequently used to derive spatial areas, but the Review understands that most of the planning was desktop in nature and there was no (or very limited) consultation with HHSs, no site investigations were undertaken and there were no clinical consultations. Some projects (eg Coomera) benefited from detailed business cases previously developed by HHSs before the CEP was conceived, however it seems that historic cost plans were not adequately escalated to capture market conditions at the time. Further, the full scope set out in previous HHS business cases was not carried over into the CEP projects.

Spatial areas were derived using a reference design and standardised room designs. Standardised room designs are not, despite some previous commentary emanating from HIQ, new to the planning and delivery of health infrastructure in Australia. Australasian Health Facility Guidelines (**AusHFGs**) were first developed around 2004 through the Australasian Health Infrastructure Alliance (**AHIA**) which reports to the Health Chief Executives Forum (HCEF), formerly the Australian Health Ministers' Advisory Council (AHMAC). Queensland Health is a member of AHIA and has contributed to the development of AusHFGs.

AusHFGs are guidelines that are freely available to hospital planners, including a 3D object library that architects can use to lay out each room in a hospital's design. As guidelines, they form the basis of clinical and health service delivery consultation, in which local needs and requirements are used to finalise the detailed designs. AusHFGs also provide detail on standardised FF&E through room data sheets.

Standardised room designs have attempted to be used in the CEP as a mechanism to short-circuit planning and remove normal consultation processes – essentially to drive a contraction of the time between announcement of the project and commencing construction by removing the usual consultation practices undertaken in a hospital design process. **The drive to rigidly use standardised designs has, in some projects, driven much angst and displeasure between HHSs, clinicians and the HIQ teams charged with delivering the projects. It has also not resulted in the assumed time savings, but rather resulted in longer processes than assumed which has had knock on contractual and cost implications.** Stage 1 Managing Contractor design teams have raised variations to cover additional user group consultations that were not provided for in their initial bids and contracts.

This push for standardisation also didn't appropriately accommodate differences between rural, regional and metropolitan hospital needs and requirements.

The spatial areas from the reference design were then translated into project budgets. In documentation prepared by HIQ in November 2024 these budgets were stated to be (reproduced as written):

- based on a price per square metre which does not adequately account for the detail that comes out in detailed design and site investigations
- before material prices had undergone such a substantial uplift and the hyper escalation of 50% in the construction sector that has impacted contractor pricing
- without an understanding of full BPP impact, with few BPP projects has been delivered and Quantity Surveyors did not understand the full impact on labor productivity beyond the BPIC's themselves (such as now seeing pricing for 2.5 days of output for each FTE and CFMEU rejecting requests for roster work on weekends even when critical path impacted)
- before trade supply had been mapped across the accelerated program and other States to understand major pinch points such as piling, ceilings and partitions and vinyl layers.

Source: HIQ Hot Issues Brief 13 November 2024

As such, HIQ itself recognises that project budgets were inadequate when originally estimated. However the Review does not agree with the implicit implications in this statement from HIQ that the “hyper escalation” was a surprise – market conditions and construction pricing was well known at the time initial project budgets were estimated, and it is difficult to understand why this market knowledge was not translated into the project budget assessments provided by HIQ’s cost planners.

Masterplanning for sites, where undertaken for the CEP, was done on a desktop basis, and didn’t seem to consider wholistic environmental and other approvals that would be required eg Bundaberg EPBC implications, EPBC implications at Coomera, scar tree at Redcliffe and so on. These omissions have generated significant cost and program implications and discord between HIQ and HHSs.

Finally, **critical upgrades to site infrastructure were fleetingly considered** and assessments were done without any or inadequate HHS consultation – it appears that HHS capital maintenance requests were reviewed to ascertain what upgrades might be required to accommodate the CEP projects. However, the lack of detailed on-site assessments of site infrastructure has led serious omissions and defects in the planning, cost estimations and program implications. More detail on this topic is set out at section 5.1.2.

In summary, planning for CEP was swift and the processes were designed to move the CEP into procurement and delivery as quickly as possible. Whilst the desire to get new clinical services built as quickly as possible was admirable and is desirable, undue haste has meant that the intended swift delivery and cost-effective collaborative projects have not been realised. Delivery timeframes for every project have been elongated beyond the announced dates.

4.3 Procurement Strategy and PPPs

The Queensland Project Assessment Framework (PAF), like most other Government infrastructure proposal processes, requires consideration of procurement strategy options to address the underlying need.

As noted in section 3.2, the business case phase of the CEP was undertaken after the announcement of the program, and as such, the Project Validation Reports reviewed as part of this Review illustrated that the two-stage Managing Contractor approach was mandated by prevailing policy for projects greater than \$100 million. Reviews of the PVRs for each CEP acknowledged this policy setting and PVRs generally did not review other procurement models in any depth.

The PVR for Bundaberg did note that the market sounding undertaken for that project highlighted that it might be suitable for a Public Private Partnership (PPP) delivery model:

new hospital as having suitable characteristics and scale for a PPP to be viable under the right structure.⁵

The Stage 2 procurement process for the CEP did create the requisite Significant Procurement Plan, which is dated August 2024. Of note is the Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis undertaken for eight different procurement models. The SWOT for the chosen model is presented in Figure 7.

Managing Contractor (Two-Stage)	
<p>Strengths</p> <ul style="list-style-type: none"> • Pre-approved contract type – for major projects under Building Policy Framework. • Scale – Used for major or complex projects • Uncertainty – Can be effective where there is some degree of uncertainty about project requirements. • ECI – Provides for early contractor involvement. • Commercial – Incorporates many of the principles and benefits of alliance contracting on more typical commercial terms. • Competitive tenders (i.e. for design, documentation and construction fees, on and off-site overheads and profit, based on Principal's project brief) for each stage. • Evaluation typically on 30% price criteria, 70% non-price criteria. • Risks allocated to the MC • Flexibility – contracts can be tailored to suit individual project needs. • Design – MC has significant ability to influence design and 'buildability' of the project. • Claims and disputes are minimal. • Incentivised – The contract can be incentivised to achieve cost, time or quality metrics 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Risks inadequate project brief leading to claims and variations. . • Audit – Principal requires cost consultants to audit ACS and may require audit design consultants to ensure compliance with the revised project brief. • Administration – Relatively complex to administer, client required to provide additional resources to administer • Risk is priced in at a premium to effectively transfer to the Contractor. • Lack of competition in Stage 2 pricing as there is no open market tension. • Limited supply chain with capabilities to undertake model of delivery • Risk that GCS exceeds NECC at the end of ECI Stage 1 and a revised procurement or scope strategy be defined. • Higher supplier costs due to three stage approach • No influence over teaming • Less incentivisation to meet project parameters than a collaborative contract. • Commit to model for the duration of the project
<p>Opportunities</p> <ul style="list-style-type: none"> • Collaboration – During Stage One, the Managing Contractor (MC) must engage with the Principal's consultants and work collaboratively with them to revise the project brief and refine the design to meet budget and time constraints. • Balance of scope against cost during Stage One. • Early works opportunity (i.e., for commencement of work on site during Stage 1) whilst design is developed. • Extensions of time are generally limited. (Note that variations to the project brief may give rise to extensions of time.) • Relationship based (rather than adversarial); objectives are aligned to encourage win/win solutions. Parties must act in good faith. • Adjustments The GCS may be adjusted in accordance with the contract, including for variations to the revised project brief. • KPI – There are opportunities for incentives to encourage better than normal performance. • Certainty – reasonable of time, cost, and quality outcomes. 	<p>Threats</p> <ul style="list-style-type: none"> • Design must be largely completed before documentation and construction can commence. • Time – Client has less control on program and delivery timeframes • Alignment on objectives – Contractor developed design, scope and technical specifications lead to the potential of misalignment of expected outcomes between stakeholders and contractor • Misalignment of deliverables – If budget, scope, time development during Stage 1 does not meet client requirements, there may be a requirement to reject a Stage 1 offer, and recommence the project with another contractor. • Management Fee – Stage 1 fee remains payable to a contractor, even in the event their Stage 1 offer is rejected. • Bonus – Public perception on incentive payments

Figure 7: Significant Procurement Plan August 2024 – HIQ Two Stage MC SWOT Analysis

Material provided to the Review indicates that following the change of Queensland Government in late 2024, initial high-level concepts for alternate procurement strategies for the unawarded projects have been contemplated again. The primary procurement option that has been canvassed is the PPP model.

During the previous development of the Significant Procurement Plan, the SWOT analysis for the PPP procurement model was as set out in Figure 8.

⁵ New Bundaberg Hospital Project Validation Report, page 175

Public Private Partnership (PPP)	
<p>Strengths</p> <ul style="list-style-type: none"> • Relief of Financial Burden - High capital costs for infrastructure development are avoided by the Owner, together with associated debt issues • Relief of Administrative Burden - Particularly with concession agreements where the scope may include the interface with the customers for billing and service delivery. • No Interfaces - One entity is responsible for design, construction and operation, so disclaiming of responsibility for problems is minimised. • Optimised 'Whole of Life' Costs - The design of the plant will endeavour to optimise the balance of construction costs and operating costs. This is driven by commercial returns to the contractor. • Operator Friendly Plant - The entity responsible for plant operation is closely involved in the treatment plant design. • Optimum Design - Good design decisions are facilitated by involvement of all parties influencing the form of the plant/ building, ie: <ul style="list-style-type: none"> ◦ designer, who is seeking elegant, robust solutions. ◦ constructor, seeking lower cost, constructible solutions. ◦ operator, seeking lower O&M costs. 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Inflexibility – Traditionally unsuitable for an entity such as QLD Health, as the Contractor seeks to recover capital costs over the life of an asset (privatisation of an asset). Not a model that typically aligns with hospitals. In addition, with a transfer of Ownership of assets, the public sector has less flexibility to accommodate change during the operating period. • Cost – The recovery of an economic profit on capital outlays, operational cost and risk transfer may lead to higher cost than public Ownership, despite potential gains from operational efficiency, economies of scale and technology changes. • Conflict Between Construction and Operations - Potential for conflict of interest between construction and operations issues unless a long operations period is incorporated. • Complex Contract - The documentation for a DBO is complex and costly to produce. The long-term nature of the contract means an error can be costly. • Contract Efficiency - Operating costs can be high in comparison to alternatives because of commercial drivers. Contract management costs are also high. • Lack of Competition - Limited experience of this form of contract. The size of the contract, duration and risk are such that local Contractors are less likely to tender.
<p>Opportunities</p> <ul style="list-style-type: none"> • Opportunity for Improved Service to Customers - Performance obligations measured against levels of service can be written into contracts. • Encouragement of Growth - The concessionary has a direct interest in expanding the size of the business. • Public Sector can Refocus and Fund Other Social Issues - A BOOT contract frees up capital and gives a source of income to fund other community needs. • Financial Reality - The true cost of providing services can be better identified and communicated to customers. • Environmental Permit Risk - The risk of meeting resource consent conditions is transferred to the private sector. • Expertise - A specialist Contractor is likely to be involved and will bring greater expertise to the increasingly complex operating environment of water and wastewater systems. • Cost Savings in Operations - Potential cost savings through letting of long-term competitive contracts for O & M. • Guaranteed Price - Costs of operating the facility are known at the outset (other than the effect of variations) 	<p>Threats</p> <ul style="list-style-type: none"> • Ownership - Privatisation of infrastructure assets can evoke negative reactions from the community. • Monopoly Profits - A price regulation process is essential if monopoly powers are not to be exploited to the disadvantage of customers. This regulation can impose another high administrative burden. • Loss of Control - The Owner loses direct control of the plant's operation. • Employee's Interests - There could be opposition from existing employees concerned at loss of job opportunities - although this issue can be resolved in the contract. • Residual Life – Unless the contract is very specific to the contrary, the Contractor is incentivised to run the plant down and not maintain it for service past the end of the operating contract period.

Figure 8: Significant Procurement Plan August 2024 – HIQ PPP SWOT Analysis

The Weaknesses identified in the SWOT for PPP are largely accurate, with the lack of flexibility and complexity of a PPP contract evidenced in many Australian hospital PPPs. In addition, whilst the noted strength of smoothing the cashflows required to fund the construction and development of the hospital exists, this is offset by the fact the embedded interest cost is typically above that at which a State Government could otherwise source capital plus accounting standards now require PPPs to be on-balance sheet.

A significant strength that was not canvassed by HIQ is that PPP hospitals are typically the best maintained hospitals in State hospital systems because maintenance is contractually required to be performed and is funded through contracted payments to the PPP company and subcontracted facility maintenance provider. PPP facilities are typically returned to the State with a known asset quality and condition, and typically with around 10 years of major capital maintenance pre-performed. Accordingly, the Review does not agree with the Residual Life threat captured by HIQ.

With appropriate programmed and preventative maintenance regimes, new hospitals constructed in Queensland may be more cost-effectively be procured other than via a PPP structure.

Other contracting models are now open for adoption under revised Government policy, and as detailed in the recommendations for unawarded CEP projects, there is scope to reconsider appropriate risk allocations and contracting models other than the present two stage Managing Contractor model.

Further, contracting models from other jurisdictions such as the NEC suite⁶ from the United Kingdom could be considered for adoption to deliver the unawarded CEP projects.

⁶ The NEC suite of contracts were first promulgated in 1991 as the “New Engineering Contract” and have been known as NEC Contracts since 1995 – see more at <https://www.neccontract.com/why-choose-nec/history>

4.4 Procurement Process

As with the planning for the CEP, the procurement of the CEP was done in a great hurry to attempt to meet the announced construction completion timeframes.

There has been much evidence provided to the Review from other parts of Queensland Government and industry providing feedback that launching procurement of all CEP projects all at once was ill advised and would be ineffective given prevailing market conditions. It should have been patently clear to HIQ that the national health infrastructure market was already beyond saturation point and, in addition, the broader Queensland construction market was significantly overheated.

The pre-cursor to HIQ did engage a infrastructure advisory firm to undertake a market sounding prior to launching the CEP procurement process. The report from that market sounding is understood to have identified significant market capacity constraints and issues and advised that procuring all projects at once was not recommended, and a staged procurement approach was advised. This advice was patently not accepted by the then HIQ leadership and Government.

The selected multi-stage procurement approach (expressions of interest to form a panel and then tender to selected proponents from that panel) is uncontroversial and was stated to drive the maximum market competition for the CEP projects. The then prevailing market conditions and paucity of trades availability meant that the procurement was adding to an already overheated market and the perceived market competition opportunity for CEP was misplaced – market competition for skills and projects on a national basis ought to have been better considered in forming the procurement strategy for CEP. Market competition was not for the CEP projects between local builders in isolation – the market competition was for every other trade and project construction resource on every other project in Queensland and health infrastructure projects across the country. These risks were identified as weaknesses in the selected procurement model by HIQ itself – see section 4.3.

Australia has a limited number of contractor project directors with the experience and capability to deliver health infrastructure projects of the scale and complexity of the CEP projects. At the time of the CEP procurement, most (if not all) of these project directors were already engaged on equally complex health projects in other States. This fact seems to have either evaded HIQ or was ignored and a misconception that awarding projects to contractors assuming that the calibre and depth of experienced health teams required would be made available to the CEP projects. Evaluation reports for the requests for tender highlight that there was limited health infrastructure delivery experience in many of the bidder teams.

A procurement process that awards substantial health infrastructure projects to (otherwise highly competent) tier 2 builders with limited experience in delivering hospital projects in Queensland whilst one of the largest tier 1 contractors was an unsuccessful bidder on 3 of the largest projects must be queried. Based on the evidence made available to this Review it seems that rather than being focussed on the calibre of the contractor's team, proposed methodology and realistic program, the procurement process was driven to select contractors who bid costs closest to the announced CEP figures or the lowest price. Experienced contractors who bid realistic methodologies, programs and costs were not always awarded projects. It appears that price was 60% of the overall assessment whilst non-price elements were 40%. As noted below, within the non-price evaluation criteria experience was weighted at 30% while program, methodology and (non-price) budget/cost control were weighted at 45%.

Further, non-price elements were adjusted using a "Price Quality Method" where the cost advisor to the evaluation panel took non-price scores for each bidder and deducted a pricing factor to the tender's price in an effort to quantify the value of a better-quality non-price score over a more moderate non-price score. This methodology was used in an attempt to normalise tenders in this situation where hospital designs were nascent. The lowest non-price (in other words the team with the lowest assessed team, methodology etc) has no deduction whilst the highest non-price scoring bid has the greatest deduction. This has the effect of reducing the assessed tender price of the highest non-price scoring team.

Experience on the CEP is that the tendered (lowest) price for the selected builder was rarely adhered to throughout the conduct of the Stage 1 and Stage 2 Managing Contractor processes. More experienced teams, with methodologies based on prior experience and programs reflecting market condition will have produced higher (and thus non-winning) bids.

It is arguable that given the CEP projects had been announced with the full budget number and construction timeframes to achieve, Government pre-determined the content of bids it received.

4.4.1 EOI and Panel Formation

During late 2022, the then Health Capital Division of Queensland Health commenced a process to form a “Construction List” to deliver the CEP, with the stated intention to disband the list at the completion of the CEP.

Prospective construction firms were invited to submit their interest in gaining access to the CEP Construction List on 25 October 2022 via the QTenders system, with submissions closing on 18 November 2022. The intent and content of EOI submissions was primarily capability, registration status and experience, and so a short period of time such as this was appropriate in the circumstances. Registration status referred to registration under the “Best Practice Principles” (BPP) administered by the then Department of Energy and Public Works.

Health received 14 submissions in total, with:

- 6 firms fully registered under BPP;
- 5 firms having submitted for BPP registration and
- 3 firms not having commenced BPP registration.

The EOI process culminated in a recommendation to the DDG to approve 12 proponents form the Construction List, with typical evaluation practices and processes following the endorsed procurement and evaluation plans.

Each Construction List appointed proponent met with the CEP team on 12-13 January 2023, where the CEP team explained the subsequent procurement processes that would be implemented and specifically the timing of the forthcoming requests for tender.

During this time, HIQ ran a parallel procurement process to select client-side project managers. Other jurisdictions would have started the procurement process with selecting experienced health infrastructure project managers to provide expertise and capability, not having done it in parallel. **This meant that HIQ did not have access to industry procurement expertise in the initial procurement phases.**

4.4.2 Stage 1 Procurement – Evaluation Plan

Following the formation of the Construction List, an evaluation plan for the CEP was developed and endorsed by the DDG in January 2023. Other evaluation panel members endorsed the evaluation plan in early March 2023, and so it is unclear when the evaluation plan was actually endorsed, and why the panel chair dated their endorsement 6 weeks before receiving endorsement from panel members. Notwithstanding this irregularity, the evaluation plan set out the process for receiving, scoring and evaluating tenders for Managing Contractors to undertake the CEP works.

As with usual Government construction project procurement practice, evaluation scoring was split into non-price criteria and price. The non-price criteria for tenders was established as follows:

Criterion	Weighting	Comments
Capability and capacity including resource strategy – 30%	15%	Organisational structure and corporate support for the project
	15%	Key personnel
Methodology – 40-45%	15%	Program
	20%	Methodology – Cairns, Mackay, Bundaberg and Toowoomba
	25%	All other projects
	5%	Budget control strategies
Local Benefits – 5-10%	10%	Project delivery methodology – Cairns, Mackay, Bundaberg and Toowoomba
	5%	All other projects
Best Practice Principles – 20%	7%	Work Health & Safety (WHS) systems and standards
	6%	Commitment to apprentices & trainees
	7%	Industrial relations

Table 8: Stage 1 Procurement evaluation criteria

4.4.3 Stage 1 Procurement – Allocation of Bidders to RFT Processes

As part of the EOI and Construction List formation process, proponents were requested to provide an indication of their interest in each of the CEP projects and their willingness to tender for each job.

The Review attempted to examine the process used to determine which proponents were allocated to each Stage 1 procurement process. The Review interviewed the HIQ team from the time of this procurement step and requested documents that would evidence how the decisions were made to allocate proponents to each project procurement.

Despite multiple requests from the Review, there has been no evidence made available to the Review of the process by which bidders were shortlisted to bid for each project. **This is irregular – there should be readily available documents and a record of formal approval or governance to allocate proponents to procurement processes off the Construction List.**

This would typically be a brief or other approval memo to the relevant delegate from the procurement/project team providing rationale for why the shortlisted bidders for each project were appropriate.

In the absence of such process and relevant documentation, it remains unclear how the project procurement shortlists were formed.

4.4.4 Stage 1 Procurement – RFT Process

Requests for Tender (RFT) were dispatched to the shortlisted bidders for each project on or around 24 January 2024.

The Review has inspected some of the evaluation reports from the RFT and can see from the project procurement artefacts that the proposed procurement processes and practices were followed. This included appointment of technical advisory services to provide the evaluation team with input on the received tenders, and the appointment of probity advisors throughout the process. The evaluation team and advisors were each provided with probity briefings as part of the process.

Evaluation of bids followed the evaluation plan, and each bid was scored against the criteria. Whilst the Review has identified some anomalies between evaluation scores and comments in the evaluation report (such as one bidder being identified as having limited health experience, limited Queensland experience and limited BPICs experience scored 9 out of 15 whilst another bidder was noted to have significant experience and scored 7 out of 15) these are highly qualitative scores and based on consensus amongst the evaluation panel. The Review has deliberately chosen not to dive deeply into a merits-based assessment of the RFT outcomes due to restrictions of time for the Review and limited utility in doing so at this juncture.

Overall it appears that the RFT Process and the evaluation of bids received followed the endorsed evaluation plans and processes.

The selected procurement strategy and contract meant that Managing Contractors were required to bid design and consulting teams to complete the designs in Stage 1 of the MC contract. This meant some consultants were included in multiple bid teams bidding for CEP projects, and on award, some consultants ended up overloaded and some missed out on work on the CEP. This procurement strategy meant that scarce health infrastructure design consultant resources were forced to tie themselves to specific bidders rather than HIQ procuring design teams on a program basis and ensuring the right fit for each project. The Review understands that this requirement to use the two stage MC contract was imposed on HIQ through previous Government policy.

This procurement strategy similarly required subcontractors to align themselves with bid teams, and in situations where there was limited subcontractor availability, further throttled by the requirement to be pre-registered under the best practice procurement rules, there were sometimes only a single subcontractor available for a specific trade across all Managing Contractor bidders for a project. Given subcontractor trade costs make up the majority of a project's costs, it meant the procurement strategy selected did not optimise market competition for the largest cost in the projects.

Exact data on subcontractor registrations has been difficult to source during the short Review duration, but anecdotal evidence suggests that at the time of the CEP procurement there were a total of just over 140 subcontractors registered. **Of these 140 around 60-65 subcontractors were relevant to CEP, whilst the likely overall subcontractor requirement would have required closer to 600 subcontractors to be pre-qualified.**

4.4.5 Two Stage MC Contract

The two-stage Managing Contractor (MC) contract used to procure the CEP was based on the standard Queensland contract developed and overseen by the former Department of Energy and Public Works (DEPW). Evidence provided to the Review sets out that this contract was the only contract HIQ was able to use at the time as a result of the Building Policy Framework. This Framework mandated the use of the two-stage MC contract for Best Practice Principles (ie BPICs) contracts over \$100 million and additionally required that head contractors and subcontractors be prequalified.

It appears that the Building Policy Framework is not based in legislation or regulation, but is understood by the Review to be a policy that was approved by the previous Government and had force through this policy approval. This policy position has been amended by the current Government, and other forms of contracting are now permissible.

The MC contract operates to:

- Engage a construction firm with the full suite of design consultants embedded within the builder team to lead the development of the design through schematic design into detailed design;
- Have the combined team engage with the client on matters of scope, price and program progressively as the design matures, including progressing the development of construction documentation;
- Drive development of a Gross Construction Sum (GCS) offer to progress into Stage 2 if the State requests an offer;
- Define the processes to accept or reject the GCS offer including adjustments to the various fees that were bid in the Stage 1 procurement for the project;
- Define reporting requirements and obligations;
- Provide the mechanisms for the MC to secure subcontractors to perform work packages including the requirement to incorporate Best Practice Industry Conditions into tendering and subcontractor engagements;
- Manage the physical construction and (technical) commissioning of the project;
- Provide the site to the MC under a range of conditions;
- Bonus payment regimes for delivering project under budget and/or ahead of time;
- Undertake enabling and early works under the Stage 1 phase as construction manager, and
- Establishing a whole range of administrative and management processes and practices – including some provisions that are of historic nature and add significant administrative overhead – for example requiring the MC to provide the State with two (hard) copies of every subcontractor contract including all attachments and appendices⁷.

The contract provides for risk allocations between the Managing Contractor and the State. The Review has received feedback from Managing Contractors, industry associations and others that this contract was well known in Queensland and had been historically used to deliver many significant projects.

However further feedback received has indicated that the risk allocations in prevailing market conditions including market capacity constraints, subcontractor registration and BPICs requirements at the time of procurement made the use of this contract problematic. This contract's risk allocations and processes have worked historically in a relatively stable subcontractor market and with a lesser volume of work in Queensland and nationally.

⁷ See clause 21.2.21 of the two stage MC Contract

The risk allocations that have been particularly problematic for the CEP include:

- Limitation of liability – MC contract provides for a cap up to 100% of the gross construction sum;
- Exclusion of consequential losses;
- COVID-19/pandemic relief – time and cost relief is not provided under MC contract;
- Liquidated damages rates and that they are uncapped;
- Set off rights operate beyond the contract to any other contract the MC has with Queensland Government;
- Force majeure clause allows for termination for frustration but no time nor cost relief to keep contract on foot;
- Security regime – MC contract does not allow for insurance bonds;
- Communication and service of notices in MC contract requires hard copies rather than via industry standard Aconex or other electronic services;
- Insurance requirements in the MC do not reflect current market standards, and
- Time and cost events – risks arising from supply chain delays, costs for wet weather, subcontractor delay costs, and a range of other risks are wholly to the account of the MC – some of these risks are beyond the control of the MC and as such are priced, plus margin, back to the State.

Evidence from one Managing Contractor illustrated that this contract was used successfully to procure a major project in a non-health sector at the same time as the CEP. This procurement was successful due to the fact that the client's design was substantially more progressed and the trades needed were not as constrained locally and nationally. This contractor advised the Review that they only raised liquidated damages as a problem with the CEP contract and accepted all other risk allocations.

Through the Review HIQ has illustrated that it did attempt to move some risk allocations in the standard contract through internal Government approvals processes – the Contracts Committee in the DEPW. HIQ and DEPW agreed a process for HIQ to submit to this Committee and a process to deal with departures to the contract proposed by the Managing Contractors through the RFT process. In June 2024 HIQ made the requested submission to amend risk sharing arrangements for trade supply, weather and other elements, but those requests were declined, and the standard contract continued to be used.

The MC contract also operates in a manner to require the MC to provide pricing very early in the design and development of the project. Coupled with market conditions, the risk allocations set out above and the present low construction sector productivity, subcontractor pricing was elevated and subcontractors incorporated buffers in their prices. These buffers have been further escalated by MCs then applying their margin and their own risk buffers.

Finally, during the Review it was made apparent that the formation of contracts and negotiations with MCs was undertaken completely separately from Project Directors and their teams – these tasks were undertaken by the HIQ Transaction Management Team. This team was made up of a small number of contractors and consultants including 4 different external legal firms. Whilst the intent was to drive contract standardisation, the exclusion of project directors from the contracting process and negotiations with builders meant that Project Directors had no idea what had been negotiated on their projects and were handed executed contracts. **This was not only detrimental to internal culture within HIQ, it meant Project Directors were commercially disadvantaged vis-à-vis the MCs.**

4.5 Furniture, fixtures and equipment (FF&E)

Furniture, fixtures and equipment procurement is a major element of successful health infrastructure projects, requiring:

- clear and precise specification of each piece of FF&E for each project;
- integration of FF&E with design;
- correct assessment of volumes of each piece of FF&E;
- clear accountability for specification and volumetric assessments;
- appropriate allocation of responsibilities for each phase of FF&E procurement including sourcing from the market, planning and managing deliveries, financial and stock control and allocation of placement/installation of FF&E, and
- resultant accurate asset management.

For the CEP it appears that there have been very mixed capabilities and understandings of the end-to-end FF&E design, specification and procurement processes required within both HIQ and the HHSs. The project governance for the CEP further made FF&E specification and procurement more complex by disaggregating responsibility for different parts of the FF&E process rather than having clear accountability for this major cost element.

With standardised rooms there seems to have been a belief that there was no need for clinical or HHS engagement on FF&E, and where HHS engagement on FF&E did take place, HHS feedback or error correction on hugely extensive FF&E lists was ignored or just overlooked. Multiple HHSs expressed dismay that repeated corrections, queries and comments on FF&E lists were provided (with significant amounts of time and effort to review thousands and thousands of lines) but subsequent versions were promulgated without addressing the issues highlighted in earlier versions. **There are residual unquantified risks on many CEP projects that FF&E lists are inaccurate and not properly coordinated with the design development.**

At some point in the CEP it was decided to move accountability for FF&E procurement away from HIQ to the Corporate Services Division (CSD) within Queensland Health, and specifically to the Chief Procurement Officer's (CPO) group. The logic for this move appears to have been that HIQ was not resourced nor appropriately skilled to undertake this major procurement task. However, the CPO's group within the CSD was also under resourced to take on this task, and has, resultantly, recruited contractors to undertake the FF&E procurement task.

Recommendation 8: Accountability and responsibility for FF&E should be moved to an appropriately skilled HIQ leadership role, and roles and responsibilities for all other FF&E tasks should be allocated on best for project approach

4.6 Major Medical Equipment (MME)

As for FF&E, the specification and procurement of MME is an essential element of health infrastructure projects.

There was little raised by the interviewees and in documents presented during the Review regarding MME, which either indicates this element of the CEP is being well managed and there are few risks or that there are latent risks that are yet to surface.

One HHS did highlight that for one CEP project that their medical imaging service was outsourced, and that the planned expansion of medical imaging in that CEP project had not properly considered this situation by understanding the commercial arrangements in place. In particular, the CEP had not appropriately consulted with the service provider and had not understood the commercial position regarding equipment provision as part of that contracted service.

Given the challenges with finalising designs and the FF&E issues set out in the preceding section and one project example, it is likely that **further investigation of the status of MME specification and procurement processes and practices is warranted.**

4.7 Risk management

HIQ and each project team has demonstrated a solid approach to capturing and reporting on risks as part of the project reporting and governance. Standard project risk templates and approach have been seen across each of the CEP projects. Individual project risks have been rolled up to a smaller number of overarching CEP risks reported to the Capital Board of Management.

CEP projects all have large numbers of risks recorded, including numerous risks rated as Very High – the highest possible risk rating against the standard consequence/likelihood matrix. This is not unusual for large and complex projects, and it appears that risk identification has been (largely) effective.

However the Review has heard through interviews and through reviewing project artefacts that many of the Very High risks have been reported for significant periods of time without sufficient action to resolve the risks. Risk registers reviewed during the Review have highlighted numerous risks where the ascribed “Critical Action / Resolution Date” has passed without adequate commentary or the risks being resolved.

Recommendation 9: Risk registers should be reviewed and updated with accurate resolution dates, or where those dates have passed without resolution the risk rating should be elevated and risk escalated to project governance.

4.8 Contract administration

Evidence from Managing Contractors was received during the Review asserting the contract chosen for this program, the onerous fortnightly reporting requirements (to HIQ) and HIQ's overall approach has required typically twice or three times the number of contract administrators than would ordinarily be required for similar projects. These additional Managing Contractor resources are factored into their price to the State for delivering the CEP.

HIQ has also stood up significant contract administration capability and procured external and embedded legal advisors. Four external legal firms have been retained to provide advice during and post the procurement of CEP projects, with overall legal spend in excess of \$5 million on what was supposed to be standardised contracts. This money has been spent, but future use of legal advisors, including embedded legal advisors will be addressed as part of Recommendation 5.

4.9 Program vs project delivery

Whilst the CEP was announced as a program, in reality, it is being run as a group of separate projects. The current organisational structure within HIQ, the scale of the projects themselves and the geographic spread of the projects makes adopting program approaches to delivery very difficult.

HIQ has attempted to provide centralised support and expertise to projects and adopt program-wide approaches, but as evidenced in preceding sections, roles and responsibilities were not clear. Functions such as the transaction management team stepped in to directly manage negotiations with builders rather than supporting each project team to drive local project ownership of outcomes. Similarly the fragmented approach to FF&E has also not delivered on the potential benefits of planning and procuring FF&E at a program level.

Through Review interviews, a number of industry participants have advocated for the adoption of a delivery partner approach to the unawarded CEP projects and/or the entire CEP. The suggested model would insert an organisation between HIQ and the construction firms charged with delivering the CEP projects.

Such a model has been used successfully to deliver projects including the new Western Sydney Airport, where the delivery partner is overseeing the two construction consortiums delivering the site infrastructure (including runways) and terminal building, respectively. With the right structure, skills and culture within HIQ, the benefits of a delivery partner can largely be achieved without procuring an additional party, and in addition, given the ongoing nature and requirement for health capital project delivery, the Review believes it is better to invest in growing capacity and capability within HIQ for the long term.

There is no doubt that the refreshed HIQ structure, with deeper commercial and project management capabilities in major projects at the leadership level will ameliorate the reasons why industry has suggested a delivery partner approach for the CEP.

5. Cost Escalations

5.1 Planning and Design

Cost escalations in the CEP commenced with the process to plan and design the projects.

5.1.1 Planning

As discussed earlier in this report, the CEP was announced following a 6-week planning exercise. Whilst well renowned and highly capable health infrastructure consultants were engaged to undertake this planning exercise, the time provided to the teams was patently insufficient to provide a level of specificity such as final scopes, considered budgets and appropriate construction timeframes.

Reference designs were established for each of the projects, and from a limited review of initial planning information that was made available to the Review, the ratios for travel and engineering were based on usual factors (circa 35%), outdoor spaces and overall grossing factors were in usual ranges.

The high-level assessments for each of the CEP projects established a planning envelope, but the level of confidence in the forecast cost for the projects would have necessarily been very low given the limited amount of planning and assessment work completed.

As such, the initial forecast costs for the projects were too preliminary to have been used as definite upper limits for the projects.

5.1.2 Site infrastructure

The Review has found that full site infrastructure assessments were not completed during the swift initial planning processes. It appears that a quick desktop review of HHS asset management plans and capital maintenance requests was undertaken, but no engagement was undertaken with relevant HHS asset management, site teams nor major service providers.

Site infrastructure typically includes:

- High voltage power supplies – typically duplicated supplies for resilience – and substations and various switchboards across a site;
- Backup power including generators and other energy storage or on-site generation;
- Potable water;
- Sewer capacity;
- Fire indicator panels;
- Fire suppression systems (including tanks where required);
- Nurse call and duress systems;
- Core telecommunications data network supplies and network distribution spaces and facilities, and
- Distributed antenna service systems.

In a normal project planning exercise for a brownfield project, an assessment of the status and nature of existing critical site infrastructure is undertaken to ensure the planned expansion can be accommodated without supplementation, replacement or upgrade. Where such upgrades are required, they are ordinarily costed and added to the proposed capital project. Such works are then often undertaken as an early works package, awarded early in the project's lifecycle as major items such as substations and switchboards can have procurement lead times well in excess of 12-18 months.

For greenfields projects the assessment typically considers the length and nature of the new service supplies required, and early engagement with the relevant provider will highlight what capacity exists in the surrounding area and what service supplementation may be required. The service provider will also provide a likely program for the works – where major upgrades in their networks are required these may require

consultation and engagement to ensure that the new hospital can, for example, be energised when ready for operation and/or construction power requirements can be provided.

High voltage requirements significantly beyond initially plans have emerged on most of the CEP projects, including not appropriately considering the need to transition off the aged low voltage power system at Queen Elizabeth II Hospital.

Greenfields CEP projects have incurred significant additional site infrastructure costs, or as yet unameliorated risks, that may give rise to additional unbudgeted expenditure:

- Bundaberg – site infrastructure works were budgeted at \$2 million and have blown out to \$23.8 million plus additional consultant fees, and
- Toowoomba – additional \$16.1 million enabling works is required for the new site

Brownfields CEP projects with site infrastructure upgrades needs include:

Site	Upgrade required	Estimated Cost	Driver
Hervey Bay Hospital	Stormwater	\$1.5m	Maintenance
Ipswich Hospital	High voltage network	\$20.0m	CEP expansion
Logan Hospital	Generators	\$8.8m	End of life assets
Mackay Hospital	Generators	\$12.0m	End of life assets
	Fire systems	\$0.3m	CEP expansion
	Chillers	\$1.0m	CEP expansion
Princess Alexandra Hospital	High voltage network	\$74.4m	End of life assets
	Generators	\$18.0m	End of life assets
	Fire systems	\$38.5m	End of life assets
	Chillers	\$42.8m	End of life assets
	Services tunnel	\$43.6m	End of life assets
The Prince Charles Hospital	High voltage network	\$9.2m	End of life assets
	High voltage network	\$4.2m	CEP expansion
	Road upgrades	\$10.0m	CEP expansion
	Communications network	\$1.5m	CEP expansion
	Communications network	\$2.2m	End of life assets
	Fire systems	\$12.0m	End of life assets
QEII Hospital	High voltage network*	\$40.0m	CEP expansion
Queensland Cancer Centre	High voltage network	\$50m+	End of life assets
	Generators	\$30m+	End of life assets
	Chillers	\$40m+	End of life assets
	Communications network	\$1m	CEP expansion
TOTAL		\$461m+	

Table 9: Site infrastructure upgrades at brownfields CEP project sites

* An additional project is being scoped by the HHS to address end of life HV and LV electrical asset replacement at QEII. This does not impact the CEP project completion.

This additional \$461 million is not presently reflected in the CEP project cost forecasts, but the infrastructure upgrades will be required to allow CEP projects to progress.

5.1.3 Site conditions

For both existing and new sites, assessments of ground conditions and soil contaminants, heritage and archaeological reviews and assessments of significant flora and fauna are usually undertaken as part of the project planning process. Heritage and archaeological assessments can be desktop reviews and should ordinarily establish a risk assessment and unexpected finds protocols. This allows for appropriate budget allocations in the proposed project to manage and resolve all of these potential site complications.

It appears that site conditions were not appropriately scoped in the initial planning process, appropriate risk assessments were not done, and significant additional costs and project delays have been incurred to resolve site conditions, deal with soil contamination including asbestos, significant trees and cultural heritage artifacts. These have arisen at:

- Townsville – approximately \$714k to remove asbestos containing material and address ground conditions on the site, and
- Mackay – cultural heritage finds and ground conditions have elongated the project with a combined impact in excess of \$87m.

5.2 Scope change management

Initial planning was done using central clinical service planning data to establish priorities and without HHS consultation. As set out in the individual project sections later in this report, there are substantial clinical scope items that remain out of scope and unfunded in the CEP projects.

The awarded projects included the so-called “Support Services” additions – these elements were core elements that should have been included in the original project scope and have added significant cost escalations to the CEP projects.

On top of these support services, awarded projects have each included clinical scope items that were not in the original planned projects. Similarly, unawarded projects also have significant additional clinical scope items that are driving project forecast costs substantially above original project budgets.

The Review has reviewed project artefacts and each CEP project has scope items that are recorded in a “scope ladder” – items of clinical scope desired by the HHS and/or clinical leadership that are presently not included in the scope of delivery of the project or the project’s budget.

The processes for allocation of project contingency have been used throughout the CEP to manage risks and include essential scope changes that have gone through project governance – briefs requesting allocation of contingency to essential scope changes have been prepared and put to project governance forums for approval. Some HHSs have expressed disquiet to the Review that they did not feel appropriately consulted or that they were adequately driving these processes and were unable to request scope changes that were not agreed by HIQ. Examples were provided where HHS proposals were not presented to project governance where HIQ did not agree with the proposed change, rather than allowing the proposal to be presented to project governance and appropriately debated in the governance forum. This has driven discord and significant disagreements between HIQ and HHS project teams and executives. **Whilst projects will always have limited ability to absorb scope changes and there will be differences of opinions regarding various scope change matters, more transparent and collaborative practices would normally allow project governance to make these decisions.**

There are also examples provided to the Review where HHSs wanted to swap clinical areas from announced elements to other services that were, in their view, higher priority. These changes were declined through project governance and HIQ as they did not accord with announced scope and changes of scope could not be accommodated within the (then) tight project timeframes.

As set out for all of the unawarded projects, there is now an opportunity to review the proposed clinical scopes for each project and ensure that contemporary priorities are being delivered and also to assess project staging opportunities.

5.3 Industry Capacity and Market Conditions

As noted in the discussion of the procurement strategy for the CEP above and in each project assessment later in this report, construction industry capacity is a major contributor to the cost overruns in awarded CEP projects and in forecasts for unawarded CEP projects.

Whilst the desire to rapidly commence substantial health infrastructure projects was admirable, attempting to do so in the face of the then, and continuing, construction industry constraints was unlikely to mean projects would be delivered on time or on budget.

5.3.1 Capacity modelling

National industry capacity was highly constrained at the time of CEP procurement, and local market conditions in Queensland presented further constraints. Analysis of health infrastructure industry capacity and capability was detailed in a report released in October 2024 by Infrastructure Partnerships Australia (IPA)⁸. This report was developed through industry consultation and collaboration with State and Territory health infrastructure delivery agencies during 2024. HIQ elected not to participate in this exercise and was overtly dismissive of the process and findings of the report.

The IPA report assessed each public hospital infrastructure project in Australia over \$100 million and used a trade demand model developed with several major construction firms that are IPA members (and delivering CEP projects) to assess specific health infrastructure trade requirements per month. The model used publicly available information for the CEP including announced budgets and delivery timeframes. Clearly the information now available to this Review illustrates those budgets and delivery timeframes were inaccurate.

This analysis highlighted that for the whole of Australia, there needed to be a 150% increase in skilled trades.

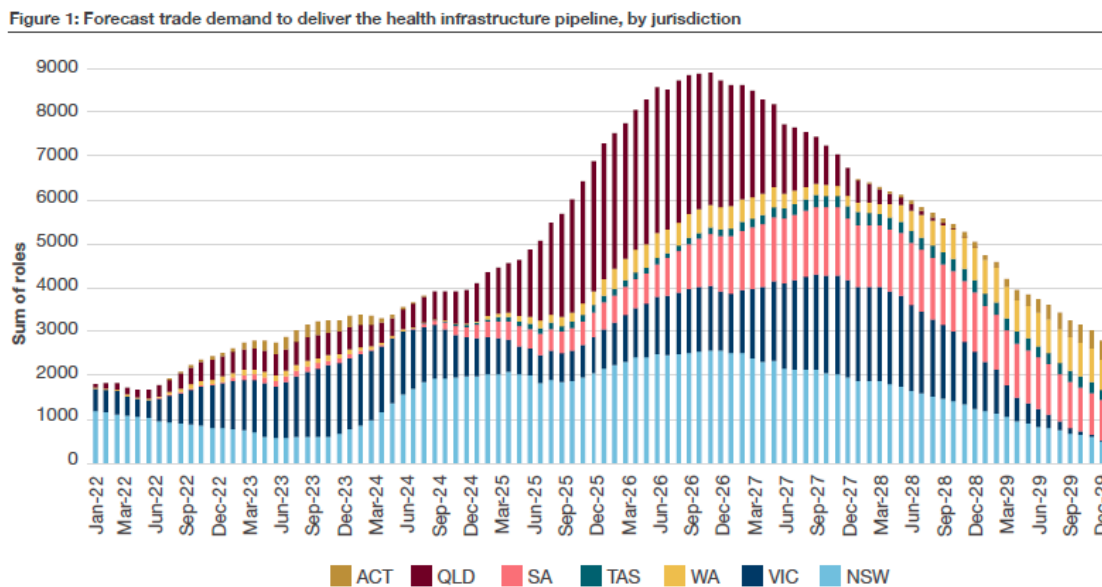


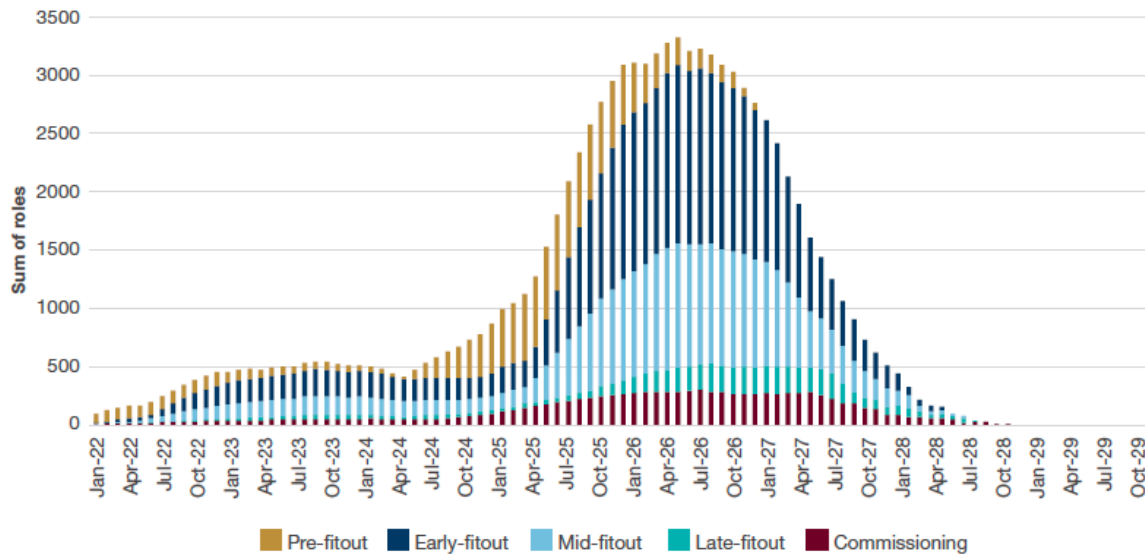
Figure 9: Forecast trade demand to deliver health infrastructure pipeline, by jurisdiction

As can be seen in Figure 9, Queensland’s CEP plays a part of the overall national trade requirement. The report highlighted that (based on the then publicly available information) for Queensland, the CEP was driving a

⁸ Klok Advisory was engaged by IPA to assist in the development of this report and leading the industry and delivery agency collaboration

requirement for a 604% growth in trade resources. This growth requirement was the most rapid and sharpest sloped uptick in resource requirements in the country, as can be seen in Figure 10 below.

Figure 17: Queensland health infrastructure trade demand, by project phase



Source: Infrastructure Partnerships Australia

Figure 10: Queensland health infrastructure trade demand, by project phase

The IPA modelling, with the information now available to this Review, would see the resource requirements elongate and lift due to the productivity constraints evidenced in this Review.

5.3.2 CEP Procurement Strategy

The CEP procurement strategy compounded industry capacity constraints and did not provide the market competition that was repeatedly stated by HIQ.

Attempting to procure all CEP projects at once using the two stage MC contract approach meant that:

- Managing contractors were bidding multiple projects at once – using limited pre-contract bid teams and expending limited bid budgets;
- Design consultants (architects, engineers and other technical specialists) were part of multiple MC bid teams across multiple projects – as noted elsewhere, this meant that some consultants ended up being overloaded whilst others who had capability missed out on work. The practical implications of this situation were presented to the Review by the consulting industry – there was high mobility of consultant firm staff away from those firms that were not successful in bids to those that had won work. Whilst this is rational on the part of the individuals, it meant that sometimes long-term employees of design firms were forced to move employers as a result of the CEP procurement process;
- Scarce (and even scarcer prequalified) subcontractors were bidding multiple projects at once and in many circumstances, this meant that through sheer lack of resources, subcontractors were unable (or unwilling) to respond to all MC requests to price subcontract work packages – this meant that MCs often were faced with limited or single subcontract pricing, and
- Contractual risk allocations were also unwelcomed by the subcontract market – some major national subcontractors declined to price trade packages given the risk allocations required for the CEP.

Each individual project assessment in this report highlights the realities of subtrade availability and the pricing implications of the chosen CEP procurement strategy.

5.3.3 Market conditions

During the Review, several MCs provided insights into the market conditions that existed at the time of the CEP procurement and continue to today.

Of particular relevance, there were a number of substantial non-health sector construction projects in Queensland that were in-flight or just completing where the MCs and subcontractors were losing substantial amounts of money. These non-health projects had been priced and contracted on a fixed price basis before the rampant price escalation came to fruition in Queensland, and the productivity and other risks that had crystallised on these projects led Boards and executives at construction firms to view Queensland jobs in a new light.

These non-health sector factors did have a significant bearing on CEP pricing from the market – risks that had crystallised in the same market cost these firms substantial amounts of money and internal governance processes within industry required heightened risk pricing allocations for CEP.

For some reason the cost plans prepared for the CEP did not adequately incorporate the implications these market conditions, and did not appropriately price the CEP projects during the initial planning process. HIQ had engaged external cost planners to provide this advice but it is unclear to the Review why market conditions were not priced into the planned CEP projects – industry seems to have been widely and openly aware of the specific cost challenges in Queensland, and as such, these factors ought to have been included in initial CEP project pricing.

5.4 Best Practice Industry Conditions policy

The lack of industry capacity was compounded by the previous policy requirements for both Managing Contractors and subcontractors to be pre-qualified under the Best Practice Policy (BPP) and to adopt the now suspended Best Practice Industry Conditions (BPICs).

The direct implication of these policies meant that:

- Not all MCs were prequalified when procurement commenced, though as noted elsewhere in this report, Government allowed MCs to proceed into procurement processes provided they had commenced pre-qualification;
- Not all health infrastructure subcontractors were prequalified and could not be considered by MCs to request trade package pricing, and
- Not all health infrastructure subcontractors were prepared to participate in the CEP or work in health infrastructure projects in Queensland.

Just one example of the implication of subcontractors not being willing to price CEP projects illustrates that a saving of around 25% in a major trade package (circa \$50 million saving) was unable to be secured from a subcontractor who was unwilling to previously participate in the CEP. That subcontractor has now provided the MC with indicative pricing that would be available under the current policy settings and revised risk allocations.

The BPICs policy required MCs to enter Enterprise Bargaining Agreements (**EBAs**) that reflected the requirements set out in BPICs. All awarded CEP project MCs have EBAs or other industrial arrangements that satisfied this policy requirement, and these arrangements run until 2026-27. The BPICs conditions that are embedded in these EBAs have been the subject of other commentary following the change of Government in Queensland in late 2024, and the new Government has now suspended BPICs requirements.

Anecdotal evidence presented to the Review by multiple interviewees suggests that the pre-qualification of MCs and subcontractors, and the intended financial health assessments, hasn't lowered insolvency rates for construction sector businesses in Queensland. It was asserted by these interviewees that in fact the volume of insolvencies in Queensland is higher than in other jurisdictions and the financial and security obligations (see more on this in section 7.2.4) are putting off prospective multinational contractors coming to Queensland.

Evidence provided to the Review illustrates that the major impact arising from BPICs is on-site productivity being around 20% lower than in other Australian jurisdictions. The various arrangements result in fewer working days per week across the CEP projects producing longer project durations and resulting higher costs for the CEP projects. Graphically, a comparison of prospective working days is at Figure 11, showing working days in Queensland at 229 days per year:

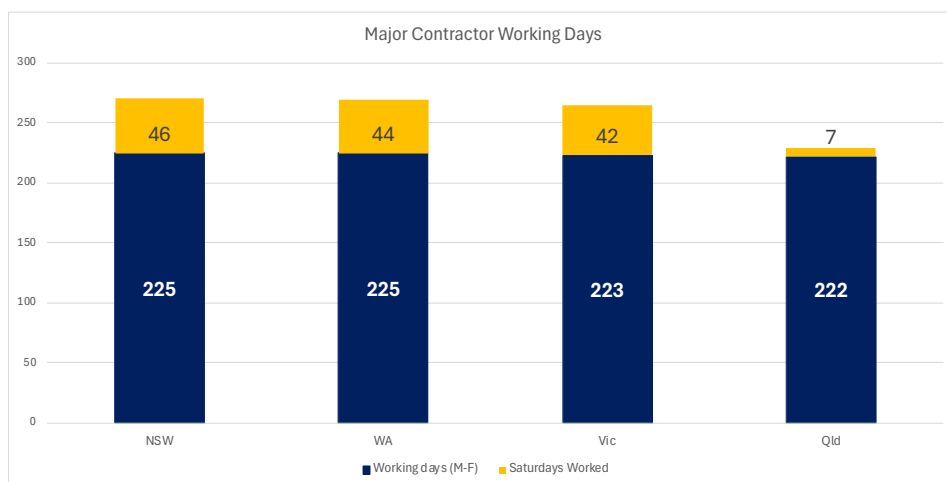


Figure 11: National major contractor prospective working days analysis

Actual days worked is reduced by a range of weather and other events encapsulated in industrial agreements, including wet weather, heat and electrical storms.

Additional costs are seen in the direct subcontract trade package prices which sourced by the MCs, and then additional MC preliminaries and overheads are incurred as a result of project durations being 20% longer than might otherwise be. One industry association has described cost increases from BPICs were 70% attributable to productivity and 30% attributable to wages.

For example, on Bundaberg, the current MC estimates that this pre-qualification and productivity challenge represent approximately \$135.6 million of additional cost.

The Review understands that the new Government is establishing a Queensland Productivity Commission and this Review strongly suggests that construction sector productivity and insolvency rates be an early area for review by this new Commission.

6. Stakeholder Engagement

6.1 Effectiveness of stakeholder engagement

The very nature of the planning and announcement of the CEP set a tone and pathway for complex stakeholder engagement, with a highly centralised control and decision-making framework established by the previous Queensland Health leadership for the program. This inherently **set the program off on a confrontational engagement basis rather than a collaborative basis, and HHSs were not viewed as clients of the central delivery agency.**

As discussed in previous sections of this report, HIQ was highly dismissive of industry and other Queensland Government feedback on the procurement strategy.

Notwithstanding the kick-off point for the CEP, the ongoing management of the program by HIQ has largely reinforced and continued this forceful approach to engagement with HHSs.

6.2 HHS & Clinical Engagement

The Independent Reviewer has met with each HHS CEO and where appropriate, their infrastructure, maintenance and capital team leads.

For most CEP project HHSs, the themes emerging from the interviews was consistent, with feedback from West Moreton HHS being notably different (in a positive sense) from all others.

The consistent themes emerging are:

- the CEP projects were being done “to” HHSs rather than “with” the local health teams;
- HHSs requests and clinical inputs have been largely dismissed where they didn’t accord with the project timeframes, scope and budget;
- HHSs have felt they have been blamed for project scope changes and requests rather than being viewed as being the clinical and operational experts in each local area;
- HHSs raising fitness for purpose concerns for the proposed projects have been dismissed;
- Standardised rooms were used as a mechanism to (attempt) to limit the normal project development consultation undertaken with health service clinicians and executives;
- Time and project programs plus announced project scope triumphed over all other aspects of usual project governance;
- Commercial matters and project financial positions were not shared with HHS executives – there were repeated examples where HHS CEOs were unaware of current forecast costs for CEP projects in their HHS as these items were excluded from project reports provided to the HHS;
- CEP budget allocations for HHS project resources have been inadequate, and as project timeframes have elongated, HHSs are struggling to reconcile fixed budget allocations with the requirement to pay HHS side project teams for a longer period of time than planned, and
- Conversely, HHSs queried the cost base and project charges added to projects by HIQ.

West Moreton HHS’s project at Ipswich appears to be operating with a more collaborative “one team” approach, with HIQ and HHS teams physically co-located and project leaders operating in the same office space. As recommended in the project specific review for that project, the lessons learned at Ipswich on project culture and collaboration should be replicated across the CEP and HIQ.

6.3 Industry Engagement

During the Review, interviews were held with a wide range of industry participants including the MCs, subcontractors, consultants, project managers and industry associations. The consistent themes emerging from industry engagement are:

- Industry has scaled up and stepped up to assist Queensland deliver the CEP;
- MCs and their design consultant teams have provided the substantial resources required to plan, design and deliver the CEP projects;
- MCs and their design consultant teams have, as a result of these resource allocations, declined to participate in other project bids in Queensland and elsewhere, and Boards and leaders of these firms are apprehensive about this Review and any potential project cancellations – such cancellations would have significant repercussions with the loss of potential revenues from CEP projects and previous decisions to prioritise CEP over other opportunities;
- As documented elsewhere in this Report, risk allocations in the MC contract are problematic and are outside of prevailing market conditions and other jurisdiction's approaches to contracting major projects. Without exception, MCs interviewed as part of the Review were willing to review risk allocations with Government and (transparently) share in the savings available;
- Some MCs and some subcontractors have also indicated that the national health infrastructure market has softened and with changed risk allocations and BPICs suspension, there may be an opportunity to bring additional subcontractors and resources to deliver the CEP – additional competition for subcontract trade packages may provide cost savings where works are not already let;
- A few industry participants suggested that subcontract trade packages were priced assuming a boom across all construction sectors in Queensland, however projects have either not proceeded, are delayed or market conditions have changed. As a result, some subcontractors in Queensland may have capacity and resource availability they did not anticipate at the time of pricing CEP projects. For unawarded projects, this presents an opportunity to drive savings in trade packages;
- HIQ has not historically operated in a collaborative and cooperative manner, and has viewed industry with a high degree of scepticism, has not listened to feedback and suggestions from MCs on a wide range of issues;
- Where HIQ did bring MCs together in a builders' forum, it opened up the opportunity for MCs to raise risks that ultimately were reflected back in risk pricing for projects;
- HIQ has not operated in a commercially savvy manner with industry, has not demonstrated the partnering approach that is contractually enshrined in the two stage MC contract and has demonstrated a lack of experience administering the MC contract and managing projects as large and complex as the CEP projects. Contract administration and reporting requirements have been implemented in many circumstances in a heavy-handed manner, and
- HIQ has not understood that the MCs and subcontractors operate in a national market and have true choice in the clients they choose to work for, and HIQ behaviours, culture and lack of commerciality have damaged the reputation of Queensland Health as a client.

Whilst some industry feedback needs to be considered with a grain of salt, the core themes illustrate that the refreshed HIQ leadership and culture must work with industry in a partnering and collaborative manner. HIQ needs to be of clear mind that industry has a choice as to which projects they elect to work on, and Queensland needs to compete with other jurisdictions and sectors to restore industry confidence and be a client of choice.

6.4 Consideration and adoption of prior external advice on program frailty

Throughout the Review, a very wide range of interviewees provided consistent feedback that previous HIQ leadership was unable to action the advice that was provided illustrating that the chosen procurement approach, risk allocations, announced project durations and budgets were all frail assumptions. It appears that HIQ was placed in an invidious situation, where it was obliged to deliver projects to the announced budgets, scope and timeframes, and that deviations from those announced targets were problematic and unacceptable.

Clearly some movement on these matters was endorsed with the additional budget allocations approved to allow for the Stage 2 awarded contracts to proceed, but the overall environment that was created within which to deliver such a complex program was not conducive to a highly collaborative and partnering approach.

7. Lessons Learned

7.1 Key lessons from the CEP and other comparable health infrastructure programs

7.1.1 Ongoing Capital Program versus Sporadic Capital

Queensland Health’s building stock of hospitals, sub-acute facilities, ambulance stations, plant and equipment and other facilities has a gross balance sheet value of \$27.82 billion as at 30 June 2024⁹, and Queensland Health has adopted a typical useful life for buildings of up to 51 years (with some exceptions up to 105 years), whilst HHSs have adopted useful lives of up to 80 years. Plant and equipment typical useful life is set by the Department up to 26 years whilst HHSs have estimate useful lives of up to 30 years.

The written down value of Health’s building and plant and equipment assets is \$14.79 billion¹⁰ with accumulated depreciation of \$13.03 billion or approximately 47% of the gross value of the assets.

\$ billion	Buildings (A)	Plant & Equipment (B)	Sum (A)+(B)	Land	WIP	Revaluations
Gross value	24.55	3.27	27.82	1.76	0.99	1.62
Accumulated depreciation	(11.19)	(1.84)	(13.03)	-	-	
Carrying amount	13.36	1.44	14.79	1.76	0.99	

Table 10: Queensland Health balance sheet analysis for infrastructure

Whilst it is often possible to use hospitals and other health facilities for many years beyond 50-51 years (or up to 80 years as is used by some HHS for accounting purposes), it is better practice to develop a capital replacement program that progressively and programmatically replaces assets at the end of their actual useful life. In addition, improvements and innovations in clinical service delivery will require replacement or refurbishment of facilities potentially well ahead of their accounting and/or useful life.

Accounting for public hospital buildings typically uses a valuation regime recognising that these assets are not typically tradeable and that replacement costs will be significantly higher than historical costs of the existing building stock. As such the Department and HHSs have booked \$1.62 billion of upwards asset revaluations as at 30 June 2024, with around 30% or \$489 million of this amount at the Sunshine Coast HHS alone. These asset revaluations are incorporated in the buildings and land elements of the financial statements.

The Queensland Audit Office’s report on Health’s financial reports for 2024 suggest that

... approximately 37.4 percent (\$8.7 billion) of buildings currently owned by the Department of Health ... and the 16 hospital and health services (HHSs) are due to be replaced within the next 10 years. This is based on their recorded remaining useful lives ...¹¹

These figures indicate that Queensland’s hospitals and other health buildings are nearly halfway through their useful life and that this is likely to be an understatement as (upwards) revaluations are likely to be skewed by newer and larger facilities (hence the fact that circa 30% of the revaluation was at the Sunshine Coast HHS). Of course, there are also many buildings which are much older than the 50-51 years in the Department’s accounts and likely to be now fully written off for accounting purposes. These simplistic calculations indicate why the CEP and future significant capital replacement funding is required and ignores future new capital requirements driven by population growth, an ageing population and changes in clinical models of care.

⁹ Source – Department of Health 2023-24 Financial Statements, note 16 and individual HHS 2023-24 Financial statements in various notes – Klok Advisory analysis

¹⁰ ditto

¹¹ Queensland Audit Office – Financial Audit Report Health 2024 (Report 8: 2024-25) published 15 January 2025, page 22

Plant and equipment is a very broad asset class that encompasses assets with accounting lives ranging from 3 to 30 years in HHS accounts, and as can be seen in the table above, accumulated depreciation is approximately 56% of the gross value. In crude terms this means that plant & equipment across Queensland Health is more than halfway through its useful life. However anecdotal evidence provided to this Review indicates that many items of plant and equipment are well beyond their useful life and have been fully depreciated for many years.

As such adequate future capital allocations to replacing plant and equipment need to be provisioned in future capital maintenance budgets to proactively replace ageing plant and equipment before heightened break/fix expenditure in the final years of (accounting) useful life is reached. This topic is covered in more detail in the Sustaining Capital Program chapter of this report.

Lastly, Work In Progress (WIP in the table above) illustrates the collective value of health infrastructure projects that were in progress as at 30 June 2024 across HIQ and HHSs.

The NSW Audit Office has previously used the capital replacement ratio as a performance metric to assess whether NSW Health is adequately funded to replace ageing hospitals and health assets. The capital replacement ratio takes the investment in new assets divided by depreciation to provide a ratio – if greater than one then there are more replacements than depreciation and hence net asset creation. If less than one there are fewer replacements than depreciation. Applying this formula to 2023-24 results for Queensland Health:

$$\frac{\text{Actual Capital Expenditure}}{\text{Depreciation}} = \frac{\$2.13 \text{ billion}}{\$1.18 \text{ billion}} = 1.79^{12}$$

This indicates that for 2023-24 there were more assets replaced or renewed than depreciation. This ratio may, however, be skewed by the high volume of fully depreciated assets across Queensland Health. Where previous capital expenditure was around one tenth or less and assuming depreciation has remained static, then for the lowest capital allocation year of 2017-18 the ratio would be 0.10. Even if depreciation was half the current year's value, the ratio would have been 0.20 – both figures represent a significant lack of asset replacement.

Table 11 below illustrates the Queensland budget allocations to Queensland Health for property, plant and equipment acquisitions – these figures include Queensland Health, Queensland Ambulance and associated Commissions, Offices and research entities. The Queensland Health and Hospital Plan 2022-23 notes that in “2015, there have been 1,350 new beds delivered across Queensland”¹³ with a large number of these at projects such as the Sunshine Coast University Hospital.

Financial year	Capital allocation \$m	Comments
2015-16	824.327	Includes \$488.7 million for Sunshine Coast University Hospital
2016-17	889.571	Includes \$627.0 million for Sunshine Coast University Hospital
2017-18	117.859	
2018-19	179.777	
2019-20	376.254	
2020-21	1,624.945	Includes \$532 million for STARS lease at Metro North
2021-22	1,096.160	
2022-23	1,293.272	includes \$25.3 million for CEP
2023-24	1,425.052	includes \$414.56 million for CEP
2024-25	2,145.644	includes \$1,152.351 million for CEP

Table 11: Queensland Health Capital allocations 2015-2025 – Source: Queensland Treasury – Budget Paper 3 for each year

¹² Data provided by Queensland Health Finance Branch, 25 February 2025

¹³ Queensland Health and Hospitals Plan 2022-23 page 7

As can be seen from this table, there has been a significant increase in capital allocated to health from 2020-21, stepping up significantly from the previous years. The 2020-21 year includes a significant lump sum accounting for the future lease of the STARS building at Herston Quarter in the Metro North HHS – even though the lease payments will be made over the life of the lease.

If Sunshine Coast University Hospital PPP is excluded from the early years, the average capital allocation between 2015-16 and 2019-20 was \$262m, and as can be seen the very low level of investment in 2017-28 through to the increase in 2020-21 has left a backlog of renewal and replacements. Had a more consistent capital allocation been provided over a medium term, the \$9.75 billion for CEP could have been delivered earlier and evenly over preceding years.

The CEP exemplifies the challenges that emerge when capital is only sporadically allocated to refreshing health infrastructure in a State. Health service delivery in any jurisdiction requires ongoing investment in new and refreshed health and hospital buildings and facilities, and along with annual operating funding to deliver services, an annual allocation of capital for replacement and refurbishment should be provided. This **regular provision of capital reduces the mind set of feast and famine**, in which health infrastructure projects end up being larger than they should be because there is no certainty of future allocations – leaders rationally plan for the biggest amount of space to be built when sporadic capital arrives, as there is no belief future capital will be allocated when required.

Whilst Government finances are planned for a typical 4 year forward estimates period, medium term capital planning will allow Treasury and Health to develop a 10-year health capital envelope. This envelope can establish detailed annual allocations over the forward estimates period and estimated allocations beyond the forward estimates. Such an approach will allow Government to have greater understanding of Health's medium term capital requirements

Recommendation 10: Health and Treasury, with the support of DPC, should develop a medium term (10 year) health capital envelope and an annual planning process to refresh priorities within that 10-year envelope

7.1.2 Appropriate Planning Budget Allocation for Future Capital Projects

The 2022-23 Queensland budget included \$21.8 million for business case development, followed by \$9.9 million in 2023-24, but there was no business case development funding provided in 2024-25.

To prevent a reoccurrence of the issues with planning for the CEP, HIQ should receive an annual allocation to properly plan future projects and develop investment decision cases for presentation in future budget processes to seek Government approvals for investment. **Without a specific planning funding allocation and without appropriate planning being undertaken, there is a risk that future investment decisions will not be based on appropriate planning work.**

For clarity, it is not necessary to fully design a prospective project for the purposes of investment decisions, however a short form investment decision template can set out the necessary elements to be considered prior to seeking approvals. Typical elements that should be included in such a template include:

- Clinical service planning and (agreed) population and demographic data agreed between the Department and relevant HHS;
- Clinical service demand volumes arising from the clinical service plan for the facility;
- Schedule of accommodation derived from the clinical planning – including all of the necessary supporting services and infrastructure and evidence of clinical engagement and endorsement;
- Updated masterplan for existing sites, and initial masterplan for new hospitals;
- For brownfields projects a detailed site analysis including ground conditions, hazardous materials, engineering assessments and assumptions for integrating new development into existing building stock – requires strong engagement with the relevant HHS;
- For greenfields projects a detailed site analysis including ground conditions, hazardous materials, engineering assessments and assumptions for services connections/siting;
- High level of block and stack for the project, demonstrating critical clinical adjacencies;
- Assessment of construction market conditions;
- Risk assessments;
- Procurement strategy and proposed go-to-market strategy, risk allocations and proposed contracting form for the project;
- Likely program, and
- Likely budget (at an agreed level of specificity) and contingency allocations.

Queensland Health does have a business case fund that is intended to be an ongoing feature of health infrastructure planning. This fund is to be used to fund the development of business cases and as projects are funded/approved, the planning moneys expended are to be replenished as part of the specific project funding. The budget allocation for this planning fund is presently set out in Table 12.

\$m	2024-25	2025-26	2026-27	2027-28	2028-29	Total
Business Case Program	28.644	16.570	12.855	14.754	0.800	73.623

Table 12: Business case program funding

Recommendation 11: Future budgets should continue to allocate planning budget for HIQ to undertake industry standard health infrastructure project planning to ensure appropriate project scopes, budgets and programs are established prior to Government approval for the project being sought.

Funding available in 2024-25 should be applied to the replanning of unawarded CEP projects

7.2 Other practical recommendations

7.2.1 Program Benefit – Common Value Management

As noted above, the CEP has been run as a bundle of individual projects rather than truly operating as a program. In the future, the benefit of running the CEP as a program should include:

- Value management – don't pay MCs and consultants individually to work up value management items for each and every project – if teams have agreed a value management item on one project it should be promulgated across the program;
- Commercial and contract management – similarly, where commercial positions or contract management improvements are arrived at on one project, they should be shared across the program;
- Design innovations – again, design innovations should be shared across the program, and
- Collaboration and engagement successes – the positive working relationships at Ipswich have been created by a range of positive factors that were established by the HHS and HIQ leaders – those successes should be shared across the program.

Recommendation 12: HIQ should assess all per-project endorsed value management items for those items that can be shared program-wide and seek to have those value management opportunities delivered on each project within the CEP

7.2.2 Program Management – Comparison of Design Efficiencies, FF&E Planning and Ownership of dRofus Models

Managing Contractors and their design consultant partners have all implemented the industry standard dRofus suite to assist with management of design and procurement of FF&E. However the dRofus software, if appropriately implemented and data ownership clarified, could be being used by HIQ to better manage the efficiency of the designs planned or being built. And in particular, HIQ could benefit from having transparent access to designs as they evolve to:

- measure the performance of different design teams;
- assess the efficiency and effectiveness of the designs;
- assess travel and engineering allocations for each project and across the program;
- assess grossing factors being used to translate clinical areas to gross building areas, and
- assess as-built drawings (or issued for construction drawings) against approved designs to assess variances.

Recommendation 13: dRofus database needs to be owned by the State not contractors and be proactively used to manage the performance of design teams and assessment of as-built drawings against signed off designs

7.2.3 Program Contract Works Insurances

During the Review, several Managing Contractors highlighted the significant increases (circa 20%) in the cost of contract works insurance during the procurement of the CEP. Contract works insurance is a very normal requirement of construction contracts, but at the scale of CEP projects policies that are factored on a percentage of the contract value plus the increase in the premium rate has seen an escalation in the insurance cost for these works. This cost is a contractors cost that is charged back to the project plus contractor margin.

Other jurisdictions, including NSW, have offered client-supplied works insurances for capital projects, and the buying power of the State, arranged through the State Government's broader insurance program may yield cost savings to the CEP.

Recommendation 14: HIQ should investigate the opportunity to secure a client-side contract works insurance policy to apply to the CEP and remove this requirement from Managing Contractors

7.2.4 Bank Guarantees

The two-stage Managing Contractor contract sets out obligations on the contractor to provide security guarantees and performance undertakings to ensure

... the due and proper performance of the Contract and for the purpose of providing security of payment to the Subcontractors of the Managing Contractor.¹⁴

The contract goes on to specify the form and nature of the security, retentions and the right of the State to dictate the form of the undertakings. The contract and annexures operate to impose a requirement for CEP projects of a total bank guarantee of 5% of the Project Construction Cost Estimate and further specify that this is provided in two 2.5% guarantees.

These security guarantees have the following characteristics:

- Come with costs for the contractor to establish – which are passed back to the State, plus builder's margin, through the construction price – the State is paying for the guarantee plus margin;
- Typically require the contractor to deposit cash to back the entire value of the guarantee – the cost of this capital to the construction business is also factored into the construction price to the State;
- Previously such security could be more readily provided in the form of an insurance bond (at a lower cost than a bank-provided) guarantee but the market for such bonds has shrunk – contractors still favour bonds as they do not require the cash backing required with bank guarantees;
- Provide little actual security for the State – by the time the State is contemplating issues with a contractor on a problematic project, the extent of the financial implications are likely to be significantly more than the 5% guarantee, and with the significant costs for subtrades, a 5% retention is a tiny fraction of the overall trade values;
- Withholding or calling on guarantees is rarely a simple and uncontested by the construction firm and/or the bank, and
- Withholding or calling on guarantees has rarely been done in other health infrastructure projects around the country.

Recommendation 15: Government should consider whether the obligation for contractors to provide bank guarantees is providing the actual security sought, and whether the removal of this obligation is better value for money as a result of reductions in the overall cost of projects to the State and reduces red tape for industry

¹⁴ Two Stage Managing Contractor contract for Logan Hospital Expansion Project clause 9.1

7.3 Mater South Brisbane

During the Review interviews, it became apparent that none of QH's current capital programs are made available to Mater's South Brisbane hospital. This hospital is, in effect, a public hospital operated by Mater under an activity-based funding basis with performance obligations and a service agreement like other peer level 5/6 facilities. The Mater South Brisbane operates largely level 5 services and some level 6 services such as neonatal intensive care.

Given the nature of this facility, it should be included in future capital planning allocations.

7.4 Leased Spaces – Clinical and Non-clinical

Throughout the Review it became apparent that Queensland Health entities are leasing very substantial volumes of property for both clinical and non-clinical uses. The historic reasons for leasing space have been explained as being a response to a lack of capital budgets to acquire new Government owned buildings, provision of some public health and ambulatory clinical spaces closer to the communities they serve and accommodating growth requirements for HHSs in a non-capital solution manner. Leased spaces exist across the State – not just in metropolitan Brisbane.

However, it appears that property leasing has been executed in a sporadic and non-system wide manner, resulting in many HHSs having substantial portfolios of small leased spaces in and around hospital sites. As a result, there will be significant inefficiency and duplication derived from multiple small leased spaces – duplicated meeting spaces, kitchens, bathrooms and other generic support spaces will each be being leased rather than an efficient non-duplicated approach being taken. This is a product of low availability of larger leased spaces and an inability to provide lease pre-commitments that would allow for a single, larger and more efficient building to be delivered.

For example, the Review was made aware that one metropolitan HHS is leasing more than 28,000m² of space across a large volume of small spaces, paying rents for some space in excess of \$800 per square metre. A high level assessment is that applying a 10-15% efficiency dividend to remove duplicate spaces would leave a requirement for between 23,800 and 25,200m² – at an average \$800 per m² this efficiency dividend would save at least \$2.24 million per annum. However, this volume of space, if provided as a single pre-commit from Government, would be more than sufficient to have a single development built near the hospital campus. The process to progress such a development has commenced on a number of previous occasions, but for various reasons was stopped.

As such, it is clear there are opportunities to rationalise off-campus lease spaces and save substantial amounts of money that can be reapplied to clinical service delivery. A State-wide leased space discovery process should be commissioned, and opportunities to aggregate spaces, including the development of purpose-built facilities funded through private capital and leased back to HHSs should be explored.

Recommendation 16: A State-wide leased space discovery process should be commissioned, and opportunities to aggregate spaces, including investigating the opportunities for development of purpose-built facilities funded through private capital and leased back to HHSs (or other funding models) should be explored.

8. Project Specific Commentary and Recommendations – Stage 1 Projects/Unawarded Projects

This section of the report covers the CEP projects that are yet to be awarded and the now terminated MC contract at Townsville.

8.1 Bundaberg Hospital

8.1.1 Project Fast Facts

Announced Scope	Greenfields new hospital 320 overnight beds. Additional operating theatres, ED treatment spaces and outpatient consult areas Expanded medical imaging, pharmacy and pathology Expansion of education & training and support services
Funding announced	21 June 2022
Original budget	\$1.2 billion
Current HIQ forecast	\$2.306 billion
Funding gap	\$1.106 billion
Announced practical completion	Second half 2027
Forecast practical completion	At the earliest first half 2029
Early works start	May 2024
Stage 1 contractor	CPB
Design status	Schematic design completed 15 Feb 2024 80% detailed design completed 14 June 2024
HHS	Wide Bay HHS

8.1.2 Current Project Status & Issues

The currently scoped project builds the announced clinical scope on a new site approximately 4 kilometres inland from the current Bundaberg Hospital, with 4 of the required 6 land acquisitions completed. The site was acquired as a result of the HHS-developed detailed business case for a single-stage construction of a wholly new hospital on a new site. That detailed business case was completed in June 2021, and was used as an input into the CEP planning process in March 2022 that ultimately resulted in the two-site strategy project announcement rather than a single site.

Planning for the project has progressed since the project was awarded to CPB Contractors on 6 July 2023.

In addition, several approvals have been secured:

- Ministerial Infrastructure Designation – 28 February 2024;
- Cultural Heritage Management Agreement – 21 March 2024, and
- Bundaberg Regional Council has approved transfer of civic and infrastructure assets to them on completion of the project.

However the Federal Government’s *EPBC* offset management plan is required before any vertical construction works can be undertaken on the new site.

Design is substantially complete, with the 100% design development report originally targeted for completion on 21 February 2025. Multiple rounds of project user groups have been undertaken with the HHS and clinicians through schematic design and detailed design development. Challenges through the design process and user engagement are evident, particularly with standardised room designs, the seismic design requirements and the cyclone rating and impact resistance requirements from HIQ. HIQ’s original planned standardised rooms was established to significantly reduce the number of user group meetings and design reviews, but actual project engagement has now totalled over 230 separate HHS and clinical project user groups – this is a significant additional effort that gave rise to a circa \$7 million variance from the originally tendered design consultancy fee.

Overall management of scope and size of the hospital has remained a challenge, with substantial variances between the schedule of accommodation (**SoA** – the clinical spatial requirements) and the drawn outcomes. The HIQ PVR set out a schedule of accommodation requiring 60,540m² but when drawn translated to 64,095m². During design development additional and new requirements (including the debris rating) have added space to the project, such that the 100% design development schedule of accommodation has grown to 62,800m² while the drawn area is now 66,283m². In tabular form:

SoA Movement: Sep 23 to Current

Concept Design:	Prioritised Schematic Design:	Schematic Design (CPB):	Developed Design (CPB):
<ul style="list-style-type: none"> • SoA = 60,541 • Drawn = 64,095 • Delta = 3,554 • Drawn Increases over SoA: <ul style="list-style-type: none"> • Outdoor Areas +2276m² • Misc. Areas +177m² • FSC +1,101m² • Non-Compliances Improved • Services Areas Increased • Outdoor Areas Added • SoA T&E Calc ~34% • Drawn T&E Calc ~35% 	<ul style="list-style-type: none"> • SoA = 60,692 • Drawn = 66,997 • Delta = 6,305 • Drawn Increases CD v PSD: <ul style="list-style-type: none"> • Increased Drawn Areas <ul style="list-style-type: none"> • ED +363m² • Wards +300m² • Theatres +263m² • Outdoor Areas +684m² • Misc. Areas +1,204m² • FSC +88m² • Total: CD v PSD = +2,902m² • Non-Compliances Improved • Services Areas Increased • SoA T&E Calc ~34% • Drawn T&E Calc ~33% 	<ul style="list-style-type: none"> • SoA = 60,951 • Drawn = 64,393 • Delta = 3,442 • Drawn Decreases PSD v SD: <ul style="list-style-type: none"> • Outdoor Areas –2,960m² to match CD SoA calculation • Clinical and Services Increases Minimised to +356m² through: <ul style="list-style-type: none"> • Block & Stack Efficiencies • Department Efficiencies • Non-Compliances Improved • Services Areas Improved • VM Proposed • SoA T&E Calc ~34% • Drawn T&E Calc ~32% 	<ul style="list-style-type: none"> • SoA = 62,800 • Drawn = 66,283 • Delta = 3,483 • Drawn Increases SD v DD: <ul style="list-style-type: none"> • Non-Compliances Resolved • Services Areas Resolved • Services Areas Increased • Outdoor Areas Excluded • Mental Health Increased • VM major items rejected • SoA T&E Calc ~35% • Drawn T&E Calc ~32%

Figure 12: Schedule of Accommodation variations

Whilst the delta in areas has been reduced, the overall size of the project is larger than originally contemplated by HIQ during planning. The growth in area from concept design SoA of 60,541m² to the currently drawn 66,283m² is a 10% increase and a major contributor to the increase in the project's overall cost. Increased cost is evident in not only additional construction cost, but a longer program to build, which when coupled with the low availability of trades in Bundaberg and escalation more than 9% per annum leads to even greater cost growth.

To progress the project and move towards construction readiness, the MC has progressed with Issued for Construction (IFC) drawings for major elements of the build, including having 100% of civil package drawn, 60% of the substructure and inground services and 20% of the structure and above ground services drawn.

The present forecast cost for the project is nearly double the originally announced budget. The key elements driving the increase in the construction partner's forecast costs are:

- Direct trade costs – 92% of the trades have been tendered or tested in the market and **costs of \$1.062 billion are nearly double the HIQ estimate of \$511.46 million**, partially offset by a circa \$9 million reduction in escalation beyond tendered prices;
- Locality – cost of providing workers camp and fringe benefits tax implications total \$107 million, more than 4 times the HIQ estimate of \$25.6 million;
- Scope items – various value management cost reductions proposed by the builder have been rejected, and a requirement for 100% of the façade to be cyclone debris resistant has added to the trade cost item above;
- Productivity and risk transfers – the MC estimates **\$135.6 million of risk attributable** to only being able to source subcontractors from the prequalified list and (low) productivity impacts of trade programs, plus an **increase in contingency for project risks allocated to the builder at \$87.7 million** compared with the HIQ forecast construction contingency of **\$39.7 million**, and
- Contract works insurance pricing escalating from 8.08% to 9.6725% of project cost to a total of circa \$12.5 million.

The planning for the new site has also been bedevilled with critical infrastructure deficits, with inadequate provisions made for roads, potable water, sewer, stormwater, electrical supply and telecommunications. These scope items have now been included and make up some of the direct trade cost variances for the project.

During the Review, the MC noted that they had explored the opportunity with HIQ to build around 350 permanent houses in Bundaberg rather than a works camp, with those permanent houses remaining in Government hands at the end of the project to house Health workforce or other local affordable housing needs. However, this was not pursued by HIQ, and instead a circa 350 person works camp will be a project cost required to accommodate the circa 80% of the workforce that will come from outside of Wide Bay. The works camp will be rented and be removed at the end of the project.

Notwithstanding all of the preceding commentary, **the single biggest issue confronting the Bundaberg project is that the scope to be delivered at the new hospital site does not allow a full replacement of the current site.** This means that there is an immediate and ongoing step up in operating costs from duplicate service requirements, ongoing maintenance costs at the old site and an inadequate consideration of what capital works may be required on the old site to keep it safe and operational. The duplication of sites will have an annual operating cost impact of a presently unconfirmed amount but could be at least \$200 million per annum, excluding keep safe and operational capital maintenance requirements – to better estimate these maintenance obligations will require a detailed condition assessment of the existing facility and such assessment will cost between \$2 and 4 million to undertake.

The PVR for the project did highlight this operational cost impact as a “High” rated risk¹⁵ with an “almost certain likelihood (>90%) but only a moderate impact. The financial analysis in the PVR highlighted the estimated annual increased labour and non-labour costs to be around \$185 million in 2027-28¹⁶. The risk register notes that the mitigation strategy is for the HHS to finalise a funding model through their service agreement to “obtain sufficient operational budget.”¹⁷ It is unclear how in an activity-based funding system such an outcome would be achieved.

The initial project budget provided a \$5 million allocation for works at the old site, but that further analysis was required to accurately estimate the “costs associated with the refit of existing Bundaberg Hospital infrastructure.”¹⁸

As such, the incremental additional operational cost impact has been known since October 2022. However, the PVR assessed the ongoing operational cost impact as being only moderate, and the appropriate investigations of capital requirements for the old hospital site have not been done.

In a regional location such as Bundaberg the ability to recruit additional clinical staff for the new facility will be a challenge, but requiring duplicate roles to be maintained across two sites on an ongoing basis will be a substantial challenge for the HHS. The PVR notes that in excess of 800 full time equivalent (FTE) additional roles will be required¹⁹ for the current project.

The duplicate site will also introduce complexities plus substantial capital and operating cost implications for the rollout of the electronic medical record solution (ieMR) for Bundaberg Hospital. eHealth Queensland has estimated that the capital costs to implement ieMR across the dual sites will be approximately \$23 million (or 1.8 times more) than implementing only at a single site and around \$1 million more in operational costs during the project period for two sites.

Finally, the old site is subject to water inundation from the immediately adjacent river. **Leaving services on the old site does not ameliorate the risk of losing clinical services during a flood event – one of the primary reasons to move onto a new site.** The PVR did briefly consider flood events in assessing the services to be left behind at the old site, and the map of the services to be retained show them to be the buildings closest to the river and most susceptible to flooding. No further analysis of the risk to service delivery seems to have been definitive in the project scope and planning.

¹⁵ New Bundaberg Hospital Project Validation Report 14 October 2022, page 16

¹⁶ Ibid, Table 60, page 157

¹⁷ New Bundaberg Hospital Costed Risk Register, risk NBH-006

¹⁸ New Bundaberg Hospital Project Validation Report 14 October 2022, page 160

¹⁹ Ibid, page 141

8.1.3 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed to GCS Stage 2 call with existing builder under existing contract	<ul style="list-style-type: none"> • Continue project with existing contractor and consultant team • No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program • Scope is known • Clinical and stakeholder consultation has been undertaken • Fastest option to have construction commence 	<ul style="list-style-type: none"> • Project results in a split campus for Bundaberg – delivery of the current project does not provide for a total replacement of services at the existing site • Flooding risk of current site is not addressed • The HHS has estimated additional operational costs to operate a dual campus for Bundaberg are likely to exceed \$200 million per annum • Significant risk in recruiting additional workforce required to staff new services and duplicate some requirements on each site • There is \$5 million project budget allocated to ensure the existing campus remains clinically safe and operationally efficient to operate – but no analysis of the actual requirement • Current project forecast running well ahead of announced budget • Current project program running well behind announced completion date • Doesn't allow for modified contractual risk allocations to be taken up
2	Cease the current project and replan the project to deliver a single stage redevelopment on the new site to allow a single decommissioning of the current site, and terminate the current construction partner's contract	<ul style="list-style-type: none"> • Full replacement of the old site plus additional capacity as was planned in the original project • Single decant and relocation onto the new site – one time disruption • Swiftest possible reduction in duplicate site operational costs 	<ul style="list-style-type: none"> • Delay in delivering services on the new site resulting from the need to replan the project • Termination of existing MC contract will require negotiation to avoid excessive costs • Need to determine process to secure design team to progress project – currently engaged via builder • Complexity of a single decant event will require exquisite planning and coordination to ameliorate commissioning and relocation risks • Acceleration and greatest immediate capital budget requirement

Option	Description	Pros	Cons
3	Cease the current project and replan the project to deliver a multi-stage development on the new site to allow a progressive/staged decommissioning of the current site	<ul style="list-style-type: none"> • Full replacement of the old site plus additional capacity as was planned in the original project (albeit slower than in option 2 above) • Multi-stage decant onto new site reduces decant and commissioning risks • Lower year-on-year capex budget requirement than option 2 	<ul style="list-style-type: none"> • Delay in delivering services on the new site resulting from the need to replan the project • Slower achievement of full site replacement • Termination of existing MC contract will require negotiation to avoid excessive costs • Need to determine process to secure design team to progress project – currently engaged via builder • Overall cost to replace hospital greater than option 2 due to effects of escalation
4	Variant of option 3 – continue with current project, existing design team and construction partner but seek to reduce and remove scope elements that can be deferred to a future development stage; plan future stages of development on the new site in parallel with progressing initial development stage; renegotiate risk allocations with existing builder [Recommended option]	<ul style="list-style-type: none"> • Continue project with existing contractor and consultant team but with modified risk allocations • Likely reduction in initial scope driving reduction in construction costs for first stage and hence reduced cash need for project • Swift on-site construction commencement and completion of initial scope • Future stages designed by existing design team and can happen in parallel with Stage 1 construction 	<ul style="list-style-type: none"> • Requires Government commitment to full replacement and concomitant costs • Potentially longer duration for dual campus operation than option 2 • Slightly slower construction commencement than for option 1
5	Cancel the current construction contract, take the present detailed design back to market to price under a revised design finalisation and construct basis	<ul style="list-style-type: none"> • Allows space and time to reconsider the project • MC contract ensures State owns design work done to date • Design finalisation and construct contract form would have simplified risk allocations and with extent of work done to date few (if any) latent conditions or unknown site risks (assuming existing car park issues are resolved) • Opportunity to split procurement of elements of the project – for example could contract the car park 	<ul style="list-style-type: none"> • Significant time and cost implications from essentially replanning project and abortive works (including a potential WIP write off in current year) • Potential contractual dispute or litigation risk if cancel contract • If cancel MC contract would need to procure design consultants • New contract form would need to be developed for HIQ • No guarantee current builder nor others would tender new project under a new contract • If elect to split contraction work packages would

Option	Description	Pros	Cons
		works separately to Acute Services Building	require deeply skilled HIQ team to manage construction workfront interfaces

8.1.4 Recommendations

Options 2, 3 and 4 spelt out above highlight a material change to the proposed project, and the incumbent builder has, at the Reviewer’s request, provided high level cost and program implications for these options. Whilst there is no ability to rely on these inputs, it is clear that they present a cogent strategy to swiftly assess options to plan for a project that results in Bundaberg Hospital being redeveloped fully onto the new site.

As noted in the Cons above, the present project has provided a \$5 million budget for delivering the capital expenditure that will be required to ensure the existing campus remains clinically safe and operationally efficient to operate. However, this estimate is not based on a detailed site assessment or asset condition review.

The project as currently formed additionally delivers a significant operational cost increment that has not been fully assessed by the HHS or HIQ, but the PVR estimated the extra cost to be at least \$185 million.

A swift assessment is necessary to understand the capital and maintenance implications of proceeding with the present project (option 1) compared with the other 3 options identified. Clearly, if one of option 2, 3 or 4 is selected, a known end date for the existing site should allow a more modest level of expenditure on the existing site and a risk-assessed approach to keeping the current site safe and operational. Where no plan to exit the existing site exists, the likely capital and maintenance costs for the existing site will be significantly higher than the \$5 million presently provisioned.

Option 4 is likely to be the least disruptive to the current project and the initial assessment indicates that it could be delivered with an overall (escalated) gross cost approximately \$654 million more than the current project’s construction forecast. This project would be delivered across 3 stages of development:

- Stage 1 – 30,917m² building plus 75% of site infrastructure – opening 2029
- Stage 2 – 30,000m² building plus additional 15% site infrastructure – opening 2030
- Stage 3 – 25,396m² building plus final 10% of site infrastructure – opening 2032

Note that under this proposition Stage 1 would be delivered around 6-9 months later than the current scope to allow for re-planning of the project into a multi-stage project. High level scope for these stages could be as follows:

Stage 1: 30,917m² (Opening in 2029)

Stage 1 focuses on establishing critically required departments as determined by the Stakeholders. However, from the current scope, it could include:

- Emergency Department, Theatres and Imaging (level 5 services);
- Birthing, Neonatal and Maternity (level 5 services);
- Pathology and Pharmacy;
- Wards/Bed Capacity to support the above;
- Other critical functions including the Kitchen and/or as determined by the Stakeholders;
- Plant, equipment, storage and loading dock facilities to support the above, and
- Containerised generators on ground and cooling towers to roof.



Figure 13: Stage 1 – Eastern Wings and Central Area (including Hospital Street)

Stage 2: 30,000m² (Opening in 2030)

Additional departments/functions to the above as determined by the Stakeholders. However, from the current scope, it could include:

- Clinical functions inc. Short Stay, Diagnostics, Transit Hub, Sleep Studies, Rehabilitation and supporting engineering and travel requirements;
- Wards/Bed Capacity to support the above and minimise requirements at the existing hospital, and
- Additional office/administration and support type areas, plant and equipment the above.



Figure 14: Stage 2 – West Wings Extension and Mental Health Building

Stage 3: 25,396m² (Opening in 2032)

Additional departments/functions to the above as determined by the Stakeholders. However, the intent of Stage 3 is to provide the functions and capacity to allow the existing Base Hospital to be closed. As described earlier in this report, the MC has not been fully briefed on extent of scope to move over to allow the closure of the existing hospital, however, it could include:

- Endoscopy, Day Medical, Medical Oncology, Oral Health;
- Radiation Oncology (provided in the private sector – service to remain as currently provided);
- Outpatients (balance not provided above);
- Administration (balance not provided above), and
- Additional office/administration and support type areas, plant and equipment the above (only).



Figure 15: Stage 3 – West Wing/Central Area Extension and Optional Mental Health Facilities Extension

The Reviewer has undertaken some high-level assessments making an assumption that the extra operational cost of running a dual site is an un-escalated \$200 million per annum. On this basis funding the total replacement of Bundaberg Hospital on the new site would be cash positive to Government in mid 2034, and would reduce cash requirements in 2025-27, but increase cash requirements in 2028-2031. It may be possible to delay the implementation of the proposed stages 2 and 3 but at the cost of the additional annual operational cost in the interregnum.

The annual estimated cashflows for taking up Option 4:

	\$ million	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Current project		179	536	447	447	179	-	-	-	-	-
	Opex impact	-	-	-	-	-	200	200	200	200	200
Total current + Opex		179	536	447	447	179	200	200	200	200	200
Option 4 - Revised risk allocations	Stage 1+OpEx	88	264	220	220	88	200	100	-	-	-
	Stage 2	-	41	204	245	245	82	-	-	-	-
	Stage 3	-	-	-	37	186	223	223	74	-	-
Total Option 4		88	305	424	502	519	505	323	74	-	-
Savings/(additional cost)		91	231	23	(55)	(340)	(305)	(123)	126	200	200

Table 13: Bundaberg prospective cash flows – Klok Advisory analysis

In addition, circa \$23 million in eHealth savings will be realised by moving to install ieMR in Stage 1 at only the new site.

Recommendation 17: The Bundaberg project should not proceed with the GCS Stage 2 call. The early works be paused on site and immediate negotiations be commenced with the incumbent builder undertaken to ameliorate costs to Government from temporarily pausing the existing contract

Recommendation 18: The Bundaberg project team should immediately engage with the incumbent builder, their design team and the HHS to derive a definitive assessment of the capital build staging options and resultant operational cost implications and revert to Government with detailed assessments of a staged development of a full development onto the new site

8.2 Coomera

8.2.1 Project Fast Facts

Announced Scope	404 overnight beds 24 day beds 45 emergency department treatment spaces and satellite medical imaging department 10 operating theatres and 2 endoscopy rooms 10 birthing suites 48 consult rooms Crisis Stabilisation Unit Clinical and facility support services Administration, education and training and staff amenity spaces
Funding announced	June 2022
Original budget	\$1.3 billion
Current HIQ forecast	\$2.254 billion
Funding gap	\$954 million
Announced practical completion	Second half 2027
Forecast practical completion	At the earliest Q2 2028
Early works start	12 June 2024
Stage 1 contractor	Multiplex
Design status	100% detailed design comments to be closed on 4 December 2024
HHS	Gold Coast HHS

8.2.2 Current Project Status & Issues

The new Coomera hospital is being built on a greenfield site close to the Coomera railway station. The site was acquired in 2007, well ahead of the CEP and the HHS had previously commenced planning for development on the site in 2016, including commencing the various required approvals, including the initial EPBC application. However, this EPBC application was for the existing site only, and as was under 10 hectares, was a simpler approval pathway than the present project which includes the resumption of adjoining land to construct a new access road (“road B”) and town planning requirements. **The HHS 2020 preliminary business case considered options between 400 and 600 overnight beds being included in the scope of the project, whilst the CEP planning adopted the 400 bed option.**

At present the forecast project construction cost is approximately 75% above the HIQ estimate and as such, it is not possible to recommend calling the Stage 2 GCS from the incumbent builder. The HIQ team has proposed that the Stage 2 GCS call be brought on with a target to negotiate significant savings with the incumbent builder under the current contractual regime. The Reviewer does not believe this to be a practical or realistic proposition; with a funding gap between the approved budget and present forecast approaching 100% (or more than \$900 million) it is impractical to expect this overrun can be reduced through negotiations with the current builder under the existing contractual framework, present scope and likely delivery timeframes.

A refreshed scope and staged development program, an updated masterplan and site access amendments, with options for a revised contractual framework and engagement with the adjoining landowner (see below) will be required to reset this project.

The current state of the project is significantly challenged in scope, program and price, and as such, opportunities to defray costs, stage development and reduce capital requirements through alternate delivery mechanisms and risk allocations need to be considered to progress this project.

The existing Ministerial Infrastructure Direction approval for the project requires that road B be completed prior to the new hospital can commence operation. An amendment application has been made to remove this condition, but not to remove the obligation to deliver the road at some point in the future. The inclusion of road B in the project adds cost to construct and resume the land from the present owner, time and (Koala habitat) EPBC approval requirements to the current project.

Design for the project has progressed since the project was awarded to Multiplex Constructions in early 2023, with 80% detailed design completed and 100% detailed design comments from HIQ and HHS were to be closed prior to Christmas 2024. Design for this project has benefitted from the HHS previously developing a business case setting out their preferred scope and previous clinical consultations.

There are some residual issues with the present design including split vertical transport for logistics and supply that are suboptimal that should be appropriately resolved before main works construction is progressed.

Given the greenfield nature of the site, enabling and early works has proceeded at significant pace following a delay in handover of the site from 31 March 2023 moving to 13 November 2023, with a construction haul road constructed and works significantly beyond ordinary early works have been undertaken. As can be seen in the images below, lift shafts have been manufactured and installed to the top of the tower extent.



Figure 16: Coomera site status images – provided by Managing Contractor

These enabling works are being delivered under a \$74 million allocation and early works with a \$135 million allocation from the overall project budget. Total design fees, MC fees and these enabling and early works for Stage 1 total \$229 million.

The current construction forecast price illustrates that around 36% (or 26,000m²) of floor space for the hospital would need to be removed to bring the project back to the original budget level. The current construction forecast has been impacted by the following major items:

- Direct trade costs – trades have been tendered or tested in the market against the 80% detailed design and costs are substantially higher than the HIQ estimates, including services pricing \$148 million more, fitout trades \$50 million more, other trades, preliminaries, margin and contingency of approximately \$91.5 million;
- Enabling works added to the MC's Stage 1 contract scope ~ \$65 million plus additional local Government requirements of \$10.2 million and a residual risk that Council will seek indemnification from Government for Council-funded adjoining road works that exceed budgeted amounts;
- Scope items – various items added to the scope including Central Sterile Services Department (CSSD) equipment \$5.2 million and Group 1a Information Communications & Technology (ICT)/FF&E of \$14 million;
- Productivity and risk transfers – the MC estimates \$57 million of risk attributable to insolvency and inclement weather risks included in contract price, plus an increase in Multiplex's delay contingency increased from 20% to 27% with an overall cost implication potentially in excess of \$270 million, and

- Offset by assumed savings across trades procurement, BPICs and onsite overheads – a commercial-in-confidence value HIQ is hoping to negotiate within the current MC contractor.

The overall program for the project has been impacted by the initial delay in providing site access, longer timeframes to deliver the Stage 1 early works and the delay in the Stage 2 GCS call. Construction completion was originally programmed to take place in September 2027 whilst the current program shows construction completion in March 2028.

During the Review, the Reviewer also engaged with private sector health developers/investors and the adjoining landowner who, during the initiation of the Coomera project, controlled a significant portion of the land immediately to the south east of the State's land. The development scheme proposed by the private sector was communicated to HIQ and Government, and presented an attractive option to deliver a collaborative development that:

- Delivered the clinical needs of the HHS;
- Provided space for a co-located private hospital;
- Presented a significantly lower infrastructure and servicing cost as the development would be built closer to existing services – reducing the need for the current haul road, long lead-ins for power, water and sewerage and obviated the need to resume land for road B;
- Did not require levelling of the hill that has now been removed;
- Was significantly closer to Coomera train station and directly opposite Westfield Coomera, providing better amenity for patients and staff;
- Did not require Government to fund multistorey carparking, and
- Would have seen the public hospital elements developed using private capital and rented back to Government on a similar basis to that for the STARS building at Herston Quarter.

This opportunity was presented to Government, however the Review was informed that at the time it was considered by the previous Government to be not appropriate to proceed through the Queensland Government's direct dealing or unsolicited proposal processes. Whilst the developer's option over the land has now lapsed, the current landowner remains willing to discuss this opportunity with Government.

As discussed below, the Robina project is within the same HHS as Coomera, and whilst is some distance apart, there may be an opportunity to pause and review the strategy for delivery of more bed stock for the Gold Coast HHS by considering both projects in concert. The Reviewer understands that the Gold Coast HHS desire for bed capacity has been expressed as an interim capacity strategy, addressing forecast bed shortages over a 10 year period until the Coomera project was initially planned to have been delivered in 2027²⁰. The proposed Robina leased space was planned to add around 116 beds, 6 theatres plus supporting infrastructures and to have them available well ahead of the completion of the Coomera project. As noted earlier, the HHS 2020 business case was for up to 600 beds, and adding 116 beds to the current Coomera scope of 404 beds is still 80 beds below the HHS business case upper end (and preferred) scope option. Given the delays to the Robina project, the facilities at Robina are yet to be agreed and construction is some way off commencing for that project. As such, the Robina project will deliver the intended capacity around the same time as Coomera.

8.2.3 Options to Proceed

Given the delays in delivery of both Robina and Coomera, the need to replan and resequence work at Coomera and the opportunity to explore adjoining land at Coomera, clinical service demand needs should be reviewed for the Gold Coast region, to determine whether it is feasible to:

- Continue with the acute services buildings at Coomera;
- Review the scale of outpatient and ambulatory services to be delivered at Coomera;
- Remove all of the non-acute services presently planned to be delivered in the Coomera buildings including Clinical and facility support services, administration, education and training facilities;
- Review if the planned scope for Robina can fit in the vacated space in the acute buildings at Coomera or whether a slight redesign can accommodate the additional beds and theatres noting there should

²⁰ Gold Coast HHS Robina Hospital Interim Project Business Case – provided to the Review by HIQ

be efficiencies from slight enlargements of existing planned Coomera facilities rather than duplicating at Robina;

- Maximise the use of existing site works and early works including piling and lift shafts;
- Remove road B from the scope of the Coomera project, including removing the requirement to compulsorily acquire the requisite land for the road and remove the need for the further Commonwealth EPBC and State-based MID planning approvals;
- Explore options to engage with the southeast adjoining owner to explore the development of an ambulatory services, clinical and facility support services, administration, education and training building in a non-clinical (class 5) building at a much lower cost per square metre to build, and
- Precinct car parking needs be replanned, including options to use private land and development funding to deliver the required car parks.

Option	Description	Pros	Cons
1	Continue current project and proceed to GCS Stage 2 call with existing builder under existing contract	<ul style="list-style-type: none"> • Continue project with existing contractor and consultant team • No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program • Scope is known • Clinical and stakeholder consultation has been undertaken • Fastest option to have construction commence 	<ul style="list-style-type: none"> • Current project forecast running well ahead of announced budget • Current project program running well behind announced completion date • Doesn't allow for modified contractual risk allocations to be taken up
2	<p>Pause the main works Stage 2 GCS call for the current Coomera project while a swift review of whole-of-HHS requirements is undertaken with a view to consolidating the short-term requirements that were to be delivered at Robina can be accommodated in a rescoped 600 bed Coomera project, including investigating the opportunity to partner with the adjoining landowner as set out above</p> <p>Site access, site infrastructure and appropriate early works for the site should continue.</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Opportunity to develop a more holistic health precinct at Coomera and engage with adjoining landowner • Resequence and restage development of Coomera – identifying opportunities to introduce staged development of the project • Complete site access and infrastructure works with current contractor • Opportunity to bring private capital to share the load of development of the precinct • Scale efficiencies from slight expansion of planned Coomera facilities (eg CSSD) to accommodate slightly more theatres rather than duplicating infrastructure at Robina • Opportunity to explore development of non-acute services in a non-class 9A building – a 	<ul style="list-style-type: none"> • Potential sunk costs of current design • Requires a probity safe process to engage with the adjoining landowner • Requires further amended MID application (withdrawal of in-flight amendment) • Change of masterplan and need to change EPBC pathway • Loss of time in completing the Coomera project • Costs and claims from MC Stage 1 builder for being paused/stood down • Distance between Coomera and Robina

Option	Description	Pros	Cons
		<p>lower cost of construction and maintenance</p> <ul style="list-style-type: none"> • Reduce the need to resume adjoining land and construct road B, and removes EPBC hurdle • Resource and operating cost efficiencies of operating from one site rather than both sites 	
3	<p>Request contractor to propose revised risk allocations, contract amendments and concomitant price and program reductions for further negotiation with HIQ</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Maintain current contractor and design team • Continue with current scope • Probable program and cost savings 	<ul style="list-style-type: none"> • Government takes increased risk but can be ameliorated through implementing workplace umpire to mediate weather and safety risks • Delay – may further delay the commencement of main works
4	<p>Cancel the current construction contract, take the present detailed design back to market to price under a revised design finalisation and construct basis</p>	<ul style="list-style-type: none"> • Allows space and time to reconsider the project • MC contract ensures State owns design work done to date • Design finalisation and construct contract form would have simplified risk allocations and with extent of work done to date few (if any) latent conditions or unknown site risks (assuming existing car park issues are resolved) • Opportunity to split procurement of elements of the project – for example could contract the car park works separately to ASB 	<ul style="list-style-type: none"> • Significant time and cost implications from essentially replanning project and abortive works (\$75m+ write off in current year) • Potential contractual dispute or litigation risk if cancel contract • If cancel MC contract would need to procure design consultants • New contract form would need to be developed for HIQ • No guarantee current builder nor others would tender new project under a new contract • If elect to split contraction work packages would require deeply skilled HIQ team to manage construction workfront interfaces

8.2.4 Recommendation

Recommendation 19: The Coomera project should be paused while a swift review of whole-of-HHS requirements is undertaken with a view to consolidating the short-term requirements that were to be delivered at Robina can be accommodated in a rescope Coomera project, including investigating the opportunity to partner with the adjoining landowner. Stage 1 site works should continue.

The incumbent MC should also be requested to propose revised contractual risk allocations and price reduction opportunities.

8.3 Mackay Hospital

Announced Scope	128 additional beds across paediatric, medical, surgical, women’s health and child & adolescent unit 12 same day beds within the Medical Day Unit Co-location of birthing, maternity, neonatal
Funding announced	21 June 2022
Original budget	\$250 million
Current HIQ forecast	\$520 million
Funding gap	\$270 million
Announced practical completion	December 2026
Forecast practical completion	At the earliest Q1 2028
Early works start	February 2024
Stage 1 contractor	Besix Watpac is the incumbent contractor
Design status	Schematic Design completed 6 December 2023 80% Detailed Design completed 4 October 2024
HHS	Mackay Hospital and Health Service (MHHS)

8.3.1 Current Project Status & Issues

The Mackay Hospital expansion was originally planned by the HHS in August 2019, and the masterplan allocated a site for growth of the existing hospital and another part of the site for a multideck car park. It appears that neither the August 2019 masterplan nor the CEP appropriately assessed ground conditions, infrastructure requirements and site servicing for the development.

Under the CEP, the Stage 1 Managing Contractor contract was awarded to Besix Watpac on 14 May 2023, and schematic design was completed on 6 December 2023. The 80% detailed design was completed on 4 October 2024.

The project’s forecast cost is more than double the original HIQ budget, arising from:

- Support services and additional scope inclusions \$64 million – scope items including generator replacement, major sewer upgrade and other site preparation requirements to facilitate development, but HHS remains concerned that all clinical and patient-centric support services are not being included in the project’s scope and budget;
- Ground conditions and cultural finds – driving program elongation and escalation of around \$87 million;
- Locality factors and risk allocations – subcontractor pricing in regional area circa \$109 million, and
- Additional costs not previously included such as ICT, internal costs and consultants \$42 million.

Cultural heritage artefact finds were identified on the site in May 2024, and an elongated period of negotiation to agreeing the process to develop a management agreement have precluded early works commencements. In addition, asbestos finds in the soil has delayed commencement of civil works until ground testing and a removal/disposal plan has been completed.

The location and redevelopment of the helipad has also been contentious, and confused division of communications and engagement responsibilities between the HHS and HIQ has made the situation more complex and slow to respond.

Further, the location and scope of paediatric and selected women’s services have delayed the completion of detailed design while engagement with stakeholders is concluded. Similarly, confused division of communications and engagement responsibilities between the HHS and HIQ has made the situation more complex and slow to respond. It appears that the current design does not provide for any overnight parent

accommodation within the paediatric service – a standard inclusion in contemporary paediatric services nation-wide.

Finally, the MC investigated the use of prefabricated components and modules as an opportunity to accelerate the delivery program and reduce cost, but this required a fundamental redesign of the building from the current triangular shape to a rectangular shape.

The Review cannot readily identify any clear pathway to resolve the stakeholder, site preparation, project scope and clinical safety issues with the time and cost pressures of progressing with the existing MC contract. As such the Review believes that the current project is undeliverable in its present combination of scope, program and cost forecast.

Removing the pressure to progress to Stage 2 of the MC and start early works and then main works construction should provide a better environment for the HHS and project team to methodically address the issues presently on the table for this project. An iterative project design process that addresses project design and staged elements of delivery with the realities of construction market capacity and capability in the Mackay region is required, appropriately incorporating accommodation for the required workforce. This will, inevitably, further delay commencement of the project, but a refreshed approach and design is the only way to resolve the otherwise intractable issues on this project.

It may also be expedient to consider how smaller packages of urgent clinical needs can be addressed, and source construction pricing from the market using more balanced risk allocations.

8.3.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken Fastest option to have construction commence 	<ul style="list-style-type: none"> Current project forecast running more than double the announced budget Current project program running well behind announced completion date Doesn't allow for modified contractual risk allocations to be taken up Appears to be no rational pathway to bring project back close to announced budget
2	<p>Terminate the current Stage 1 MC contract and have HIQ engage new design consultants to work up a clinically-prioritised scope with the HHS, with a staged delivery model. This may include engaging Besix Watpac to provide buildability and construction advice given their intimate knowledge of the site and the existing constraints.</p> <p>HIQ should also develop a revised procurement strategy that delivers best value for money for the State. The strategy should consider alternate procurement and contracting models appropriate for this location, together with appropriate risk allocations. HIQ</p>	<ul style="list-style-type: none"> Clinical priorities and good design practices can be reinstated Cultural artefact management plan can be resolved without MC time and cost pressure Ground testing can be completed without time pressure, and asbestos removal can be appropriately planned Fit for purpose design with refreshed staging and bundling can be assembled, likely to allow tier 2 and tier 3 builders 	<ul style="list-style-type: none"> Further project delays while project design is reworked Potential loss of current MC from willingness to bid or participate in future HIQ projects Community disquiet regarding the project

Option	Description	Pros	Cons
	<p>may also wish to design a stand-alone early works package to deliver on site preparation and decontamination tasks</p> <p>Small packages of urgent clinical needs should be considered for early procurement</p> <p>[Recommended option]</p>	<p>to deliver smaller packages of work with a main works package potentially awarded to a tier 2 contractor</p> <ul style="list-style-type: none"> • Early works package developed to resolve site preparation and ground conditions • Urgent clinical needs can be considered as small works packages for early procurement • Staged development that is planned based on the construction market in Mackay and the availability of accommodation for trades workforce required for each stage of development 	

8.3.3 Recommendation

Recommendation 20: Mackay Stage 1 MC contract should be terminated and HIQ should engage new design consultants to work up a clinically prioritised scope agreed with the HHS. A revised procurement strategy that delivers best value for money for the State should be developed, including staging options and early delivery of small packages of urgent clinical needs

8.4 The Prince Charles Hospital

Announced Scope	93 additional beds Satellite Medical Imaging Pharmacy Pathology Emergency Department with 53 new treatment spaces 2 Operating Theatres 16 Paediatric Outpatient spaces Satellite CSSD
Funding announced	21 June 2022
Original budget	\$300 million with additional \$60 million budget allocation announced 25 May 2023 to cover additional scope – see current project status below
Current HIQ forecast	\$788 million
Funding gap	\$428 million (or \$488 million prior to additional \$60 million provision)
Announced practical completion	Q2 2027
Forecast practical completion	At the earliest Q2 2029
Early works start	August 2024
Stage 1 contractor	Hutchinson Builders is the incumbent contractor
Design status	Schematic Design completed on 15 May 2024 80% Detailed Design to be completed early 2025
HHS	Metro North Health (MNHHS)

8.4.1 Current Project Status & Issues

The Prince Charles Hospital (TPCH) capacity expansion project is planned to add additional clinical spaces for emergency department, theatres and in-patient beds. Early works are progressing on site, and at the end of the Stage 1 MC contract total expenditure on completed design plus early and enabling works is likely to be \$64 million. The initial 80% detailed design was submitted in late 2024 but rejected and is subject to additional clinical and end user engagement

The significant cost increment to the forecast cost of the project is being driven by:

- Inclusion of support services and clinical scope – \$66.95 million – including paediatric area within ED and supporting ED short stay area, satellite pharmacy, satellite sterilising space, staff amenities and administration areas;
- Site infrastructure including high voltage system upgrade;
- Market pricing for trades and risk allocations, and
- FF&E and eHealth costs greater than budgeted.

At present the HHS is also preparing a submission to provide a full rebuild of the central sterilising department in lieu of the satellite sterilising unit included in the additional support services costs above. The new central sterilising unit is estimated to be an additional (net) \$34m, provides operational efficiencies from a single sterilising service and allows for the replacement of end-of-life equipment in the existing central sterilising department that is not provided for in the current scope. This is another example of where project prioritisation and budgeting could have addressed this issue from the start.

In addition, the project is tracking a disproportionately high number of scope risks and unresolved scope decisions all of which will add to the present cost challenge for this project. During the Review it was also apparent that a Functional Design Brief (a critical document translating the clinical service plan into the schedule of accommodation usually created by the design team with clinical input from the HHS and with project manager and HIQ oversight) has not been completed.

Governance has approved drawdowns of \$6 million of the project's overall \$30 million of contingency.

At present, the Stage 2 MC GCS call has not been actioned, and cost forecasts from the Stage 1 MC contractor are presently vastly in excess of the project budget for the currently documented scope – a scope that does not appear to be aligned with HHS clinical needs and priorities and is not supported by an endorsed Functional Design Brief.

The Review also met with St Vincent’s Health Australia who expressed a desire for their adjoining Northside Private Hospital to be included in expansion considerations at TPHC. The Review understands from this brief engagement that a co-ordinated site-wide masterplan could see the private operator expand their private emergency department, surgical services and supporting bed base. The PVR for TPCB does note in a single sentence:

St Vincent’s Northside Private Hospital is planning an extension within their existing lease boundary in the near future.²¹

but no further consideration of that opportunity to defray capital requirements for the State, consideration of shared back of house services or any kind of joined up masterplanning process was established.

Without substantial scope deletions (moving even further away from the scope proposed by the HHS) and a different construction contract risk allocation there is no apparent pathway to procure this project with the present scope and allocated budget with the currently contracted MC. Forecast completion is already 2 years later than was initially announced and it is unlikely with a replan of the project that this program elongation will be reduced. Additionally, it is likely that a staged development program will be required to be able to physically deliver the project, including decanting existing departments.

8.4.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken Fastest option to have construction commence 	<ul style="list-style-type: none"> Current project forecast running well ahead of announced budget Current project program running well behind announced completion date Doesn’t allow for modified contractual risk allocations to be taken up
2	<p>Complete Stage 1 MC contract including finalising 100% detailed design and then bring the Stage 1 MC to an end without calling for a Stage 2 MC GCS.</p> <p>Re tender project in the market with the finalised detailed design, amended risk allocations under a design finalisation and construct model</p>	<ul style="list-style-type: none"> Early and enabling works completed in most expeditious manner User groups and stakeholder engagement can complete in an orderly fashion with existing design team Provides pathway to resolve design and FF&E challenges 	<ul style="list-style-type: none"> Early and enabling works completed under current risk allocations and price Ability to attract market interest in tendering the works HIQ would need to novate design and other consultants out of Stage 1 MC contract Requires a new design finalisation and construct contract

²¹ The Prince Charles Hospital Project Validation Report, February 2023, page 85

Option	Description	Pros	Cons
3	<p>Complete Stage 1 MC contract including finalising 100% detailed design and then bring the Stage 1 MC to an end without calling for a Stage 2 GCS.</p> <p>HIQ engage a design team to refresh clinical priorities to ensure are contemporary and match service need, and provide a staged development option, including consideration of development scope and scale at Northside Private and what site masterplanning opportunities exist</p> <p>HIQ should also develop a revised procurement strategy that delivers best value for money for the State. Should consider alternate procurement and contracting models, together with appropriate risk allocations.</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Early and enabling works completed in most expeditious manner • Stage 1 user groups and stakeholder engagement can complete in an orderly fashion with existing design team before handing over to a refreshed design team to finalise the functional design brief • Provides pathway to resolve design and FF&E challenges • Staged development allows for slower cashflows • Masterplan and joint planning with Northside may reduce the capital requirements for the State and allow shared infrastructure and services to be delivered 	<ul style="list-style-type: none"> • Delayed start to construction and potentially higher escalation • Early and enabling works completed under current risk allocations and price • Ability to attract market interest in tendering the works • HIQ would need to novate design and other consultants out of Stage 1 MC contract or otherwise procure a refreshed design team • Requires a new design finalisation and construct contract • Delayed start to construction and potentially higher escalation

8.4.3 Recommendation

Recommendation 21: *The Prince Charles Hospital Stage 1 MC contract should run to conclusion including finalising 100% detailed design and the Stage 1 MC should be brought to an end without calling for a Stage 2 GCS. HIQ should engage a design team to refresh the project’s clinical priorities to ensure they match service need and are agreed with the HHS, are supported by an endorsed Functional Design Brief, include a site masterplan including the adjoining private hospital and provide a staged development option for the project*

8.5 Queensland Cancer Centre

Announced Scope	150 beds will be delivered to care for Queenslanders with cancer. The Centre will be one of only two in Australia to offer proton beam therapy, a specialised form of radiation therapy. A range of new and innovative cancer treatments for Queenslanders, including cellular therapy and nuclear theragnostic. Clinical education and research.
Funding announced	21 June 2022
Original budget	\$750 million increased to \$1.18 billion in October 2023 made up of the original CEP budget allocation of \$750 million, \$375 million Federal and (unsecured) \$55 million in philanthropic donations
Current HIQ forecast	\$1.8 billion
Funding gap	\$620 million
Announced practical completion	First half 2028
Forecast practical completion	At the earliest circa February 2031
Early works start	February 2025 (has not commenced as at date of report)
Stage 1 contractor	There is no incumbent contractor
Design status	Delays to Schematic Design have resulted in a program impact of one month and will remain on the critical path for finalisation by 31 January 2025 (Forecast).
HHS	Metro North HHS (MNHHS)

8.5.1 Current Project Status & Issues

The Queensland Cancer Centre (**QCC**) project was announced as part of the CEP but was intended to be delivered under a different procurement model from all other CEP projects. The genesis of this project was intended to upscale State-wide cancer care services, add cancer research facilities, add cancer care for Metro North and resolve administrative space provision on the campus. The initial \$750 million budget was increased in October 2023 to the new \$1.18 billion figure, incorporating a \$375 million Commonwealth Government contribution and a proposed \$55 million philanthropic donation for the project. As at December 2024 that philanthropic donation is not secured. Significant project contingency of \$173 million remains unallocated and available within the (increased) approved budget.

HIQ ran a registration of interest process to select a project partner in November 2022, which resulted in two proponents shortlisted. This process was cancelled in April 2023. A subsequent process was then run in late 2023 – early 2024 to select a design and construction partner for the project, and a Lend Lease led consortium was selected as the project partner. The QCC project was paused in December 2024.

The Lendlease consortium progressed with design for the QCC, including an (accepted) recommendation to use a different site within the campus based on the site conditions (very hard rock) and services and delivery complexities in the original site. The design work for the project has produced a comprehensive schematic design solution at the end of December 2024 with a project cost significantly higher than the original budget.

Key challenges with progressing the project included:

- Delays in completion of a Metro North HHS car park project – construction is complete but title registration complications and delays have precluded subsequent decants of other Metro North facilities, and
- An upgrade to the Royal Brisbane and Women’s Hospital high voltage substation is required to accommodate the QCC, on top of replacement of the existing substation on site. This additional requirement adds approximately 4,000m² to the space requirement for the substation and the replacement of the legacy substation equipment is not presently funded.

The need for Queensland to develop a centre of excellence for cancer research holds a strong level of appeal, but no business case (nor PVR) has yet been developed for this project. As such it is unclear what detailed business case (or PVR) scope has been used by the project team to develop the schematic design so far,

notwithstanding the project reporting noting that the scope had been approved by the previous Government and Capital Board of Management. It is also unclear what business case documentation or funding request submission was developed to support the substantial increase in the project budget from \$750 million to \$1.18 billion in October 2023 with the Commonwealth Government's contribution.

Project governance reporting does include the following baseline scope:

- New front of house services;
- New 44 chair day therapy service including a patient and family wellness centre;
- 48 outpatient consult rooms (including one within an allied health gym), plus 4 for telehealth;
- 150 beds across medical oncology, haematology, cellular therapies, radiation oncology, surgical oncology and recovery areas;
- Operating theatres, including a brachytherapy suite and interventional spaces;
- 2 clinical proton therapy rooms, establishing proton therapy in Queensland;
- A satellite imaging service;
- A satellite nuclear theranostics service;
- Pharmacy services to support clinical services and research;
- Expanded areas for clinical trials and translational research;
- Research/administration, education and training spaces;
- Expansion of facility support services, and
- Helipad.

It is not immediately clear which of this scope is needed for Metro North's immediate clinical needs versus broader State-wide clinical services requirements. A helipad is not a normal requirement for a standalone cancer or research facility but appears to be additive to the Herston Precinct's overall needs. The research needs are included and are supported by the administration, education and training spaces, but the current project reporting indicates that these requirements are not finalised.

As such, the Review believes that the scope and need for the project requires significant tightening, and for staged development options to be developed, clearly identifying the three elements of scope:

- Centre of excellence/cancer research facility;
- Metro North's immediate and future cancer services needs, and
- State-wide cancer services needs.

A planning exercise should be undertaken to determine whether these disparate scope needs are best delivered in a single project, a single building and/or at a single location. It seems that the present project has not been able to pause and reflect on this most significant planning hypothesis, and the resulting project scale and budget over-run is, in part, due to the aggregation of these scope items all being requested to be delivered as one project. Compounding this significant assumption is that the chosen location is a highly complex environment – a very substantial existing hospital campus with difficult ground conditions (including very hard rock and service tunnels), legacy site infrastructure challenges and physical space constraints.

It may be that each of these scope elements is required, but development options to deliver them either in stages or in different locations needs to be considered.

In considering the development of construction options, procurement strategy and clinical service delivery, the business case for the overarching project needs to be developed. Should proton therapy facilities continue to be in scope for the project, a detailed operating cost and Commonwealth funding agreement assessment needs to be undertaken. This may require cross-jurisdictional arrangements to be established ahead of any development, as should this proton facility proceed it will not only be expensive to operate and maintain, but the Review understands that funding arrangements for treatment and accommodation for patients and their families and carers are not settled between Queensland and the Commonwealth. Funding arrangements will also be required with other States and Territories as it is likely that interstate patient flow volumes may be required to make the proton therapy service financially viable.

8.5.2 Options to Proceed

The following table sets out the most evident options to proceed with this project.

Option	Description	Pros	Cons
1	Continue current project and retender project to market	<ul style="list-style-type: none"> • Scope is known • Clinical and stakeholder consultation has been undertaken • Metro North HHS tertiary cancer services upgraded to cater for growth and replacing aged existing infrastructure • Intention to find a delivery model with a low or zero capital contribution from Queensland Government • Opportunity to drive innovative project delivery and funding models 	<ul style="list-style-type: none"> • Scope doesn't deliver on broader necessity for a Statewide cancer facility driving research and innovation • Project delivers services for only a limited volume of Statewide requirements – bulk of new space delivers local demand requirements • Cost of retendering project • Likely market reticence to bid for the project given market conditions, risk allocations and previous market approaches • Uncertainty over the Commonwealth's capital contribution • Philanthropic funding is not guaranteed • No operating funding contribution secured from either the Commonwealth and no inter-State agreements in place for Proton treatments • Operational funding has not been allocated for Proton treatments for Queenslanders • Doesn't deal with Metro North HHS's other infrastructure requirements
2	Continue with current project scope, re-baseline project budget and program against a traditional design finalisation and construct procurement model	<ul style="list-style-type: none"> • Realistic project budget and program established • Simplified risk allocations and contracting model may be attractive to construction market 	<ul style="list-style-type: none"> • Lack of clarity of scope needs persists • Project budget likely to be significantly higher than previously announced • Project program likely to be longer than previously announced • Funds expended to date will need to be assessed and any redundant elements to be written off out of work in progress in current year • Proton therapy funding agreements remain at large
3	Rescope current services planned for QCC to fit within current expansion space at Sunshine Coast University Hospital [Note that Exemplar Health provided a submission to the Review reinforcing this opportunity]	<ul style="list-style-type: none"> • Existing agreement has framework to fund expansion through additional availability payments – no upfront capital required 	<ul style="list-style-type: none"> • Unclear whether service demand exists in this geography to support the service • Does not deliver local service requirements in Metro North

Option	Description	Pros	Cons
		<ul style="list-style-type: none"> • SCUH was planned with horizontal expansion space that could accommodate an expanded cancer service including already-provisioned infrastructure services to support such a facility • Leverage existing cancer services on site and existing surrounding support services 	<ul style="list-style-type: none"> • Ability to source requisite additional cancer services workforce on the Sunshine Coast • Potentially difficult to establish connections with clinical research networks • Would need to fund service demand and design consultancies • Proton therapy funding agreements remain at large
4	<p>Reconsider scope of existing project and commission a Statewide cancer services demand review</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Allows Statewide cancer services demand to be determined • Allows for resultant cancer services requirements to be translated into a more normal health infrastructure planning process • Allows for assessment of operating costs and workforce availability to form part of an informed business case for future cancer services • Reduces immediate funding requirement from Government 	<ul style="list-style-type: none"> • Funds expended to date will need to be assessed and any redundant elements to be written off out of work in progress in current year • Requires allocation of planning funding • Demand review may take 4-6 months to complete before any capital project planning can commence • Services planned for current project will not be delivered • Commonwealth co-contribution of \$375 million may be lost to Queensland
5	<p>Appoint a design team to plan and develop business cases (or a single business case) for:</p> <p>(a) immediate cancer services requirements for the Metro North HHS at the proposed site considering reuse of existing buildings, site masterplan and new development in a feasible and market-tested manner</p> <p>(b) Statewide cancer services requirements and where best to locate these services (requires option 4 to be completed) including those required at the presently-suggested site and elsewhere</p> <p>(c) research excellence centre for cancer services, including investigating site options at Herston and proximity to other research facilities including QIMR Berghofer MRI</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Ability to develop a business case for cancer services for both HHS and Statewide need – starting with HHS needs ahead of completion of State-wide needs assessment • Ability to develop a business case for cancer research for Queensland • Clear, unambiguous scope and locations for development of fit-for-purpose facilities • Construction market conditions appropriately considered in business case • Operating cost and funding models for proton therapy can be developed 	<ul style="list-style-type: none"> • Funds expended to date will need to be assessed and any redundant elements to be written off out of work in progress in current year • Requires allocation of planning funding • Replanning may take 4-6 months to complete before any capital project can seek funding • Requires procurement of new design team

8.5.3 Recommendation

The Review identified that Queensland Health completed a Cancer Strategy planning document in 2024, which should form the basis of the service demand review and allow the (swift) 4-6 month assessment of Statewide cancer services needs – without this strategy being in existence the review would require a significantly longer period of time. This strategy and recommended service need review should also consider workforce requirements and the likely availability of the requisite skills in the areas determined to need cancer service enhancements.

The demand review should conclude with a prioritisation of services that require a capital solution.

Following this demand review, Government should provide planning funding in the 2025-26 financial year to Health to allow the production of a cancer services infrastructure business case over a 9-12 month period. This business case will identify a prioritised list of cancer services infrastructure projects across the State, planning infrastructure development and refurbishment projects in an orderly fashion to deliver services aligned with capital and operational funding envelopes, considering existing site conditions and workforce availability, and proposing procurement models reflective of present and likely future construction market conditions.

Recommendation 22: Queensland Cancer Centre Project should be reconsidered and a business case for the three disparate areas of scope be developed – covering HHS requirements, Statewide requirements and a cancer research centre of excellence.

To support the development of future Statewide cancer services infrastructure for the QCC and elsewhere, a Statewide cancer services demand review should be commissioned to ensure cancer services are planned to be delivered closer to where the demand exists and where the requisite workforce can be sourced. Following this clinical demand modelling, Government should allocate planning funds to allow appropriate local and Statewide cancer services infrastructure projects be planned for future submission to Government for funding either as a program or individual projects.

8.6 Redcliffe Hospital

Announced Scope	204 beds Operating Theatres Emergency Department Treatment Spaces Endoscopy Rooms Birthing Suites Outpatient Consult Rooms Diagnostic Rooms Medical Imaging Expansion Pharmacy Pathology
Funding announced	21 June 2022
Original budget	\$1.06 billion (uplift to \$1.148 billion)
Current HIQ forecast	\$2.122 billion
Funding gap	\$1.062 billion
Announced practical completion	Q4 2027
Forecast practical completion	At the earliest Q4 2030
Early works start	July 2024
Stage 1 contractor	Multiplex
Design status	Schematic Design completed February 2024 80% Detailed Design to be completed February 2025 (Forecast)
HHS	Metro North Health (MNHHS)

8.6.1 Current Project Status & Issues

Stage 1 of the Redcliffe Hospital project was awarded to Multiplex on 27 September 2023 to deliver the scope set out above under the two-stage Managing Contractor contract. Multiplex has established themselves on site, created a new walkway from the existing car park to the existing front door of the hospital and undertaken significant ground preparation, infrastructure, services, piling and underground works. The Ministerial Infrastructure Designation (MID) approval is yet to be received and as a result structural core installation cannot commence. In an attempt to continue to achieve the required program, HIQ instructed Multiplex to construct the (modular) structural cores in anticipation of MID approval being received. These cores are complete and are presently sitting in storage awaiting direction on the project and MID approval – with storage costs an additional and ongoing cost to the project.

Inception to date works expenditure on the project is approximately \$75 million, and the estimated cost to complete is \$2.122 billion against an announced budget of \$1.06 billion. Primary drivers of this substantial cost over-run include:

- Original HIQ-supplied budget was deficient, including:
 - Refurbishment of B01 – HIQ \$34 million vs current provisional sum of \$104 million;
 - Services trades – HIQ \$128 million vs current market \$490 million;
 - Inground services and diversions – HIQ \$455,000 vs current market \$41 million;
 - Landscaping – HIQ \$260,000 vs current market \$7 million;
- Market pricing from trades – particular challenge with services trades and additionally façade, ceilings and partitions;
- Program and consultant cost implications from tendered offer assuming HIQ’s standardised rooms would mean only consult on 30% of standard rooms blew out to 3 rounds of user groups through both schematic design and detailed design on nearly 100% of rooms;
- Program and cost implications from MID approval revised date – revised MID required due to planning adding ~7,500m² beyond previous approval;
- Program and cost implications of significant enabling works that were not in initial scope of works contracted with builder (eg carpark access way);

- Program and cost implications of variation to divert existing sewer;
- Program and cost implications from delayed access to commence West Block demolition (planned 17 January 2024, revised date 3 June 2024);
- Program and cost implications from operational readiness increased from 12 to 20 weeks;
- Program and cost implications from group 1A ICT program impacts;
- Detailed design delayed by FF&E delays and design re-work;
- Program delays and re-sequencing piling arising from scar tree – issue has been unresolved for at least 7 months and has meant Multiplex has demobilised the piling rig – additional cost to remobilise piling rig to recommence piling;
- Escalation, builder preliminaries and overhead costs from all the above program delays, and
- Contracted risk allocations and subcontractor willingness to accept passed-down risk allocations.

Multiplex’s tendered program was for 1,138 gross working days with handover 9 December 2027 and an end date of 15 December 2028, whilst the most recent detailed program demonstrates 1,751 gross working days and delayed dates for handover being 11 January 2029 and end date 29 September 2031. A delay allowance of 20% remained consistent through the project until 22 November 2024 when Multiplex increased the delay allowance to 27% based on their corporate position on risk allocated to them under the two stage contract. These program delays not only mean that the hospital will not be ready for service when initially anticipated, but Queensland’s steep escalation (circa 9.6% per annum or around double the national average) increases overall price plus builder preliminaries, overheads and other project costs are all higher due to the elongated project program.

Services trades make up a very significant portion of the overall project cost for a hospital, and as seen on Coomera and CEP projects, the original HIQ budget allocation for this line item of \$128 million is around a quarter of the prevailing \$490 million market price for these trades. During this Review, Multiplex provided additional information regarding one of the larger services packages – the electrical package. Under this significant package (actual amounts are withheld here due to commercial sensitives) the proposed subcontracted trade price, inclusive of the passed down risk allocations from the two stage Managing Contractor has been tested against a subcontractor unwilling to provide a price to Multiplex with the inclusions of the present risk allocations. Without the principal risk allocations around productivity and insolvency, the **potential second price is around 25% lower than the fully risk laden price.**

Substantial design work has been undertaken by the project team, but the HHS remains unconvinced that several significant elements of the design are appropriate and as a result clinical endorsement has not been achieved. The Review understands that around 1,000 comments were made by the HHS on the 80% detailed design that was submitted to HIQ on 15 November 2024 and 100% detailed design was completed on 19 February 2025 by the project team. **Given the HHS’s concerns with the design and unresolved or unsettled matters, the 100% detailed design milestone cannot be agreed at this time.**

More importantly, the design for the acute services building cannot be built without resolving the future status of a substantial scar tree with indigenous significance that sits within the planned building’s envelope. Efforts to engage with the local Kabi Kabi peoples have not been successful, and neither of the HHS nor HIQ has been successful in undertaking meaningful engagement to resolve the issue. The Review has been provided with anecdotal evidence of attempts by the HIQ project team to progress the matter without utilising HHS team members with existing relationships with the Kabi Kabi people. Given the past engagements and need to progress this project, it is likely that the State has no option but to seek to redesign or shift the building to avoid impinging on the scar tree.

Finally, the scope of the project includes the extension of carparking, originally intended to be achieved by adding additional levels to the exiting multideck car park. The existing car park was constructed with the intention of adding future levels at a future date, and was supposed to have been planned and delivered with the appropriate structural strength and grounding to allow for the current tin roof to be removed and existing columns extended to hold up new levels of car parking. However, during the Review, it has become apparent that the existing car park’s construction may actually have been structurally deficient to allow additional height and, additionally, underlying ground conditions would preclude any further weight being added to the existing structure. Multiplex have undertaken preliminary non-invasive investigations of the structure and

ground conditions, but more detailed and invasive investigations are required before progressing with adding additional levels to the existing car park. **It is likely that the technical outcomes will make it infeasible to construct the additional levels on the existing car park, and an alternate location will need to be identified.**

HIQ has not yet called for the Stage 2 GCS due to these issues; the original GCS Stage 2 call was due to occur on 5 August 2023 but in July 2024 was pushed to 13 September 2024 and in November 2024 was pushed out further to 21 February 2025. The lack of resolution of the scar tree issue has meant that the project has been **delayed day-on-day with an estimated daily cost of \$54,000 since September 2024.**

As such, the present project is undeliverable in its current form – without resolution of the scar tree issue, the resolution of clinical scope matters, the technical challenges with expanding the car park and the risk allocations driving subcontractor pricing, the project will continue to experience delays and unmitigable increased forecast costs.

8.6.2 Options to Proceed

Through engagement with the HHS and the contracted builder during the Review, several significant changes to the project were canvassed. In particular:

- Options to review and resolve the outstanding design and clinical planning and priorities;
- Options to revise risk allocations between the State and contractor (and their subcontractors) – with a view to significantly reduce the program and project’s cost;
- An option to spin the acute services building through 90 degrees to align the long side of the building along Anzac Avenue, thereby avoiding the building impinging on the scar tree and redesigning the front entrance to the hospital;
- An option to replan the acute services building into a squared U shape to avoid the scar tree and redesigning site access;
- An option to replan an alternate location of additional multideck car parking – potentially in the space vacated by the rotation of the acute services building, and
- Options to reprogram/re-sequence services and infrastructure works, including options to demolish the un-used boiler chimney.

Multiplex has undertaken some preliminary siting studies and has provided the Review with a drawing that illustrates the feasibility of rotating the building and redesign the hospital front entrance.

The options to proceed with this project are set out in the following table:

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract and call Stage 2 GCS	<ul style="list-style-type: none"> • Continue project with existing contractor and consultant team • No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program • Scope is known • Clinical and stakeholder consultation has been undertaken • Potentially fastest option to have construction commence • MID approval consistent with scope and planned project 	<ul style="list-style-type: none"> • Can’t proceed with existing design without resolution of scar tree issue • No ability to resolve HHS concerns with current design • Current project forecast running well ahead of announced budget • Current project program running well behind announced completion date • Doesn’t allow for modified contractual risk allocations to be taken up

Option	Description	Pros	Cons
2	<p>Pause current works onsite and immediately replan the acute services building siting to avoid the scar tree by re-siting the acute services building by either rotating it through 90 degrees or adopting a squared U shape and other changes that avoid the tree plus consider HHS clinical design concerns</p> <p>Additionally seek revised risk allocations from existing MC (with option to terminate and go back to market)</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> • Replan with existing consultant team and Managing Contractor • No need to wholesale redesign project – rotate existing design so as to limit the amount of redesign • Provide HHS with a window to re-engage with the design team to swiftly resolve residual issues • Opens a part of the site to re-plan new multideck car park should expansion of existing carpark not be feasible • Avoids impacting on scar tree 	<ul style="list-style-type: none"> • Pause introduces program delay and cost • Rotating building requires redesign of front entrance and traffic flows in and out of the site • Alternate building siting option (squared U shape) replanning may require an additional floor to be added to the building which may introduce a town planning risk • Potential contractual dispute or litigation risk if cancel contract • If cancel MC contract would need to procure design consultants • New contract form would need to be developed for HIQ • No guarantee current builder nor others would tender new project under a new contract
3	<p>Stop current project and redesign the masterplan for the site including a fully redesigned acute services building to avoid impinging on the scar tree.</p> <p>Review extent and form of contract with current MC</p>	<ul style="list-style-type: none"> • Allows space and time to reconsider the project • MC contract ensures State owns design work done to date • Design finalisation and construct contract form would have simplified risk allocations and with extent of work done to date few (if any) latent conditions or unknown site risks (assuming existing car park issues are resolved) • Opportunity to split procurement of elements of the project – for example could contract the car park works separately to ASB 	<ul style="list-style-type: none"> • Significant time and cost implications from essentially replanning project and abortive works (\$75-100 million write off in current year) • Potential contractual dispute or litigation risk if cancel contract • If cancel MC contract would need to procure design consultants • New contract form would need to be developed for HIQ • No guarantee current builder nor others would tender new project under a new contract • If elect to split construction work packages would require deeply skilled HIQ team to manage construction workfront interfaces
4	<p>Cancel the current construction contract, swiftly replan the siting of the acute building to avoid the scar tree and take the present detailed design back to market to price under a revised design finalisation and construct basis</p>	<ul style="list-style-type: none"> • Allows space and time to reconsider the project • MC contract ensures State owns design work done to date • Design finalisation and construct contract form would have simplified risk allocations and with 	<ul style="list-style-type: none"> • Significant time and cost implications from essentially replanning project and abortive works (WIP write off in current year) • Potential contractual dispute or litigation risk if cancel contract

Option	Description	Pros	Cons
		<ul style="list-style-type: none"> extent of work done to date few (if any) latent conditions or unknown site risks (assuming existing car park issues are resolved) Opportunity to split procurement of elements of the project – for example could contract the car park works separately to ASB 	<ul style="list-style-type: none"> If cancel MC contract would need to procure design consultants New contract form would need to be developed for HIQ No guarantee current builder nor others would tender new project under a new contract If elect to split contraction work packages would require deeply skilled HIQ team to manage construction workfront interfaces
5	Request contractor to propose revised risk allocations, contract amendments and concomitant price and program reductions for further negotiation with HIQ	<ul style="list-style-type: none"> Maintain current contractor and design team Continue with current scope Probable program and cost savings 	<ul style="list-style-type: none"> Government takes increased risk but can be ameliorated through implementing workplace umpire to mediate weather and safety risks Delay – will further delay the commencement of main works

Initial engagement by the Review with the MC indicate that there are multiple pathways to redesign the acute services building that would avoid the scar tree – either by simply rotating the existing building through 90 degrees or a more substantial replanning of the building that may require renewed clinical consultation and introduce a town planning risk as it may require the addition of another floor to the building. The two options are presented in the following diagrams:

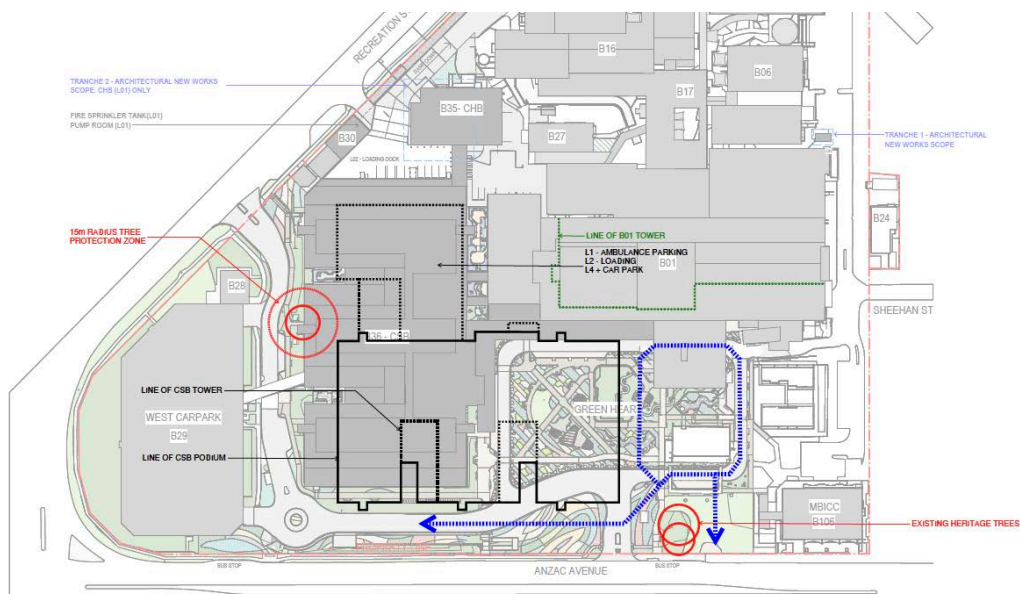


Figure 17: Potential siting rotating the building

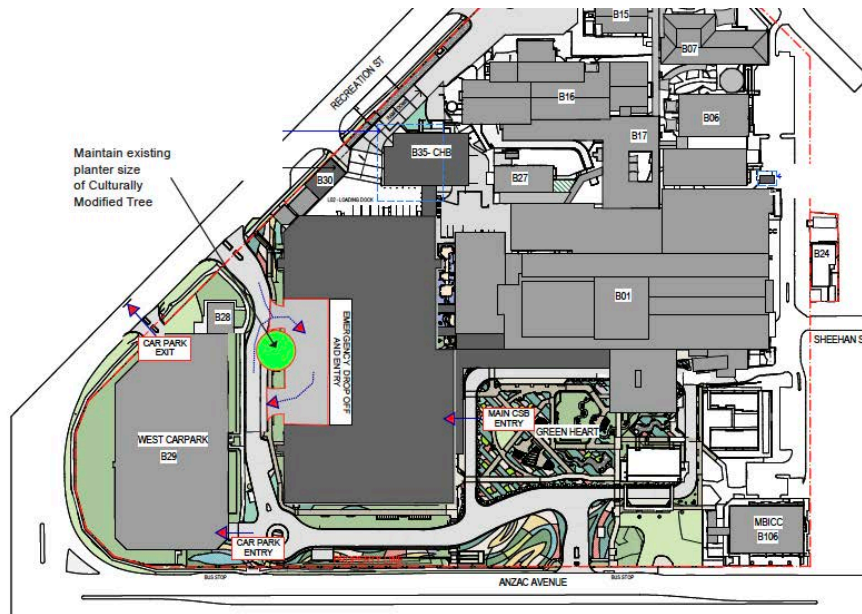


Figure 18: Potential siting replanning building into a square U shape

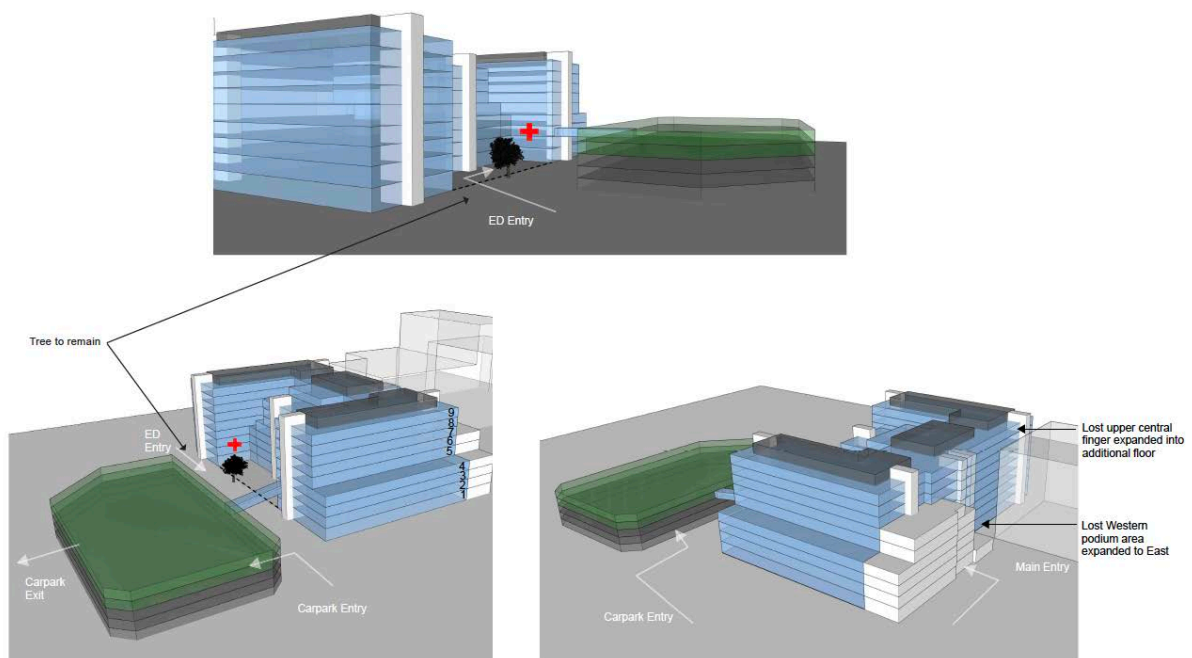


Figure 19: Potential massing for replanning building into a square U shape

8.6.3 Recommendation

Recommendation 23: Redcliffe Project should be paused, with the current site, infrastructure and services works paused. The project team should swiftly replan the delivery of the project rotating the building 90 degrees or otherwise replanned to avoid the scar tree and appropriately consider the HHS concerns relating to the emergency department and clinical priorities.

8.7 Toowoomba

Announced Scope	Additional 118 bed across medical, surgical, maternity, coronary and ICUs Emergency Department Outpatient consultation rooms and diagnostic rooms Medical Imaging Pharmacy Pathology Administration Education and training
Funding announced	June 2022
Original budget	\$1.3 billion
Current HIQ forecast	\$1.98 billion
Funding gap	\$680 million
Announced practical completion	Second half 2027
Forecast practical completion	At the earliest Q2 2028
Early works start	February 2024
Stage 1 contractor	John Holland Group
Design status	80% Detailed Design completed on 10 December 2024
HHS	Darling Downs HHS

8.7.1 Current Project Status & Issues

The Toowoomba CEP project provides additional capacity and clinical services onto the existing Baillie Henderson Hospital site on the outskirts of Toowoomba. This is an active hospital site with a around 38 existing buildings on site. The location of the new development is separated from these existing buildings and as such, can be thought of as a greenfield development with future space for later expansions of the new hospital. A recent image of the site's early works is below:



Figure 20: Baillie Henderson site works status February 2025

Early works have been allocated \$122 million and the MC is approximately 50% through the works.

The design for the main works has progressed to the 80% detailed design stage, with the 50% detailed design submitted by the MC on 13 August 2024 and the project team led a design review process with the HHS and other stakeholders to provide feedback to the MC on 23 September 2024.

Current forecast cost to complete the project is approximately \$1.98 billion, \$680 million above the announced project budget. The major elements driving this increase in forecast cost from the HIQ estimate include:

- Direct trade costs – \$214 million – JHG now has approximately 85% of construction costs substantiated with market pricing for trade packages – are higher than the estimates applied by HIQ at the program announcement;
- Location – the Toowoomba location has, through market testing of subcontractor pricing and EBA conditions, given rise to:
 - \$17 million impact arising from higher site allowances at Toowoomba than for other JHG projects – nearly double the hourly site allowance (\$11 per hour) than seen at PA (\$6 per hour) or Logan (\$7 per hour);
 - \$75 million impact from living away from home allowances – approximately 80% of workforce have a primary place of residence more than 90km from the site;
 - \$57.2 million for workers camp;
- Risk allocations – approximately \$70.4 million in procurement and insolvency risk;
- Escalation and contingency percentage allocations against all of the above, and
- Support services – adding back into scope essential clinical service needs including imaging, rehabilitation, pharmacy and kitchens.

The current date for practical completion is reliant on achieving Stage 2 GCS award by 1 May 2025 – beyond that date the critical path for the project will be directly impacted and the MC will commence demobilising the project site as current early works will be completed by then. To achieve a Stage 2 GCS award by 1 May 2025 a GCS stage call should have been made by 3 February 2025 – an event that has not occurred. **This means that the current program is at large.**

Funding for implementation of the electronic medical record system (**ieMR**) at the new Baillie Henderson Hospital development is not included in the forecast project cost above, and separate funding bids are progressing through governance. Without confirmed funding for the ieMR at the new site, redesign of the new development will be required, as it has been designed to be “paper light” such that patient spaces do not include allowances for paper records, and there is no provision for paper records in the new building.

However funding of ieMR for the new project is only one part of the challenge. If the present two site strategy persists, ieMR will need to be rolled out at the Toowoomba CBD site in parallel with the new site for patient safety – patients will need to move frequently between campuses and clinical risk will be extreme if both sites are not on the same platform. Both sites will need to be on paper or ieMR but not one of each.

Additionally, Darling Downs HHS operates across a significant geographical area, and Toowoomba operates as the hub to 28 spoke facilities across the HHS. Whilst it is unlikely that it is feasible to go live with ieMR on an HHS-wide basis on the same day, a well thought through strategy needs to be developed and funded to adopt ieMR across the HHS on a staged basis.

Recommendation 24: A rollout strategy and funding for adoption of electronic medical records across the Darling Downs HHS needs to be developed by eHealth appropriately contemplating the timing for the adoption of ieMR at the new Toowoomba Hospital

As described for Bundaberg, the **Toowoomba Hospital project as presently defined is confronted with the issue that the scope to be delivered at the Baillie Henderson Hospital site does not allow a full replacement of the current Toowoomba CBD site.** This means that there is an immediate and ongoing step up in operating costs from duplicate service requirements, ongoing maintenance costs at the old site and no consideration of what capital works may be required on the old site to keep it safe and operational. The project team’s communications are not wholly accurate in that they assert that there will be no acute services left at the CBD campus – during this Review the Reviewer had the opportunity to tour the CBD campus and see first-hand a number of acute services that will remain on that campus.

The duplication of sites will cost a presently unknown amount but initial considerations by the HHS indicate it **could be at least \$300 million or as much as \$400 million per annum or more, excluding keep safe and operational capital maintenance requirements at the CBD site** – to better estimate these maintenance obligations will require a detailed condition assessment of the existing facility and that assessment will cost between \$2 and 4 million. The PVR developed in February 2023 for this project estimated these extra operational costs at \$236 million²² and further highlighted that the risk of these increased operational costs was of the highest possible risk rating – Very High.²³ **As such, the risk and extent of potential additional costs have been known since at least 2023, and probably since the revised business case was developed between 2020 and April 2022.**

Operationally and clinically, some of the design decisions that have been made in the current project are problematic – for example inpatient wards on four floors of the circa 1960's six storey tower at the CBD site are slated to be replaced at the Baillie Henderson Hospital, and the remaining two discontinuous floors will be left in that ageing tower – an end of useful life asset. This will necessitate a level of careful operational redesign to continue to provide clinically safe and physically safe spaces and will continue to drive operational costs such as energy and air conditioning for the whole tower – the existing air conditioning plant cannot readily be reconfigured to only service individual floors.

In a regional location such as Toowoomba the ability to recruit additional clinical staff for the new facility will be a challenge, but requiring duplicate roles to be maintained across two sites on an ongoing basis will be an even greater challenge for the HHS. The PVR estimated an incremental full time equivalent workforce requirement of 1,426.

As previously described for the Bundaberg project and above for this project, the duplicate Toowoomba site will also introduce complexities plus substantial capital and operating cost implications for the rollout of the electronic medical record solution (ieMR) at Toowoomba. eHealth Queensland has estimated that the capital costs to implement ieMR across the dual sites will be approximately \$57 million more (or around 2.5 times more) than implementing only at a single site and around \$5 million more in operational costs during the project period to support two sites.

8.7.2 Moving to a Single Site

In 2020 the Darling Downs HHS developed a detailed business case for a single stage replacement of the current Toowoomba Hospital at the Baillie Henderson Hospital site. However this business case was not approved by the then Government, and instead, Government requested a revised version with reduced capital costs be developed with reduced new services at the Baillie Henderson site and retained the existing hospital. This revised business case informed the CEP project's scope. However the HHS original business case for a total replacement, if affordable, remains a preferred option.

As part of the Review, the Reviewer has engaged with the MC to understand potential opportunities to stage a full redevelopment of all services at the CBD Toowoomba hospital onto the Baillie Henderson Hospital site. The following concepts have not been consulted with the HHS and have been done in the very short period of this Review to investigate whether there is any utility in exploring other delivery options.

The scope of the new hospital build has, positively, considered future proofing, with masterplanning and detailed planning done so as to provide for future stages of construction. Services and inground infrastructure are provided for in the present scope.

²² New Toowoomba Hospital Project Validation Report 20 February 2023, page 136

²³ Ibid, page 16, Risk ID NTH-R-006



Figure 21: Expansion zones overlaid on Baillie Henderson site works

The main hospital expansion zone (illustrated in Figure 21) would require further planning to develop clinical services scale and scope, but the initial major scope items to bring across into the expansion zone would include:

- Cancer care including nuclear medicine;
- Additional ambulatory services;
- Rehabilitation and geriatric evaluation and management, and
- Supporting services such as pharmacy, sterilising etc.

These services can be accommodated in a building developed in the expansion zone shown as a grey box in Figure 22.

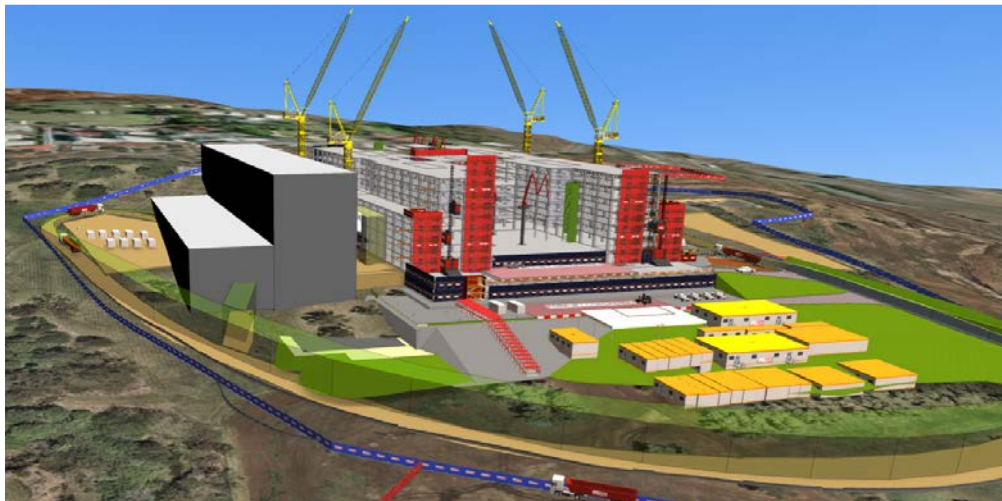


Figure 22: Potential development massing on the main hospital expansion zone

Development of a second separable portion could be sequenced in a manner to optimise trade resources and given a longer construction program seek to entice more of the workforce to move to Toowoomba for the (longer period), creating an overall benefit for the city. Preliminaries for items such as cranes, site sheds and other MC costs should also be more efficient over a project delivered in this model

Delivery of the planned multideck carpark can also be considered if re-scoping is undertaken – it may be more efficient to procure the designed car park with a tier 2 or 3 builder rather than use the MC.

Further planning is required to assess the scale and scope of mental health services that need to be relocated onto the new site and whether they are best located in a stand-alone structure or incorporated into the expanded hospital site.

Finally, the costings of this potential option have not been done at this point and will need to be assessed taking into account the prospective operational costs that will arise from running a dual campus. As part of this assessment the future use of the old CBD campus can be considered and potential divestment of the site considered and valued. This option should also only be contemplated with a revised risk allocation and contractual structure.

8.7.3 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed to GCS Stage 2 call with existing builder under existing contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken Fastest option to have construction commence 	<ul style="list-style-type: none"> Project results in a split campus for Toowoomba – delivery of the current project does not provide for a total replacement of services at the existing site The HHS has estimated additional operational costs to operate a dual campus for Toowoomba are likely to exceed \$400 million per annum Significant risk in recruiting additional workforce required to staff new services and duplicate some requirements on each site There is no project budget allocated to ensure the existing campus remains clinically safe and operationally efficient to operate Current project forecast running well ahead of announced budget Current project program running well behind announced completion date Doesn't allow for modified contractual risk allocations to be taken up
2	Cease the current project and replan the project to deliver a single stage redevelopment on the Baillie Henderson Hospital site to allow a single decommissioning of the current site	<ul style="list-style-type: none"> Full replacement of the old site is achieved Single decant and relocation onto the new site – one time disruption Swiftest possible reduction in duplicate site operational costs 	<ul style="list-style-type: none"> Delay in delivering services on the new site resulting from the need to replan the project Need to determine process to secure design team to progress project – currently engaged via builder, or use existing MC structure to do planning at higher cost Complexity of a single decant event will require exquisite planning and coordination to ameliorate

Option	Description	Pros	Cons
			<ul style="list-style-type: none"> commissioning and relocation risks Acceleration and potential greatest immediate capital budget requirement
3	Cease the current project and replan the project to deliver a multi-stage development on the new site to allow a progressive/staged decommissioning of the current site	<ul style="list-style-type: none"> Full replacement of the old site plus additional capacity as was planned in the original project (albeit slower than in option 2 above) Multi-stage decant onto new site reduces decant and commissioning risks Lower year-on-year capex budget requirement than option 2 	<ul style="list-style-type: none"> Delay in delivering services on the new site resulting from the need to replan the project Slower achievement of full site replacement Renegotiation of existing MC contract will require negotiation to avoid excessive costs Need to determine process to secure design team to progress project – currently engaged via builder Overall cost to replace hospital greater than option 2 due to effects of escalation
4	Variant of option 3 – continue with current project but seek to reduce and remove scope elements that can be deferred to a future development stage; plan future stages of development on the new site in parallel with progressing initial development stage; renegotiate risk allocations with existing builder [Recommended option]	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team but with modified risk allocations Likely reduction in initial scope driving reduction in construction costs for first stage and hence reduced cash need for project Swift on-site construction commencement and completion of initial scope Future stages designed by existing design team and can happen in parallel with Stage 1 construction 	<ul style="list-style-type: none"> Requires Government commitment to full replacement and concomitant costs Potentially longer duration for dual campus operation than option 2 Slightly slower construction commencement than for option 1

8.7.4 Recommendations

The last 3 options spelt out above highlight a material change to the proposed project, and the incumbent builder has, at the reviewer’s request, provided high level viability and program implications. Whilst there is no contractual ability to rely on these inputs, it is clear that they present a cogent strategy to swiftly assess options to plan for a project that results in Toowoomba Hospital being redeveloped fully onto the new site.

As noted in the Cons above, the present project has not provided any budget or planning for the capital expenditure that will be required to ensure the existing Toowoomba CBD campus remains clinically safe and operationally efficient to operate. A swift assessment is necessary to understand the capital and maintenance implications of proceeding with the present project (option 1) compared with the other 3 options identified. Clearly, if one of option 2, 3 or 4 is selected, a known end date for the existing site should allow a more modest level of expenditure on the existing site and a risk-assessed approach to keeping the current site safe and operational. Where no plan to exit the existing site exists, the likely capital and maintenance costs for the existing site will be significantly higher.

Option 4 is likely to be the least disruptive to the current project and an initial assessment is required to assess the variance against the current project's construction forecast, including realising savings in the ieMR implementation at just the Baillie Henderson Hospital site.

Lastly, the existing 38 buildings at the Baillie Henderson Hospital site are in various states of care and maintenance, and a large number of the buildings are either on heritage protection lists or otherwise have local significance. The project team should engage an assessment of services presently being delivered in these ageing buildings to assess which could be incorporated into the new build, and work with the HHS on developing a long-term maintenance strategy for the heritage protected buildings on-site.

Recommendation 25: The Toowoomba project should not proceed with the GCS Stage 2 call at this stage, the early works be paused on site and immediate negotiations be commenced with the incumbent builder undertaken to ameliorate costs to Government from temporarily pausing the existing contract

Recommendation 26: The Toowoomba project team should immediately engage with the incumbent builder, their design team and the HHS to derive a definitive assessment of the capital build staging options to fully locate onto the new site, including an assessment of operational cost implications and revert to Government with detailed assessments

Recommendation 27: The project team should engage an assessment of services presently being delivered in ageing buildings on the Baillie Henderson Hospital site to assess which could be incorporated into the new build, and work with the HHS on a long term maintenance strategy for the heritage protected buildings on-site

8.8 Townsville University Hospital

Announced Scope	143 Beds State of the Art Clinical Services Building Integrated Helipad
Funding announced	21 June 2022
Original budget	\$530 million
Current HIQ forecast	\$1.029 billion
Funding gap	\$499 million
Announced practical completion	Q4 2026
Forecast practical completion	At the earliest Q1 2029
Early works start	July 2024
Stage 1 contractor	There is no incumbent contractor (Stage 2 offer rejected)
Design status	80% Detailed Design to be finalised in Q1 2025
HHS	Townsville HHS

8.8.1 Current Project Status & Issues

The CEP announced project at the Townsville University Hospital (**TUH**) follows previous clinical service planning, masterplanning and scoping work undertaken by the HHS, and the CEP project scope represents approximately 70% of the HHS planned scope. Further masterplanning will be required to plan for future development stages and to deal with a growing traffic management issue between TUH and the adjacent James Cook University campus.

The CEP scope adds significant clinical capacity and capability to TUH, and reinforces the nature of TUH as the regional referral hospital for the north of Queensland. TUH is also a major employer in the region. The \$530 million announced budget doubled to \$1.029 billion, with the major cost drivers including:

- Direct trade costs and regionality;
- Support services \$174m, and
- Risk allocations.

Besix Watpac were appointed as MC for this project and have completed early and enabling works on site to a total value of \$40.1 million. Total costs of early and enabling works will be approximately \$56.1 million. These costs include \$714k of funding from project contingency to deal with asbestos finds and latent ground conditions.

Besix Watpac provided their Stage 2 offer to HIQ in late 2024 which was more than twice the original accepted Stage 1 contract estimate. The HIQ team's negotiation strategy rapidly identified that given the extent of the variance from the initial estimate that there was no pathway to secure a revised or negotiated offer that was within the available budget, and that the likely savings that may be secured would be in the range of \$42-96 million – about 8-18% of the overrun.

Initial pricing for the multideck carpark was also sought from Besix Watpac, and the 644 car spaces were estimated to cost \$163,000 per space – more than double that seen in metropolitan Brisbane projects and triple the cost of other car parking construction projects across the country.

Given this situation, on 18 December 2024, Government announced that the Stage 2 offer would not be accepted and the project be taken back to market.

The key question for the Review is then to recommend a pathway back to market and build the project.

Simply retendering the current project's design with the current MC contract is unlikely to be attractive to the market and very unlikely to produce a result that will be under the announced project budget.

Industry will likely respond better to a more appropriate risk allocation and simpler contract arrangement such as a standard design finalisation and construct (D&C) contract. However, given prevailing market conditions in Queensland, locality factors for the project and ongoing escalation in excess of 9% per annum, a price from the market for delivery of the full scope as designed is likely to provide a tender outcome above available budget.

It is most likely that the only way a project can be delivered at the announced budget is to remove substantial amounts of clinical scope. This is clearly problematic as the required clinical service delivery needs will not be met if significant scope items are (permanently) deleted from scope.

The HHS has previously undertaken clinical service planning and an accompanying masterplan. The best way to develop a more affordable project would be to immediately rescope the present project into a series of staged developments, noting that this will push delivery of clinical spaces further into the future and become subject to future development stage business cases being approved and funded.

This immediate replanning should consider the highest clinical priorities and develop an initial stage of development that can be delivered within the present budget envelope. Whilst this does not provide all the desired clinical spaces to the HHS in the timeframe desired, it does begin the expansion and development of the TUH. Engagement with the HHS as part of this Review has highlighted that there is no immediately apparent or simple way to split the current scope. Revised prioritisation and thinking about alternate models of care may provide a pathway to deliver a more affordable initial stage, including contemplation of moving ambulatory care and other non-acute services into a lower acuity hospital building immediately adjacent to the existing hospital. These services normally include outpatient clinics, allied health services, specialist suites, infusion services, phlebotomy services and diagnostic testing clinics.

Such lower acuity buildings are not only lower cost per square metre to build, but their lower complexity also (particularly in electrical and mechanical services elements) opens a broader range of builders who may be able to build such a building in Townsville. With lesser engineering complexity and being used for a lesser number of hours per day than a 24 hour per day 7 day a week acute hospital, these lower acuity buildings also yield operational costs.

A revised planning approach may also introduce an opportunity to consider the current traffic management issues on the site in conjunction with James Cook University, and a package of works to address that scope be co-funded between Health and the University. A medium-term masterplan for the site, addressing traffic management in and around the two neighbouring significant institutions should be developed.

Once revised planning for clinical services and infrastructure delivery is completed, a procurement approach that accurately represents local Townsville construction industry capacity and capability should be developed, coupled with an appropriate risk allocation between HIQ and potential project proponents.

The combined revised planning outcome and procurement strategy should then be presented to Government for a future investment decision.

Additionally, there may be a way to acquire additional surgical and bed capacity in Townsville in the short term. There are two substantial private hospitals in Townsville who could be requested to provide offers to lease clinical space to the HHS – Mater and West State. Both facilities have theatres and inpatient units which the Review understands may not be operating at full capacity (Mater) or not yet commissioned (West State), and as such, there may be a willingness to sell access to surgical capacity for a period of time until TUH can be more fully expanded.

Finally, the carpark project should go to market with a simple D&C contract, and **local and tier 3 construction firms should be provided the opportunity to bid to construct this element of the TUH.**

8.8.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project scope and proceed to tender under existing contract	<ul style="list-style-type: none"> No major contract negotiations/changed risk allocations – proceed with existing MC contract and tender to the market Scope is known Clinical and stakeholder consultation has been undertaken 	<ul style="list-style-type: none"> Doesn't allow for modified contractual risk allocations to be taken up Low appetite in construction market to adopt the existing MC contract Unlikely to produce a viable project Doesn't consider masterplanning for hospital and university campus
2	Continue current project scope, develop new design finalisation and construct (D&C) contract and go back to tender with new project	<ul style="list-style-type: none"> Simplified and moderate risk allocations between the State and market Likely to attract other bidders to undertake the project Scope is known and documented Clinical and stakeholder consultation has been undertaken 	<ul style="list-style-type: none"> Likely cost of project will remain above present budget allocation HIQ will need to procure design review consultants Requires development of D&C contract for Health Doesn't consider masterplanning for hospital and university campus
3	Consider procuring short term clinical service delivery options from existing private hospital facilities in Townsville [Recommended option]	<ul style="list-style-type: none"> There are two private hospitals in Townsville who may have latent theatre and bed capacity Swiftest pathway to deliver additional surgical and bed capacity without any construction 	<ul style="list-style-type: none"> Unclear procurement pathway to source clinical operational service delivery Need to consider regulatory frameworks for licencing and appropriateness of the existing facilities and infrastructure Will split workforce away from single TUH site for a period of time
4	Pause current project and seek rescope and redesign the project, with smaller stages of development or different components and develop a medium-term masterplan for the site and adjoining university campus [Recommended option]	<ul style="list-style-type: none"> Allows reconsideration of clinical priorities and models of care Allows consideration of different development typologies, including adopting options for non-acute services to be delivered in more affordable spaces Ability to refresh design team with new thinking Allows development of masterplan 	<ul style="list-style-type: none"> Slow to respond to clinical need, as construction commencement will be delayed Redesign costs on top of existing/sunk design costs, and need to procure a new design team
5	Car parking should be procured in the market using a simple D&C contract, opening up opportunities for local and tier 3 builders [Recommended option]	<ul style="list-style-type: none"> Simplified contract Attractive to a wide range of local and tier 3 builders Will deliver carpark significantly cheaper than previous procurement strategy 	<ul style="list-style-type: none"> Need to develop D&C contract for HIQ

8.8.3 Recommendations

Recommendation 28: The Townsville University Hospital project team should rework the clinical services plan and derive a staged development pathway and accompanying masterplan, and the revised planning outcome and procurement strategy should then be presented to Government for a future investment decision.

A short term option to procure surgical services should also be assessed and implemented if feasible.

Recommendation 29: Townsville University Hospital car park should be procured using a simple design finalisation and construct contract, opening up opportunities for local and tier 3 builders

8.9 Robina

Announced Scope	6 operating theatres Additional 114 overnight surgical beds Build-to-lease arrangement with Australian Unity Healthcare Property Trust (AUHPT) 30 year initial lease term, with 2 x 10 year options
Funding announced	June 2022 – Lease announced in Queensland Health and Hospitals Plan November 2022 – Non-binding commercial terms executed between AUHPT and GCHSS
Original budget	Original budget - \$0 Forecast capital contribution - \$80 million for fit out (FFE, ICT) and link bridge
Current HIQ forecast	N/A
Funding gap	N/A
Announced practical completion	
Forecast practical completion	At the earliest 2028 (TBC)
Early works start	N/A
Stage 1 contractor	N/A
Design status	
HHS	Gold Coast Hospital and Health Service (CGHHS)

8.9.1 Current Project Status & Issues

The Robina project differs from other projects in the CEP in that it is a commercial arrangement to acquire access to surgical and bed capacity through a lease structure.

Non-binding commercial terms were executed between the HHS and Australian Unity Healthcare Property Trust (**AU**) in November 2022, and the parties have subsequently been progressing design for a new building to be funded by AU and leased to the HHS and a private hospital operator (Aurora Healthcare).

In August 2023 AU entered into a fixed price building contract (with Built Constructions), however in October 2023 Aurora Healthcare withdrew from the commercial arrangements between them and AU. As a result, AU paused the project as it was unable to progress without the private hospital operator tenancy. Subsequent negotiations between the private sector proponents have resulted in the HHS being offered the opportunity to lease space in a new stage of the existing Robina Private Hospital site.

This existing private hospital site is attractive to the HHS, as with the construction of a link bridge, could connect directly to the existing Robina Public Hospital. This link bridge would require approval from the Department of Resources to link across Bayberry Lane.

A site plan follows in Figure 23.

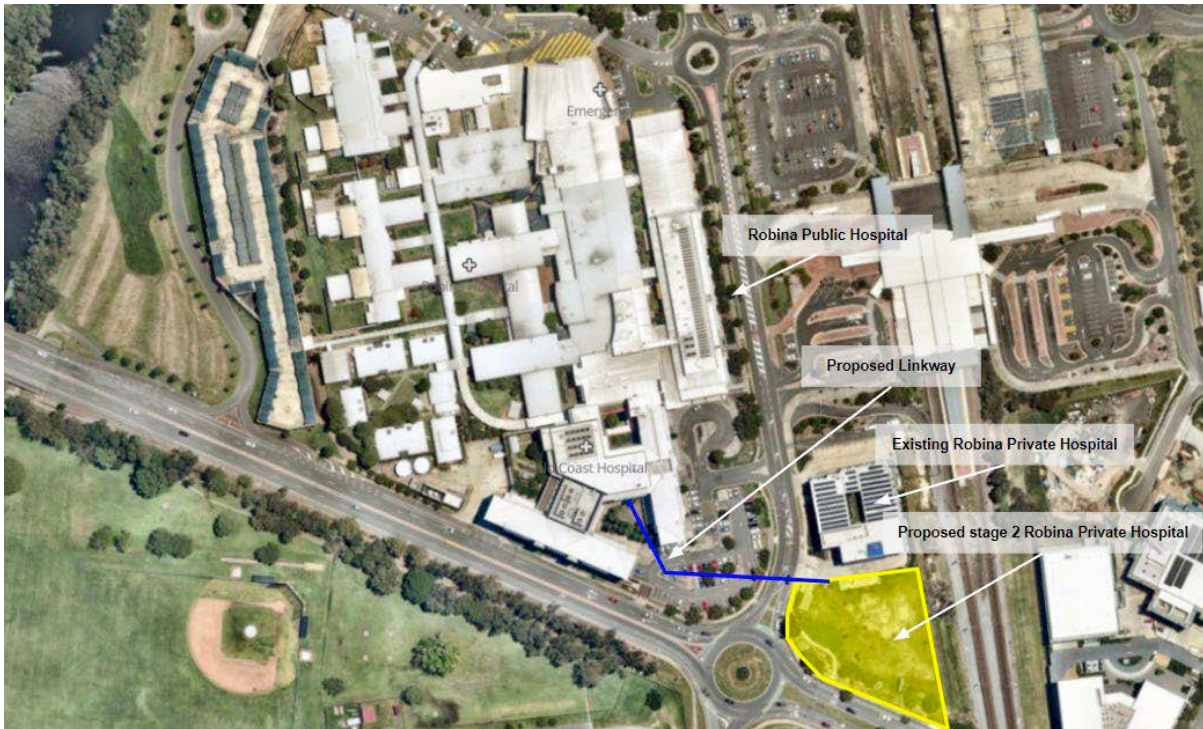


Figure 23: Robina Hospital site plan

Source: Robina Hospital Interim Capacity Project Business Case – Final Draft – supplied

The collective project team has continued to develop the necessary commercial documents and Government approvals, and received confirmation that the original commercial terms offered by AU would remain available to the HHS. On top of the base building leased space costs, an estimated capital contribution of \$75 million from the State will be required to fit out the space, acquire FF&E and ICT equipment and fund the link bridge. The base building lease arrangements would offer:

- Approximately 12,000m² of leased space;
- Initial 30-year lease with 2 further 10 year options;
- Capped total project cost (understood to be approximately \$100 million);
- Commencement rent calculated using a rentalisation rate²⁴ as offered by AU;
- CPI rent increases with 10 yearly market reviews of rent, and
- Outgoings and building management costs being to the HHS’s account.

This style of transaction, in effect, sees Government borrow money from AU at the rentalisation rate plus the market review rent increases. Whether this represents value for money is to be tested as part of the forthcoming Government approvals. Likely commencement rent is in excess of \$7 million per annum, with outgoings and building management in excess of \$2 million per annum. If CPI is assumed to be 3% per annum over the 30 year lease term (and 10 yearly market increases are assumed not to increase rent above CPI) then the minimum total rental payments (excluding outgoings) the State will pay will be at least \$310 million (in current day dollars). This assumes that the total project costs for the landlord are to be recovered in the initial 30 year term rents. AU’s likely development cost was estimated in 2023 to be circa \$89 million plus a \$5.3 million allocation of the underlying land’s value to the project. As such a \$100 million total development cost estimate (including land) is conservative and may now be 20-25% higher with construction cost and land value escalations. A higher development cost will increase the rent payable by the HHS.

It is unclear when a final commitment to the project would be required, however the Review understands that the AU Board approved the revised project on 16 December 2024. The HIQ team has mapped out an eight-week process to seek requisite Government approvals, including other parts of Queensland Government, but

²⁴ Rentalisation rate is the interest rate used in the formula to calculate rent payments.

these have not commenced. The Review understands that, as a result, Government is not presently committed to continue with this project as the commercial arrangements signed between the HHS and AU are believed to be non-binding.

As described under the Coomera project assessment, the bed requirement being provided at Robina was part of a HHS-wide short term bed need pending the completion of the Coomera project. The intention was for these beds to be available within 2-3 years from the time of the Robina commercial agreement in November 2022 – so around the time of this report (early 2025), whereas Coomera’s announced completion was to be the second half of 2027. This would have therefore provided the HHS with additional bed capacity for 2-3 years. Given Robina has yet to commence, and the reshaped Coomera is likely to be deliverable in the middle to second half of 2028, the bed capacity at Robina would now be available for potentially less than one year prior to the completion of Coomera.

As such, the option to deliver the additional beds at Coomera appears to the Review to be a preferable outcome, and the comments set out in section 8.2 above on the Coomera project are carried forward to Robina.

8.9.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue the current project to lease space directly opposite existing public hospital	<ul style="list-style-type: none"> Continue project with existing commercial negotiations and approvals processes Delivers clinical facilities immediately adjacent to existing public hospital Existing counterparty for Queensland (AU is counterparty on STARS) 	<ul style="list-style-type: none"> 30 year lease with commencing rent of at least \$7 million per annum escalating by CPI to an overall cost in excess of \$310 million plus outgoings and maintenance costs Unclear whether offered capitalisation rate represents value for money for the State Future market review clause for rent could provide uncapped cost exposure to the State Still requires construction of a new facility to provide new beds and services taking at least 2 years from today Doesn't provide beds to the HHS in 2025 as originally contemplated
2	Cease the current Robina project while a swift review of whole-of-HHS requirements is undertaken with a view to consolidating the short-term requirements that were to be delivered at Robina can alternately or better be accommodated in a rescoped Coomera project [Recommended option]	<ul style="list-style-type: none"> Opportunity to develop a more holistic health precinct at Coomera and engage with adjoining landowner Opportunity to bring private capital to share the load of development of the precinct Scale efficiencies from slight expansion of planned Coomera facilities (eg CSSD) to accommodate slightly more theatres rather 	<ul style="list-style-type: none"> Potential sunk costs of current design for Robina Loss of time in completing the Robina project Short term bed provision is not resolved Distance between Coomera and Robina

Option	Description	Pros	Cons
		than duplicating infrastructure at Robina <ul style="list-style-type: none"> <li data-bbox="735 286 1021 405">• Resource and operating cost efficiencies of operating from one site rather than both sites 	

8.9.3 Recommendation

Recommendation 30: Cease any further negotiations on the Robina lease pending the outcome of the whole-of-HHS bed requirement review in conjunction with the Coomera project

9. Project Specific Commentary and Recommendations – Stage 2 Projects/Awarded Projects

This section of the Report covers projects where main works construction contracts have been let and construction is underway. The projects considered in this section of the report are set out in Table 14.

Project name	Award date	Original Budget	Current Budget	Budget uplifts	Current Forecast	Variance to Original	Variance to Current
Ipswich Hospital Expansion Stage 2	27 September 2024	710	1,066	356	925	215	(141)
Logan Hospital Expansion Stage 2	26 September 2024	530	875	345	875	345	-
QEII Hospital Expansion	26 September 2024	465	619	154	648	183	29
PA Hospital Expansion	30 September 2024	345	748	403	761	416	13
Cairns Hospital Refurbishment	8 October 2024	-	179	179	181	181	2
Hervey Bay	6 November 2024	-	94	94	94	94	-
Totals		2,055	3,581 +75%	1,352	3,457 +69%	1,407	(123)

Table 14: Awarded CEP Project Budgets and Forecasts

9.1 Common Issues and Themes

As can be seen in Table 14, none of the awarded projects were awarded anywhere close to their initial planned budgets – the total overrun was 75% from the original budgets. The explanations for each of these individual cost variances sit within the project details in subsequent sections.

Four of these projects were also awarded within days of the caretaker period of 2024, and it appears that much of the necessary procurement activity was unduly rushed to achieve this timetable. The likely impacts of rushed procurement of such major projects is:

- Time pressure on the State team being used by the commercial counterpart to drive less value for the State than might otherwise have been available in a more moderate procurement process, and
- Pace at which contractual documentation and the range of detailed attachments with project scope and other project artefacts were delivered gives rise to presently unknown errors and omissions that may lead to further cost overruns or program delays.

9.2 Overarching Recommendations for Awarded Projects

In addition to specific project recommendations in subsequent sections, the Review makes the following overall suggestions regarding awarded projects:

- Request existing MC to propose revised risk allocations, contract amendments and concomitant price and program reductions for further negotiation with HIQ;
- Project governance should review open risks to ensure unmitigated, escalating or overdue risks are appropriately treated or mitigation plans are in place;
- Site infrastructure risks identified for these awarded projects (see further section 5.1.2) are appropriately reported through project governance and plans to seek funding for these items are developed and addressed, and
- Request contracted MCs to provide proposals for post-warranty post-completion proactive asset maintenance and management for a period of up to 5 years – this may assist in ensuring that programmed maintenance is properly established for new builds and may aid in ensuring MCs consider whole of life perspectives in construction decisions. The current two stage MC contract provides for 12 months of defect liability and equipment warranties for some of the critical equipment are also only for 12 months, such as medical gas equipment. This presents a risk to HHS maintenance budgets 12 months after completion.

9.3 Cairns Hospital

Announced Scope	New: Surgical Centre, including 4 operating theatres & 32 short-stay beds Refurbishment: 64 overnight beds (32 beds D Block, 32 beds B Block)
Funding announced	21 June 2022
Original budget	\$250 million
Current HIQ forecast	\$628 million (\$181 million forecasted for 64-bed refurbishment. \$447 million forecast for new surgical centre)
Funding gap	\$378 million
Announced practical completion	Second half 2027
Forecast practical completion	At the earliest Second half 2027 (refurbishment only) Nil for Surgical Centre
Early works start	Mid 2025
Stage 1 contractor	Hansen Yuncken
Design status	80% Detailed Design completed February 2024 Surgical Centre at 100% Detailed Design
HHS	Cairns and Hinterland HHS (CHHHS)

9.3.1 Current Project Status & Issues

The originally announced Cairns Hospital project has been significantly amended so that only the refurbishment elements are being delivered under the two-stage managing contract awarded to Hansen Yuncken on 26 September 2024.

The Stage 1 MC contract was awarded to Hansen Yuncken and detailed design work for the original total scope of the project was completed during 2024. As design work and the Stage 1 market testing of subcontract trades proceeded, the forecast costs of the project accelerated rapidly beyond the original budget to a total funding requirement of \$626 million – vastly beyond the originally planned total cost of \$250 million. The major drivers of the forecast cost overrun arose from:

- Scope additions - \$160 million – to include the required support services (kitchen, sterilising department), updated clinical models of care and missing clinical services including elective surgical and ambulatory care facilities, and
- Market conditions plus escalation - \$287 million – reflecting difficulty in attracting the requisite labour force in Cairns, constrained subcontractor market, productivity and MC contract risk allocations.

The HHS were not adequately consulted on the proposed siting of the new surgical centre, and the proposed location was likely to be clinically and operationally challenging for the HHS to operate. The proposed site would remain land locked and not provide any potential for future expansion spaces. Further, the project did not address one of the highest clinical and public safety risks for Cairns – the reconstruction of the helipad away from the esplanade site.

In addition, the substantially higher project forecast went way beyond the MC's then prequalification level in Queensland, such that HIQ was unable to award the full scope to the contracted MC even if budget was made available.

Accordingly, HIQ proposed a solution to split the project into two elements – an immediate award of the refurbishment component of the project to the existing MC utilising 71.6% of the available budget and leaving just \$71 million of budget to fund \$447 million for the original scope not covered in the refurbishment works.

Finally, several universities have expressed interest in a co-located development of a health innovation and research precinct at Cairns, with one university having secured substantial funding for the innovation precinct project. The current surgical centre project, if delivered in isolation of this opportunity, risks the development of such a precinct at Cairns.

9.3.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken Construction has commenced 	<ul style="list-style-type: none"> Only part of the original scope being delivered No pathway to deliver the non-contracted scope without substantial budget supplementation Doesn't address urgent clinical and public safety needs to rebuild helipad Current total project forecast running well ahead of announced budget Doesn't allow for modified contractual risk allocations to be taken up
2	Continue the refurbishment works scope of work under the current contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken 	<ul style="list-style-type: none"> No pathway to deliver the non-contracted scope Doesn't allow for modified contractual risk allocations to be taken up
3	<p>Option 2 plus allocate part of the \$71 million unallocated budget to HIQ to appoint new design team to work with the HHS to collaboratively plan:</p> <ul style="list-style-type: none"> a precinct that incorporates the proposed surgical centre and university spaces future prioritised clinical scope for the Cairns hospital not delivered in the present refurbishment scope staging options for development procurement options for the future development <p>Balance of \$71 million should be allocated to urgently addressing plans to relocate the helipad</p> <p>[Recommended option]</p>	<ul style="list-style-type: none"> Continue refurbishment project with existing contractor and consultant team and other benefits from option 2 Opportunity to refresh the clinical prioritisation for Cairns hospital development Opportunity to plan for the inclusion of tertiary education and research facilities Can plan a scope of works with staged developments to spread cashflows over a longer period of time Can investigate procurement options for the surgical centre and innovation centre Time to identify and acquire appropriate lands adjacent to the hospital to provide opportunities for future growth 	<ul style="list-style-type: none"> Non-refurbishment works have no timing or commitment for delivery Delayed start to development works drive higher escalation

The Review has engaged with the HHS and they are supportive of pausing the un-commenced works to allow for a new planning process to commence to appropriately consider the opportunities for the innovation precinct incorporating Cairns Hospital requirements including the originally planned surgical centre. This re-planning exercise can also explore recently delivered health and innovation precinct projects, including alternate funding and financing structures that have been successful in driving institutional investment into such developments.

Additionally, this planning exercise should also consider the status and future needs for Cairns Hospital's helipad, potentially moving it away from the esplanade. Should this move not be planned and executed swiftly there is a risk that the helipad will need to be closed, and aeromedical services be delivered from the Cairns airport. This is clearly unviable for service delivery at Cairns and is a threat to ongoing clinical services.

Finally, Treasury has advised the Review that whilst the refurbishment package scope of works has been awarded, Government has not formally approved splitting the Cairns project into two packages.

9.3.3 Recommendation

Recommendation 31: The current refurbishment works at Cairns should progress to completion. HIQ should appoint a new design team to work collaboratively with the HHS to plan a precinct for the health and tertiary education development and propose staging and procurement options for future developments.

Recommendation 32: Options to urgently address the Cairns helipad should be explored, with planning to relocate the helipad away from the current esplanade site.

9.4 Hervey Bay

Announced Scope	Fit out of the existing HBH Emergency Department (ED) Building including: <ul style="list-style-type: none"> • Fit out Level 2 – 35 beds: <ul style="list-style-type: none"> o Impatient Unit = 25 medical beds o Intensive Care Unit = 10 ICU beds o Shared staff areas, comms room and plant rooms • Base Building works: <ul style="list-style-type: none"> o Install new lift in an existing life shaft. o Replace existing temporary roof o Relocate existing helipad to rooftop
Funding announced	June 2022
Original budget	\$40 million
Current HIQ forecast	\$94 million (see below for comments on this value)
Funding gap	\$nil
Announced practical completion	November 2023
Forecast practical completion	At the earliest June 2026
Early works start	N/A
Stage 1 contractor	Apollo Property Group
Design status	Detailed Design completed June 2023 Issued for Construction documents in progress
HHS	Wide Bay Hospital and Health Service (WBHHS)

9.4.1 Current Project Status & Issues

The upgrade and fit out of the Hervey Bay Hospital Project Commencement Approval was granted on 5 September 2024, Apollo Property Group was contracted on 6 November 2024 and works commenced on site on 20 November 2024. Forecast practical completion of the project is June 2026, which is around 21 months later than originally announced.

As would be expected for a project at this stage, project contingency of \$9.85 million remains untouched, and expenditure to date of \$2.8 million is within budget and has been focussed on design, engineering and project management costs.

Whilst small in value compared with the overall scheme of the CEP, HIQ forecast costs for the project in the project reporting portal, dated post the budget uplift announcement, show a forecast cost of \$41 million rather than the uplifted \$94 million. Project Steering Committee reporting notes that the divergence in values is a timing issue with updating project budgets and forecasts in the reporting portal; the Review has adopted \$94 million amount as the correct forecast value. However, **it is unclear why this substantially uplifted budget was required given the reported HIQ forecast values** – the previously forecast values are less than half the revised budget which is stated to have been required to award the construction contract for the project.

9.4.2 Options to Proceed

Given the project's current status, the Review believes that there is no need to consider any options other than continue with the current project and proceed with the existing builder under the existing contract, continuing good project governance and reporting.

9.4.3 Recommendation

Given the current status of this in-flight project, the Review makes no recommendations to change this project.

9.5 Ipswich Hospital

Announced Scope	200 beds (including Cardiac Care Unit (CCU) and Intensive Care Unit (ICU)) Emergency Department 6 Operating Theatres Satellite Medical Imaging Service New Central Sterilising Department Kitchen and Back of House Pharmacy Mortuary Cardiac Catheter Lab High Voltage Upgrade
Funding announced	Q2 2023
Original budget	\$710 million (Updated uplift budget: 1.066 billion)
Current HIQ forecast	\$925 million
Funding gap	\$215 million
Announced practical completion	Second half of 2027
Forecast practical completion	3 May 2028
Early works start	25 September 2020
Stage 1 contractor	Besix Watpac
Design status	Complete – under construction
HHS	West Moreton Health

9.5.1 Current Project Status & Issues

The Ipswich Hospital project is delivering a significant upgrade to an area experiencing strong population growth and a HHS that has a relatively low level of self-sufficiency at present. The HHS has, prior to the CEP, developed a masterplan and a \$1.5 billion business case for a full redevelopment of the Ipswich hospital. The current CEP scope, delivering 200 beds across a 48,000m² 12 storey building, delivers only a part of that overarching growth planned in the business case. The project additionally provides additional support to the significant corrections facilities in the region.

Main works Stage 2 MC award took place on 26 September 2024, following the Stage 2 GCS submission by the MC on 22 August 2024. This is a huge volume of complex procurement activity to have taken place in a such a short period of time.

Early and enabling works on the constrained brownfields site continue, with over 37,000m³ of bulk excavation completed, more than one third of the piling completed, and tower crane installed.

The significant increase in the allocated budget for this project was largely driven by:

- Support services and additional scope – \$137 million was required to add critical support services to the planned bed expansion. The additional scope included support services including pharmacy, mortuary and kitchen – all elements required with such a growth of beds. In addition, substantial upgrades to high voltage electricity supply (including a new ring main) have been provided for and cardiac catheterisation lab has been added to the project;
- Direct trade costs, escalation and contract risk of \$107 million – market reality for trades and pricing aligned to program, together with pricing for contract risk allocations, and
- Increase in eHealth allocation \$25 million.

The project team appears to be operating effectively and collaboratively, with good relationships between the HHS, HIQ, consultants and the builder. Planning for the CEP project did not include the support services described above, and HIQ's project team worked with the HHS post announcement to ensure clinical

prioritisation and support services were incorporated, clinical flows were addressed and the intended adjacencies and resultant block and stack planning required significant amendment.

Unlike other CEP projects the collective team on this project has worked collaboratively and more cohesively than seen elsewhere, and the combined State-side team are physically co-located. Clearly the combination of individuals, skills and approach has resulted in a good outcome – a comprehensive lessons learned and an understanding of technical and behaviour competencies exhibited from all parties should be captured and disseminated across HIQ and HHSs working on CEP.

9.5.2 Options to Proceed

The current project has been awarded and additional budget allocated. The present project should continue on its current trajectory.

Given the very short Stage 2 MC procurement process, project governance needs to remain vigilant to any contractual errors or omissions to ensure no untoward risks emerge that put pressure on the project budget.

9.5.3 Recommendation

Recommendation 33: HIQ should capture lessons learned from the Ipswich Hospital project's approach to clinical prioritisation, clinical flow assessments, stakeholder engagement and project management on this project as best practice across the CEP and distil across the balance of the CEP projects

9.6 Logan Hospital

Announced Scope	112 Inpatient beds 10 Operating Theatres 6 Endoscopy rooms Centralised Sterilisation Services Department (CSSD) 3 Catheterisation laboratories (including one interventional radiology laboratory) Expanded pharmacy Expansion of administration spaces supporting clinical areas in Building 4 New loading dock Undercroft space for future kitchen and associated plant
Funding announced	June 2022
Original budget	\$530 million (uplift to \$875 million)
Current HIQ forecast	\$875 million
Funding gap	\$345 million
Announced practical completion	December 2026
Forecast practical completion	At the earliest first half of 2027
Early works start	July 2024
Stage 1 contractor	John Holland Group
Design status	Schematic design for the interim and permanent options (in Building 1) commenced in December 2024, while preparing for a design & construct procurement process to engage a building contractor for the interim stage.
HHS	Metro South Health (MSHHS)

9.6.1 Current Project Status & Issues

The Logan Hospital Expansion was announced with a budget of \$530 million, and with additional funding of \$345 million provided in September 2024, the Stage 2 Managing Contractor deed was executed on 26 September 2024 with John Holland Group following submission of their offer on 28 August 2024. This is a huge volume of complex procurement activity to have taken place in a such a short period of time.

The latest figures available indicate inception to date expenditure of \$34.2 million, and an overall forecast final cost around \$2.7 million below the revised budget. The full project contingency of \$67.2 million was unallocated save for a minor allocation (\$124k) approved in November 2024.

The additional funding was required to meet the revised construction pricing, including:

- Support services \$99.75 million – original scope didn't include essential services such as a main entry, CSSD (despite the original scope adding 10 new theatres and 6 new endoscopy suites), pharmacy, loading dock and administration space. Three additional cardiac catheterisation laboratories were included in this scope item but are not support services but core clinical services;
- Escalation – HIQ has asserted that 40% increase in the 15 months between the Stage 1 HIQ construction estimate and the MC GCS Stage 2 offer was due to escalation – industry engagement through the Review indicates that escalation was between 9 and 10 % per annum and so this claim is difficult to support. The better view is that the HIQ construction estimate was not accurate nor reflective of the market realities, and
- Risk – the accepted Stage 2 MC offer included a gross allocation of \$80.3 million that was reduced by \$54.8 million during contract negotiations, leaving a residual extra risk allocation of \$25.5 million

Key residual risks within the project are:

- Design sees food and linen trolleys being pushed through the emergency department from the loading dock to the balance of the hospital – this is a very high risk on the project's risk register but it is not clear how this will be ameliorated;
- FF&E and MME specification and selection may exceed the allocated budget and

- Extraordinarily high number of decants required (more than 75) plus has produced a need to lease offsite space;
- Clinical fitness for purpose – project value management has reduced operating theatre shielding to only 7 of the 10 theatres which reduces the operational flexibility to have consistent infrastructure across the theatres;
- Residual support service upgrades that remain out of scope including not including any expansion of the mortuary in the project scope and rejection of proposed changed model of food service delivery through project governance (HHS has moved to on-demand meal service in other locations but even with the additional funding provided to the Logan project, no money was made available for this operational efficiency and requested service model), and
- Site conditions and services infrastructure – the project adds to existing building stock and site services including power.

Aside from a redesign to accommodate a different logistics path, the risks above can be managed within the project, particularly as project contingency is (practically) untouched.

9.6.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract	<ul style="list-style-type: none"> • Continue project with existing contractor and consultant team • No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program • Scope is known • Clinical and stakeholder consultation has been undertaken • Fastest option to have construction commence 	<ul style="list-style-type: none"> • Current project forecast running well ahead of announced budget • Current project program running well behind announced completion date • Doesn't allow for modified contractual risk allocations to be taken up
2	Request contractor to propose revised risk allocations, contract amendments and concomitant price and program reductions for further negotiation with HIQ	<ul style="list-style-type: none"> • Maintain current contractor and design team • Continue with current scope • Probable program and cost savings 	<ul style="list-style-type: none"> • Government takes increased risk but can be ameliorated through implementing workplace umpire to mediate weather and safety risks • Delay – will further delay the commencement of main works

Given the very short Stage 2 MC procurement process, project governance needs to remain vigilant to any contractual errors or omissions to ensure no untoward risks emerge that put pressure on the project budget.

9.6.3 Recommendation

Recommendation 34: *The Logan project should continue as contracted, with a strong focus on managing key risks and retention of contingency to address outstanding clinical fitness for purpose risks.*

9.7 Princess Alexandra Hospital

Announced Scope	249 beds 13 Oncology treatment bays Expansion of the Pharmacy, kitchen, bed store and medical imaging department
Funding announced	Q1 2023
Original budget	\$350 million
Current HIQ forecast	\$761 million
Funding gap	\$411 million
Announced practical completion	Q4 2027
Forecast practical completion	At the earliest Q4 2028
Early works start	May 2024
Stage 1 contractor	John Holland
Design status	80% Detailed Design Assurance Review completed with revised material supplied from the project team
HHS	Metro South Hospital and Health Service (MSHHS)

9.7.1 Current Project Status & Issues

The Princess Alexandra (PA) Hospital expansion project has progressed to the award of the Stage 2 Managing Contractor engagement to John Holland on 26 September 2024, as a culmination of the design and planning for the project and the GCS call being made on 1 July 2024. John Holland was awarded Stage 1 on 1 May 2023, and submitted their Stage 2 offer on 27 August 2024 and presented their detailed bid on 3 September 2024. HIQ very swiftly assessed the offer, sought clarifications and concluded evaluation on 18 September 2024. This is a huge volume of complex procurement activity to have taken place in a such a short period of time.

Works are well underway on site, and the project has spent \$34.9 million since inception.

The PA project forecast cost escalated from the announced \$444 million to the present \$761 million with the major elements of change in the forecast cost arising from:

- Complexity of decanting requirements – \$80 million – original budget understated the complexity of 30 stages of decanting and construction within an brownfields project so as to allow continued service delivery of essential services including the emergency department;
- Trades costs - \$169 million – market reality of trade prices;
- MC risk allocation - \$104.5 million or which around \$88 million was negotiated downwards by HIQ;
- Escalation – \$58.3 million – additional escalation for elongated program from decanting requirements;
- FF&E not included in initial budget – \$20.6 million, and
- Support services – new scope to the project which were removed from John Holland’s scope and a fresh procurement for these works are due to conclude at the end of February 2025.

Project contingency of \$53.9 million remains unallocated.

Key project risks that the HHS and project team are managing include:

- FF&E coordination – despite current state of project, FF&E remains uncoordinated between FF&E procurement team, design team, HHS and MC – risks are twofold – design rework to accommodate final FF&E or wrong/inaccurate FF&E procurement (multiple risks summarised here);
- Security technology upgrades are not included in project scope;
- Commissioning of new lifts impacts up to 17 patient spaces in ED – there is no alternate location to place these patient beds;
- Integration of new works into existing fire systems may mis-align, and
- Provisional sums from the MC may be inadequate.

While not spelt out in the project’s current top risks, brownfield redevelopment directly above the existing emergency department is inherently risky. Additionally, the project team has appropriately identified the complexities of integrating new construction fire services and designs into existing fire building systems. Further, PA already operates multiple nurse call systems, so integration of clinical technology should be a highly rated risk to manage for this project.

Finally, the development will present significant decant and operational service delivery continuity challenges, and cranes on site may cause challenges with providing 24x7 critical care services.

9.7.2 Options to Proceed

Option	Description	Pros	Cons
1	Continue current project and proceed with existing builder under existing contract	<ul style="list-style-type: none"> Continue project with existing contractor and consultant team No major contract negotiations/changed risk allocations – proceed with existing MC contract and negotiate construction costs and program Scope is known Clinical and stakeholder consultation has been undertaken Fastest option to have construction complete per current program 	<ul style="list-style-type: none"> Current project forecast running well ahead of original budget, but budget allocation was approved by the previous Governments Current project program running well behind announced completion date Doesn’t allow for modified contractual risk allocations to be taken up Brownfield redevelopment risks will require close ongoing management of the MC by HIQ to prevent Latent conditions and tired infrastructure in a brownfield setting eg fire systems, nurse call etc
2	Support services	<ul style="list-style-type: none"> Current tender to 12 potential bidders will demonstrate contemporary market pricing for these works Pitching smaller work packages to tier 2 and 3 builders opens opportunities to a wider group of builders Apply refreshed risk allocations to the construction market 	<ul style="list-style-type: none"> Awarding works to a second builder will require high calibre onsite contractor management to avoid clashes and supply chain and logistics challenges Different risk allocations, resourcing and contractual model for two builders on the one site may give rise to a range of challenges

Given the very short Stage 2 MC procurement process, project governance needs to remain vigilant to any contractual errors or omissions to ensure no untoward risks emerge that put pressure on the project budget.

9.7.3 Recommendation

Recommendation 35: The Princess Alexandra project should continue as contracted, with a strong focus on managing key risks and retention of contingency to address outstanding clinical fitness for purpose risks. HIQ should conclude the procurement for additional support services expeditiously.

9.8 QEII Hospital

Announced Scope	112 overnight beds 7 Intensive Care Unit beds 16 same day beds 8 Operating Theatres Support service expansions: <ul style="list-style-type: none"> • Medical Imaging • Expansion to Outpatients Services • Maintenance Areas (Building 1) • Medical Records Multistorey car park
Funding announced	December 2022
Original budget	\$465 million (Uplift to \$619 million)
Current HIQ forecast	\$621 million
Funding gap	\$156 million
Announced practical completion	Second half 2027
Forecast practical completion	At the earliest October 2028
Early works start	19 January 2022
Stage 1 contractor	Built.
Design status	80% Detailed Design feedback received from MSHHS and Technical Assurance. Feedback under review for inclusion in 100% Design Pack issued in December 2024
HHS	Metro South Hospital and Health Service

9.8.1 Current Project Status & Issues

The QEII expansion project is delivering two separate projects – the new clinical services building (CSB) and associated refurbishments plus a new carpark that is required prior to the CSB going live. The original \$465 million project budget was uplifted to \$619.5 million in September 2024 to allow the Stage 2 contract to be awarded to Built on 26 September 2024 following their GCS submission on 2 August 2024. Once again, a substantial procurement exercise was completed in a very short period of time for this project.

The increase in budget requirement was driven by:

- Support services scope – \$44 million – including medical records and maintenance areas plus allocations towards addressing medical imaging and an expansion to outpatients;
- Direct trade costs – \$20 million for early works actual prices compared with budget plus circa \$94.4 million for main works;
- FF&E – \$6 million extra allocation over and above original budget;
- Escalation and contract risk – circa \$42 million, and
- Planning program and scope – whilst a small overall increase in design consultant fees of \$0.6 million provided from project contingency, the initially planned approach to clinical engagement and user groups was not accepted by the HHS and a more fulsome suite of detailed design user groups was reinstated for the project.

Construction works commenced on site in October 2024, and the design phase and site setup works have seen expenditure from inception of \$32.1 million. Project contingency of \$44.7 million remains unallocated.

There are two major outstanding risks for this project is that the CEP project did not adequately contemplate:

- Energy supply for the hospital – The existing hospital operates on a legacy low voltage (LV) system which is insufficient and inappropriate for the existing hospital and the new CSB cannot be fed from this LV supply. Energex, the energy supplier to the hospital, have provided advice that they will provide a short grace period of ongoing provision of the legacy LV supply, and are providing the new high voltage (HV) supply for the CEP developments. However, this split supply is a significant

operational risk that is not adequately addressed within the CEP project budget and there is no other source of funding presently available to address this risk beyond the present budget risk allocation.

In addition, the late recognition of the requirement for a new HV supply by the team has meant there is a substantial risk that Energex will be unable to provide the required energy feed to enable energisation of the CSB on time. The scope of on-site works required is not presently included in the MC contract and HIQ is assessing options to procure these works, and

- Radiology scope – the CEP did not recognise the requirement to provide additional imaging capabilities to support clinical expansions and upgrades being delivered by the project. Additionally, the CEP planning did not appropriately contemplate that the existing facilities at QEII are provided by an external service provider under contract. The project’s risk assessment is that this risk is >90% to occur and without appropriate funding and inclusion of the requisite scope in the CEP the result will be that QEII does not have the diagnostic imaging requirements to ensure safe clinical management of patients and will impede efficient patient flow. The project has made a \$11 million allocation to address this risk, but the design and clinical flows need urgent attention in consultation with the HHS and the outsourced imaging provider

A new 8 level multistorey car park is adding much needed additional 1,379 car parking spaces on the campus and being funded through the car park portfolio funding model. In addition, the CEP project is funding an on grade 460 space car park to offset losses from the construction activity on site.

9.8.2 Options to Proceed

The current QEII project should continue, but with a strong focus on resolving the residual clinical priority scope items, together with the major risks highlighted earlier. This may require an assessment whether the present project contingency and budget allocations are sufficient to address these risks.

Given the very short Stage 2 MC procurement process, project governance needs to remain vigilant to any contractual errors or omissions to ensure no untoward risks emerge that put pressure on the project budget.

In addition, the HHS should develop a business case in conjunction with Energex to move the current LV supply to a HV supply within the grace period provided by Energex.

9.8.3 Recommendation

Recommendation 36: A business case for moving the existing QEII facilities from low voltage to a new high voltage should be prepared in conjunction with Energex and assessed for future funding against the clinical and operational risk

10. Hospital Car Park Program

10.1 Structure & funding arrangements

The 2023-24 budget provided \$58.4 million of funding for hospital parking projects to meet increasing demand for parking, including two projects from the CEP programme:

- **\$43.7 million** for construction of a new 1,503 space multi-storey car park at **The Prince Charles Hospital** (total estimated cost \$81.9 million), and
- **\$10.0 million** for construction of a new 1,379 multi-storey car park at **The Queen Elizabeth II Jubilee Hospital** (total expected cost \$29.81 million).

The 2024-25 budget reannounced these projects but with increased total project cost of \$92.48 million for The Prince Charles Hospital. No further budget was separately identified for QEII.

Other hospital car parking projects mentioned were:

- **\$2.7 million** for completion of the new \$46.6 million multi-storey car park at Caboolture Hospital, providing approximately 1,080 parking spaces in a mix of multi-storey and at grade facilities, and
- **\$2 million** for completion of a new \$50.5 million multi-level car park for Redland Hospital.

The Government Portfolio Model for delivery of car parking introduced as part of the CEP is in addition to directly funded car parks in the budget. Under this funding structure, Queensland Treasury provides a loan to Health to construct the car park, and then the car parking fees collected from the car park are used to repay that loan. This program provides an alternate funding source for the delivery of car spaces, but with the car parking charges moderated by local conditions, coupled with escalating construction costs, there is an emergent risk that loans may not be able to be repaid in the intended loan period.

This funding structure was required to provide an alternate funding source to supplement the capital allocation provided to Health and to provide requisite extra car parking capacity at hospitals for patients, visitors and staff.

This form of funding does allow funding flexibility for Health, however without tight cost controls, good maintenance of car parks (funding for which is not provided for in the loan) and maintaining car parking charges, there are risks of the loans being unable to be repaid to Treasury in accordance with the loan timeframes.

As a direct result of the CEP, demand for car parking will increase as services come on line and 2,348 car parking spaces will be permanently removed across eight CEP sites to enable the construction of clinical facilities. Furthermore, six CEP sites already have existing car parking deficits based on current service demand.

The Hospital Car Parking Program (HCPP) was designed to address these requirements and support delivery of fit-for-purpose car parking facilities that meet demand, are future-proofed, are commercially viable, and meet end-user requirements in respect of being safe, accessible and affordable. To date the HCPP has had approved funding of \$1.38 billion to deliver 14 car parking projects across Queensland. There are currently 15 projects in planning.

10.2 Car park cost assessments

The Review has assessed announced CEP car park project costs, and the summary is set out in Table 15.

Carpark location	Number of spaces	Project budget \$	Cost per space \$	Tender/award forecast date
Coomera Hospital	1,290	117,226,912	90,874	Q1 2025 (tender)
Hervey Bay Hospital Stage 1	219	5,848,113	26,704	Q2 2025 (at grade only)
Ipswich Hospital	924	147,210,000	159,318	Q3 2024 (awarded)
Logan Hospital	1,249	193,680,000	155,068	Q3 2024 (awarded)
Mackay Hospital	1,289	166,196,700	128,935	Q1 2025 (tender)
PA Hospital	650	162,290,700	249,678	Q1 2025 (tender)
QEII	1,379	127,440,000	92,415	Q3 2024 (awarded)
Redcliffe	494	39,880,000	80,729	Q4 2024 (3 level extension to existing)
Toowoomba Hospital	1,720	205,182,000	119,292	Q1 2025 (tender)
Townsville University Hospital	636	104,796,924	164,775	Q1 2025 (tender)
Program Contingency	-	112,888,651		
Total	9,850	1,382,640,000	140,370	
Total excluding Hervey Bay	9,631	1,376,791,887	142,954	

Table 15: Hospital Car Park Program

The car parking projects above illustrate a very wide variance in costs per space, with obvious outliers in remote and regional locations forecast to cost substantially more per space than in southeast Queensland. The average costs for these projects are all higher than seen in other jurisdictions, where actual costs to construct multideck car parks are in the range of \$40-65,000 per space. It is unclear what is driving such a substantial variance in forecast costs against actual delivered project costs in other jurisdictions. It is also unclear what is driving the out-of-range forecast cost per space at PA Hospital, and further enquiries should be made as to the scope and inclusions in this project that are driving such a high per space cost plan.

If the at-grade car park at Hervey Bay is excluded from the analysis, then average forecast costs per space to construct multideck car parks are \$142,954 per space – more than double the highest end of the national market reference costs per space (\$65,000 per space). Applying the top of end of the market range to the cost of the car parks to be delivered under the CEP would have saved \$750 million, and if rates could have been reduced to the lower end of the reference range (\$40,000 per space – 28% of the current forecast costs) then the savings would have increased to over \$990 million. For just the unawarded multi-deck car parks, the available savings are in the range of \$513–665 million.

Unfortunately HIQ has already awarded contracts for three of the car park projects at these grossly inflated prices and unless these can be terminated and retendered at a more moderate cost, potential savings of between \$237 million and \$326 million have been lost.

As such, the Review finds that the currently planned car park projects are at significantly higher costs than should be expected and these projects should not be allowed to continue in their current form.

A number of car parking projects have not yet progressed into procurement; a number of projects that were to go to market in the first quarter of 2025 have been delayed following the announcement of this Review (see Table 15 above). There is, accordingly, an opportunity to review the designs for planned carparks, to rationalise and simplify designs and seek to procure construction of these car parks from tier 2 or tier 3 builders, and in particular in regional areas, to use local construction firms.

Recommendation 37: Designs for carparks should be reviewed to simplify and rationalise detailed designs, and future tenders should be on a simplified construction contract to tier 2 and 3 construction firms – with local firms encouraged to tender in regional areas

Part 2: Sustaining Capital Program

11. Sustaining Capital Program

11.1 Queensland Government Strategic Asset Management Plan Framework

The Queensland Government Building Policy Framework – Growth and Renewal requires agencies to develop both a Strategic Asset Management Plan and a Strategic Maintenance Plan. The Strategic Maintenance Plan sets out the provisions made for proactive and reactive maintenance, and defines the following policy requirements:

- Policy requirement 11 – building asset information record management, including asset condition assessments;
- Policy requirement 12 – asset assessments and performance – mandating asset assessments every 3 years (or more often following natural disasters);
- Policy requirement 13 – planning Government building maintenance program and pipeline – which establishes positive obligation on agencies to have arrangements for asset maintenance in place with appropriate suppliers and report on funded and unfunded maintenance programs, and
- Policy requirement 14 – sustainability indicators.

11.2 Queensland Health Processes and Practices

Each HHS prepares a Strategic Asset Management Plan (SAMP), supported by more detailed Asset Management Plans (AMP).

There are significant differences in the manner in which HHSs develop SAMPs and AMPs, some of which is based on capability and experience of local teams, with HHS resources often supplemented with external advisors especially to do asset condition assessments.

The level and quality of data captured as a result of these assessments is highly variable, and through the Review it became apparent that there is no centralised tool for capturing asset condition and preparing the AMPs and SAMPs. In addition, there is no data dictionary nor asset condition ratings guidance – the ways assets are graded is presently left to each HHS to determine. Whilst asset condition assessments can be subjective, guidance on a Queensland Health approach to rating asset condition should be developed and promulgated.

Recommendation 38: Clear guidance on a Queensland Health approach to rating asset conditions should be developed and promulgated

To support standardisation of asset management across Queensland Health, reduce administrative overhead for HHSs and the Department by limiting the amount of information prepared in spreadsheets in HHSs and submitted to the Department and to create a central repository of asset information, the asset management module of S/4HANA (the present Queensland Health enterprise resource planning and finance management system) should be implemented. The Review understands that a small pilot of this module is presently being contemplated by the Corporate Services Division. This pilot should be accelerated with a view to rolling out this module as soon as practical.

Recommendation 39: the S/4HANA asset management module pilot should be accelerated and Statewide rollout implemented as soon as practical

Providing Statewide visibility of asset maintenance opens the opportunity to begin to move to a programmatic and preventive maintenance regime by having visibility of the conditions of essential assets Statewide. This also allows for procurement of asset replacements (assuming budget is available) on a greater than HHS basis. Especially for rural and regional HHSs, this opens up the ability to procure multi-year preventative maintenance and asset replacement for major plant items such as chillers, lifts, energy supply and local

generators and core data communications equipment, together with major medical equipment with long supply lead times.

Clear roles and responsibilities will need to be defined between HHSs and Divisions within the Department, as at the moment multiple Divisions are involved in asset maintenance and procurement. Should a programmatic procurement model be implemented, absolute clarity of governance and roles and responsibility is essential, and high calibre asset management contract management skills will be required.

Given the other roles being undertaken in a re-shaped HIQ, the Review suggests that this whole-of-system asset management procurement, contract management and oversight function be added to HIQ. This is covered in more detail in section 3.6 above.

11.3 Queensland Audit Office Review

The Queensland Audit Office (QAO) report on the Department of Health's financial statements for 2024-25 was tabled on 15 January 2025²⁵, dedicating a chapter on asset management.

This report noted that in the 2024-25 budget, \$215 million was allocated for the Sustaining Capital Program which was announced in 2021-22 to include not only the refurbishment and upgrade of facilities and equipment, but also to fund the *Accelerated Infrastructure Delivery Program* and the *Health Building Rural and Remote Health Program*.

The report also set out that the 2023-24 capital budget for Health was \$1.6 billion, but actual capital expenditure was 30% above budget at \$2.1 billion.

However the bulk of the chapter was focussed on maintenance needs of Health's assets, and the fact that

HHSs reported a 40 per cent increase in maintenance needs of their assets, which indicates they continue to face significant challenges in funding the maintenance of their assets. This includes operational maintenance that has been deferred, capital maintenance that has been deferred and, in some cases, forecast future asset renewals, replacements and refurbishments.²⁶

The significant increase of \$580 million in maintenance liabilities to \$2 billion in total was driven by one HHS alone increasing maintenance requirements by \$330 million following an updated asset condition review by that HHS. In addition, the increase in the costs of maintenance was also attributed as a factor to the increase in the overall costs forecast.

The QAO noted that the increase, irrespective of the attribution of the actual drivers of the increase, suggested that additional maintenance funding is required to reduce the deferred maintenance. (Note the QAO also spent some time on the definitional differences between deferred and backlog maintenance which are not repeated in this report.)

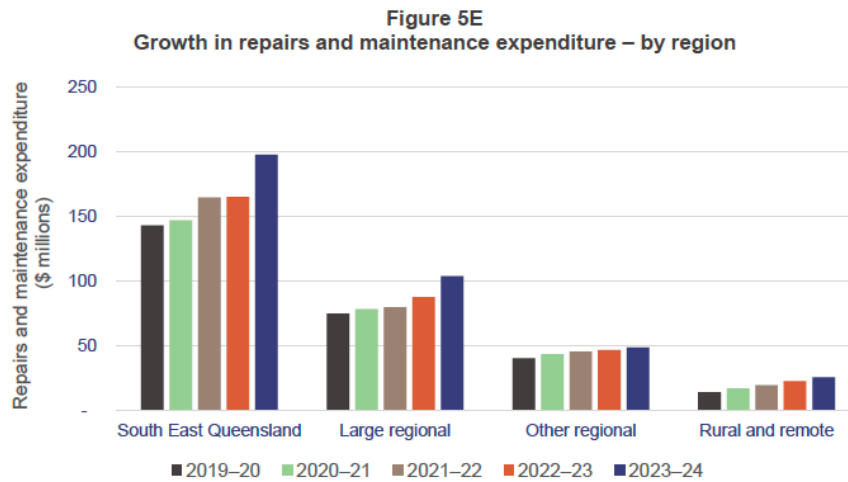
However the report details the actual amounts spent on maintenance in the 2023-24 years which the QAO concludes demonstrates that "HHSs are making progress in narrowing the gap between actual repairs and maintenance and deferred maintenance"²⁷.

²⁵ Queensland Audit Office, Health 2024 (Report 8: 2024-25) released 15 January 2025, accessed via <https://www.qao.qld.gov.au/reports-resources/reports-parliament/health-2024>

²⁶ Ibid p25

²⁷ Ibid p29

Graphically:



Source: Queensland Audit Office, from Department of Health data.

Figure 24: Growth in repairs and maintenance expenditure

11.4 Historic SCP Funding and Performance

Queensland Health has been provided with a static level of \$325 million of SCP funding in successive State Budgets as far back as 2010, with a small increase to \$385 million in 2022-23 and a further step up to \$500 million in 2023-24. However these increases were provided to fund non capital maintenance projects.

The SCP is operated as follows:

Queensland Health’s current asset maintenance and renewal funding arrangements

Maintenance and renewal of Queensland Health assets are collectively administered in two components with different funding sources.

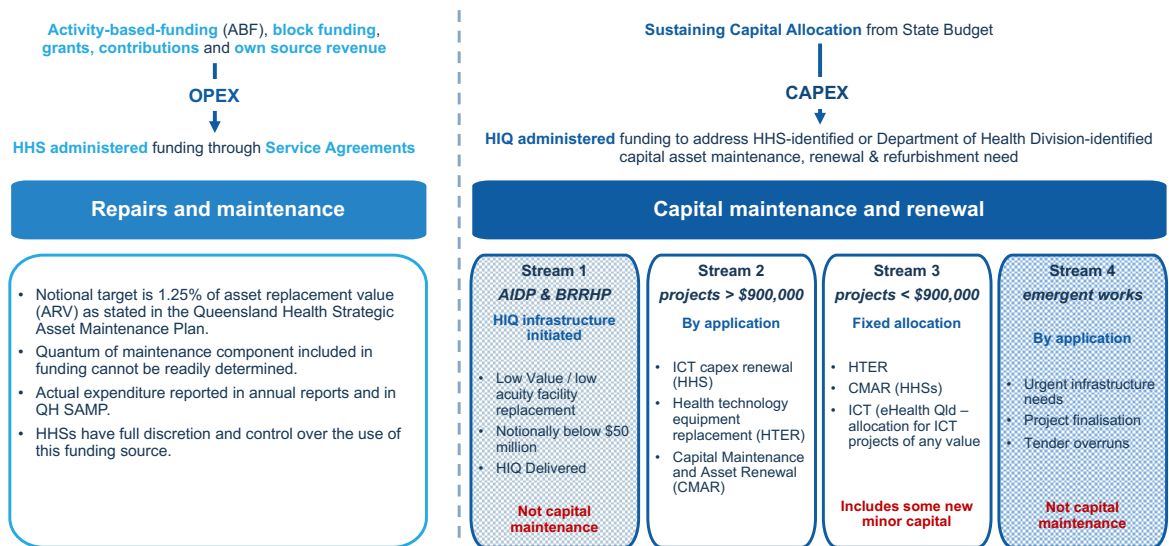


Figure 25: SCP Funding approach

Historically, Queensland Health had not fully expended the \$325 million SCP allocation, and as such, there was no rational driver to increase the annual capital maintenance funding allocation.

The 2022-23 Budget announced a change to the way the SCP was to be used and changed the funding envelope as follows:

\$943.5 million over 7 years from the Sustaining Capital Program to replace ageing rural and regional health facilities and staff accommodation as part of the next stage of the Queensland Health Building Rural and Remote Health Program. Locations include Darling Downs, Cairns and Hinterland, Central Queensland, Mackay, North West, Torres and Cape, Townsville, West Moreton and Wide Bay Hospital and Health Services.

\$229.7 million over 2 years from the Sustaining Capital Program to immediately increase bed capacity across South East Queensland under the Accelerated Infrastructure Delivery Program. The program will use off-site construction and standard designs to reduce time to commissioning with 289 overnight beds across 7 projects in West Moreton, Metro South, Cairns and Hinterland, and Gold Coast Hospital and Health Services, to be delivered within 2 years.

\$281.6 million under the Sustaining Capital Program will be distributed across Hospital and Health Services and the Department of Health for a range of minor capital projects, to efficiently replace and renew Queensland Health's existing asset base to maintain business and service delivery. The program will seek to enhance, optimise, renew, and replace the asset base to ensure facilities and equipment are fit for purpose.

Source: Queensland Treasury 2022-23 Capital Statement page 78

These new multi-year programs were couched as new SCP elements, but neither the Building Rural and Remote Health Program nor the Accelerated Infrastructure Delivery Program were for capital maintenance, and the SCP framework was adjusted to allocate these elements into Stream 1 as set out in Figure 25.

Further, the detailed budget allocations illustrate that over the forward estimates the actual Total Estimated Cost (TEC) and annual budget allocations were significantly lower than the headline figures quoted in the commentary to the budget, viz:

\$m	BRRHP TEC	BRRHP Allocation	SCP Allocation
2022-23	94.660	35.200	281.620
2023-24	94.660	45.592	346.540
2024-25	95.219	8.600	215.042

Table 16: Klok Advisory analysis of BRRHP and SCP allocations in budget papers

It is unclear why the TEC for BRRHP in the detailed budget line item in each of the budget years set out in Table 16 was not the \$943.5 million or a number representing the four years of current and forward estimates (if not the TEC over the 7 years). Table 18 sets out the known cashflows for 2024-25 and beyond, and even if the 2022-23 and 2023-24 years budgets were set without the benefit of currently known forecasts, at least the 2024-25 BRRHP TEC should have been \$1.364 billion for the forward estimates period (to 2027-28), not \$95.219 million.

The net outcome of these changed approaches to the allocation and use of SCP means that, overall, there has been a reduced amount of capital maintenance budget allocated to true capital maintenance works. As can be seen in Table 16, the amount allocated in the current financial year has fallen from the historic \$325 million to \$215 million. This is significantly below the needs of Queensland Health now and into the future.

11.5 Building Regional and Remote Hospital Program

As described above, the BRRHP is a program of replacing regional and remote hospitals across Queensland. On top of the awarded and in-construction BRRHP projects, the following projects are presently undergoing planning for future procurement:

Site	HHS	Project status	Earliest delivery completion	Forecast Cost (\$m)
Bamaga PHCC	TCHHS	Land tenure issues	2029	29.00
Doomadgee Hospital	NWHHS	Early Contractor Involvement	2026	57.00
Biloela Hospital	CQHHS	Concept planning & design	2028	49.30
Jandowae Hospital	DDHHS	Concept planning & design	2026	5.00
Laura PHCC	TCHHS	Concept planning & design	2028	16.80
Boigu PHCC	TCHHS	Land acquisition issues	2028	42.20
Badu Island PHCC	TCHHS	Concept planning & design	2027	42.20
Lockhart River PHCC	TCHHS	Concept planning & design	2028	29.30
Horn Island PHCC	TCHHS	Land acquisition & service planning issues	2028	43.00
Laidley Hospital	WMHHS	Concept planning & design	2027	16.90
Boonah Hospital	WMHHS	Concept planning & design	2027	68.50
Chinchilla Hospital	DDHHS	Concept planning & design	2026	97.40
Murgon Hospital	DDHHS	Concept planning & design	2027	48.70
Proserpine Hospital	MHHHS	Concept planning & design	2027	9.80
Hughenden MPHS	THHS	Concept planning & design	2028	75.90
Richmond MPHS	THHS	Concept planning & design	2028	64.70
Home Hill Health Service	THHS	Concept planning & design	2028	71.80
Childers MPHS	WBHHS	Concept planning & design	2027	24.70
Total				792.20

Table 17: Planned BRRHP projects

HIQ has provided the Review with an assessment of likely cashflows required to deliver the in-construction and committed BRRHP projects out until the 2028-29 financial years.

\$m	2024-25	2025-26	2026-27	2027-28	2028-29	Total
BHHRP Projects – committed and forecast	156	198	333	245	61	993
BHHRP Potential further budget needs	40	55	153	184	0	432
Total BHHRP Requirement	196	253	486	429	61	1,425
BHHRP Budget allocation	8.6	-	-	-	-	8.6
Current/Future funding requirement	187.4	253	486	429	61	1,416

Table 18: BHHRP cashflows and funding requirements

It is unclear how the BHHRP forecast overrun in the current financial year will be accommodated.

This analysis indicates that future funding requirements for the BRRHP **will exceed \$1.4 billion**, significantly greater than announced in 2022-23 as \$0.9435 billion. As noted above, it is also unclear what the Total Expected Cost in the last few budget years can be reconciled against compared with actual and forecast project costs. **The forward estimates requirements for BRRHP, based on the figures above, for the current and future 3 financial years is \$1.364 billion, not \$94.219 million. It is unclear to the Review why there is such a disparity between the known and forecast costs for BRRHP and the detailed budget allocations. This disparity will need to be addressed and rectified in the 2025-26 budget.**

11.6 Accelerated Infrastructure Delivery Program

The AIDP will be completed by the end of the 2025-26 financial year, with total funding required of \$116 million in 2024-25 and \$56 million in 2025-26.

These amounts are understood to be funded out of the SCP allocation in each of the current and future years.

Projects included in the AIDP are:

- Ripley Satellite Hospital Site Modular Sub-Acute Expansion;
- Ripley Satellite Hospital Site Multi-Storey Car Park;
- Gold Coast University Hospital Modular Expansion;
- QEII Hospital Modular Wards;
- Redland Hospital Modular Wards;
- Robina Emergency Department Expansion;
- Princess Alexandra Hospital Renal Refurbishment, and
- Cairns Sub-Acute Expansion.

The Review recommends that these projects are completed as planned, but with the AIDP program clearly identified in the 2025-26 budget rather than being part of the SCP budget line item.

11.7 eHealth SCP Planning and Requirements

eHealth Queensland has developed a comprehensive and mature capability to assess and plan capital maintenance for the assets, platforms and systems for which they are responsible. This capability includes making use of the Gartner TIME assessment methodology to assess an appropriate level of asset maintenance and replacement for eHealth's asset base. The TIME methodology allocates assets against four criteria – Tolerate, Invest, Migrate or Eliminate – and then eHealth plans asset management practices against these criteria.

Over the last two years eHealth has been allocated approximately \$120 million for maintenance capital, with prior year allocations historically set at \$75 million. eHealth's most recent TIME analysis, with appropriate risk tolerances indicates that their lower bound asset maintenance requirement is circa \$180 million.

Finally, eHealth's ongoing role in SCP governance should be continued, providing input and advice to the SCP allocation governance on ICT duplication, architecture and standards reviews as part of HHS SCP applications that involve ICT elements.

11.8 Need for (Quarantined) SCP and Reformed Governance

It is clear from the interviews and materials provided to the Review, plus the QAO report, that capital maintenance funding is required in current and future years. The exact future year requirements for SCP are difficult to ascertain from the range of material presented to the Review but could be in the range of \$525 million to \$850 million per annum. This amount needs to consider the needs of HHSs, eHealth, QAS and affiliated research institutes that rely on the SCP for asset maintenance and research equipment replacements.

The AIDP and BRRHP initiatives, whilst adding or renewing assets in their entirety that were clearly required, should not have been structured so as to draw on prior, current or future years SCP funding. These programs should be separately budget funded as separate line items in the budget.

As set out above, funding for AIDP and BRRHP seems to have been provided by allocating current and future year SCP funding to these programs, drawing down against future year SCP capital maintenance allowances. This has left the SCP with significantly less funding than is required for current and future years for capital maintenance purposes.

Future Queensland budgets will hence need to transparently accommodate SCP, AIDP and BRRHP and difficult decisions will be required as part of the overall budget construction. Some BRRHP projects may need to be deferred or delayed whilst any increased allocation to SCP (even back to historical levels) may need to be phased in over multiple future budgets.

With a renewed and refreshed (and quarantined) SCP budget allocation, there is a need to update and reform:

- governance processes for assessing HHS submissions;
- categorisation of clinical and operational categorisation of maintenance needs;
- prioritisation of submissions;
- allocation of (multi-year) funding against submissions;
- actual cash dispensing to deliver SCP projects;
- processes to return unspent funds or unprocured projects to SCP pool;
- HHS reporting performance against SCP projects;
- reviewing and assessing HHS capabilities to delivery SCP projects, and
- processes and practices for HIQ assistance for HHSs in executing SCP projects.

In particular, with a known and agreed multi-year SCP allocation, proper planning and procurement for long lead time site infrastructure and major medical equipment can be facilitated. As previously recommended in this report, there is a need to implement State-wide systems to provide clearer assessments of capital maintenance requirements and to plan and procure Statewide capital maintenance programs.

Recommendation 40: Treasury and Health, with the support of DPC, should determine an appropriate ongoing Sustaining Capital Program funding profile for the current fiscal period and forward estimates period, providing a short term provision to address critical safety and regulatory maintenance projects and a longer term funding source for a Statewide preventative maintenance program

Recommendation 41: HIQ should prepare a Statewide SCP governance strategy for approval by the Director General, with accompanying processes and practices to prioritise and allocate funding and performance manage implementation of maintenance projects under the SCP

Recommendation 42: The Accelerated Infrastructure Delivery Program and Building Regional and Remote Hospital Program should be separately budget funded as separate line items in the 2025-26 budget rather than being assumed to be funded from future year SCP allocations

Part 3: Report Mechanics

12. Table of Recommendations

The Review has made recommendations to the Queensland Government throughout this report. For ease of reference, these recommendations are summarised below.

Recommendation 1: The Health Investment Assurance Committee should be disbanded and the Department of State Development, Infrastructure and Planning should institute appropriate assurance gateway reviews, using entirely independent and experienced reviewers to assess the readiness of future projects to progress through project approval gates.	22
Recommendation 2: The renewed HIQ structure, leadership and culture should run PSCs and PCGs for their intended purpose and in the manner set out in their terms of reference, with all project information accurately presented in reports to these governance forums.....	24
Recommendation 3: Health Infrastructure Queensland should continue to be an important part of QH but with a refreshed lean structure, clear role, appropriately skilled team and a new advisory board providing governance to assist QH to deliver major capex projects.....	25
Recommendation 4: An infrastructure and construction project leadership capability framework should be developed for HIQ (and more broadly for Queensland infrastructure delivery agencies).....	27
Recommendation 5: A revised structure for HIQ should be implemented, with all leadership roles advertised and filled through appropriate recruitment processes.	28
Recommendation 6: an Advisory Board for HIQ with appropriate external industry and HHS representation and regional representation should be created and roles filled with an appropriate skill mix.....	29
Recommendation 7: Responsibility for capital project masterplanning and site analysis should be moved from Clinical Planning and Service Strategy Division to HIQ, and HIQ should remain responsible for capital projects until successful completion. HHSs should lead operational commissioning with the support of HIQ.	31
Recommendation 8: Accountability and responsibility for FF&E should be moved to an appropriately skilled HIQ leadership role, and roles and responsibilities for all other FF&E tasks should be allocated on best for project approach.....	42
Recommendation 9: Risk registers should be reviewed and updated with accurate resolution dates, or where those dates have passed without resolution the risk rating should be elevated and risk escalated to project governance.	43
Recommendation 10: Health and Treasury, with the support of DPC, should develop a medium term (10 year) health capital envelope and an annual planning process to refresh priorities within that 10-year envelope.....	58
Recommendation 11: Future budgets should continue to allocate planning budget for HIQ to undertake industry standard health infrastructure project planning to ensure appropriate project scopes, budgets and programs are established prior to Government approval for the project being sought. Funding available in 2024-25 should be applied to the replanning of unawarded CEP projects.....	59
Recommendation 12: HIQ should assess all per-project endorsed value management items for those items that can be shared program-wide and seek to have those value management opportunities delivered on each project within the CEP.....	60
Recommendation 13: dRofus database needs to be owned by the State not contractors and be proactively used to manage the performance of design teams and assessment of as-built drawings against signed off designs.....	60
Recommendation 14: HIQ should investigate the opportunity to secure a client-side contract works insurance policy to apply to the CEP and remove this requirement from Managing Contractors.....	61
Recommendation 15: Government should consider whether the obligation for contractors to provide bank guarantees is providing the actual security sought, and whether the removal of this obligation is better value for money as a result of reductions in the overall cost of projects to the State and reduces red tape for industry.....	61
Recommendation 16: A State-wide leased space discovery process should be commissioned, and opportunities to aggregate spaces, including investigating the opportunities for development of purpose-built facilities funded through private capital and leased back to HHSs (or other funding models) should be explored.....	62

Recommendation 17: The Bundaberg project should not proceed with the GCS Stage 2 call. The early works be paused on site and immediate negotiations be commenced with the incumbent builder undertaken to ameliorate costs to Government from temporarily pausing the existing contract	70
Recommendation 18: The Bundaberg project team should immediately engage with the incumbent builder, their design team and the HHS to derive a definitive assessment of the capital build staging options and resultant operational cost implications and revert to Government with detailed assessments of a staged development of a full development onto the new site	70
Recommendation 19: The Coomera project should be paused while a swift review of whole-of-HHS requirements is undertaken with a view to consolidating the short-term requirements that were to be delivered at Robina can be accommodated in a rescoped Coomera project, including investigating the opportunity to partner with the adjoining landowner. Stage 1 site works should continue. The incumbent MC should also be requested to propose revised contractual risk allocations and price reduction opportunities.	75
Recommendation 20: Mackay Stage 1 MC contract should be terminated and HIQ should engage new design consultants to work up a clinically prioritised scope agreed with the HHS. A revised procurement strategy that delivers best value for money for the State should be developed, including staging options and early delivery of small packages of urgent clinical needs	78
Recommendation 21: The Prince Charles Hospital Stage 1 MC contract should run to conclusion including finalising 100% detailed design and the Stage 1 MC should be brought to an end without calling for a Stage 2 GCS. HIQ should engage a design team to refresh the project’s clinical priorities to ensure they match service need and are agreed with the HHS, are supported by an endorsed Functional Design Brief, include a site masterplan including the adjoining private hospital and provide a staged development option for the project.....	81
Recommendation 22: Queensland Cancer Centre Project should be reconsidered and a business case for the three disparate areas of scope be developed – covering HHS requirements, Statewide requirements and a cancer research centre of excellence. To support the development of future Statewide cancer services infrastructure for the QCC and elsewhere, a Statewide cancer services demand review should be commissioned to ensure cancer services are planned to be delivered closer to where the demand exists and where the requisite workforce can be sourced. Following this clinical demand modelling, Government should allocate planning funds to allow appropriate local and Statewide cancer services infrastructure projects be planned for future submission to Government for funding either as a program or individual projects.	86
Recommendation 23: Redcliffe Project should be paused, with the current site, infrastructure and services works paused. The project team should swiftly replan the delivery of the project rotating the building 90 degrees or otherwise replanned to avoid the scar tree and appropriately consider the HHS concerns relating to the emergency department and clinical priorities.	92
Recommendation 24: A rollout strategy and funding for adoption of electronic medical records across the Darling Downs HHS needs to be developed by eHealth appropriately contemplating the timing for the adoption of ieMR at the new Toowoomba Hospital	94
Recommendation 25: The Toowoomba project should not proceed with the GCS Stage 2 call at this stage, the early works be paused on site and immediate negotiations be commenced with the incumbent builder undertaken to ameliorate costs to Government from temporarily pausing the existing contract	99
Recommendation 26: The Toowoomba project team should immediately engage with the incumbent builder, their design team and the HHS to derive a definitive assessment of the capital build staging options to fully locate onto the new site, including an assessment of operational cost implications and revert to Government with detailed assessments	99
Recommendation 27: The project team should engage an assessment of services presently being delivered in ageing buildings on the Baillie Henderson Hospital site to assess which could be incorporated into the new build, and work with the HHS on a long term maintenance strategy for the heritage protected buildings on-site	99
Recommendation 28: The Townsville University Hospital project team should rework the clinical services plan and derive a staged development pathway and accompanying masterplan, and the revised planning outcome and procurement strategy should then be presented to Government for a future investment decision. A short term option to procure surgical services should also be assessed and implemented if feasible.	103

Recommendation 29: Townsville University Hospital car park should be procured using a simple design finalisation and construct contract, opening up opportunities for local and tier 3 builders.....	103
Recommendation 30: Cease any further negotiations on the Robina lease pending the outcome of the whole-of-HHS bed requirement review in conjunction with the Coomera project	107
Recommendation 31: The current refurbishment works at Cairns should progress to completion. HIQ should appoint a new design team to work collaboratively with the HHS to plan a precinct for the health and tertiary education development and propose staging and procurement options for future developments.....	111
Recommendation 32: Options to urgently address the Cairns helipad should be explored, with planning to relocate the helipad away from the current esplanade site.....	111
Recommendation 33: HIQ should capture lessons learned from the Ipswich Hospital project’s approach to clinical prioritisation, clinical flow assessments, stakeholder engagement and project management on this project as best practice across the CEP and distil across the balance of the CEP projects	114
Recommendation 34: The Logan project should continue as contracted, with a strong focus on managing key risks and retention of contingency to address outstanding clinical fitness for purpose risks.	116
Recommendation 35: The Princess Alexandra project should continue as contracted, with a strong focus on managing key risks and retention of contingency to address outstanding clinical fitness for purpose risks. HIQ should conclude the procurement for additional support services expeditiously.....	118
Recommendation 36: A business case for moving the existing QEII facilities from low voltage to a new high voltage should be prepared in conjunction with Energex and assessed for future funding against the clinical and operational risk	120
Recommendation 37: Designs for carparks should be reviewed to simplify and rationalise detailed designs, and future tenders should be on a simplified construction contract to tier 2 and 3 construction firms – with local firms encouraged to tender in regional areas	122
Recommendation 38: Clear guidance on a Queensland Health approach to rating asset conditions should be developed and promulgated	124
Recommendation 39: the S/4HANA asset management module pilot should be accelerated and Statewide rollout implemented as soon as practical	124
Recommendation 40: Treasury and Health, with the support of DPC, should determine an appropriate ongoing Sustaining Capital Program funding profile for the current fiscal period and forward estimates period, providing a short term provision to address critical safety and regulatory maintenance projects and a longer term funding source for a Statewide preventative maintenance program.....	130
Recommendation 41: HIQ should prepare a Statewide SCP governance strategy for approval by the Director General, with accompanying processes and practices to prioritise and allocate funding and performance manage implementation of maintenance projects under the SCP	130
Recommendation 42: The Accelerated Infrastructure Delivery Program and Building Regional and Remote Hospital Program should be separately budget funded as separate line items in the 2025-26 budget rather than being assumed to be funded from future year SCP allocations	130

13. Review Engagements and Interviewees

The Review undertook extensive engagements with a range of relevant organisations, teams and individuals, including:

- Minister for Health and Ambulance Services;
- Directors General for Health and Premier & Cabinet;
- Deputy Directors General and other executives from Health, Treasury and Premier & Cabinet;
- HIQ acting Deputy Director General, Executive Directors and all project teams;
- HHS Board Chairs, CEOs and executives;
- Independent members of governance forums;
- Managing contractor CEOs, executives and project directors;
- Subcontractor executives;
- Consultant firm executives, and
- Industry associations and representative groups.

The Review also undertook site visits to a range of metropolitan, rural and regional hospitals.

In addition, a number of organisations elected to provide written submissions to accompany in-person interviews and discussions.

14. Glossary and Abbreviations

Abbreviation	Full description
AMP	Asset Management Plan
BPICBPICs	Best Practice Industry Conditions
CBoM	Capital Board of Management
CEP	Capacity Expansion Program
CSSD	Central Sterile Services Department
DDG	Deputy Director General
DG	Director General
EPBC	<i>Environmental Protection and Biodiversity Conservation Act 1999</i> – (Commonwealth legislation)
FDB	Functional Design Brief
FF&E	Furniture, fixtures and equipment
GCS	Gross Construction Sum
HHS	Health and Hospital Service
HIQ	Health Infrastructure Queensland
HVHR	High Value High Risk
IAC	Investment Assurance Committee
ICT	Information & Communications Technology
ICU	Intensive Care Unit
IFC	Issued for construction
MC	Managing Contractor
MME	Major medical equipment
PA	Princess Alexandra Hospital
PCG	Project Control Group
PSC	Project Steering Committee
PSG	Program Steering Group
QAO	Queensland Audit Office
QH	Queensland Health
SAMP	Strategic Asset Management Plan
SCP	Sustaining Capital Program
SoA	Schedule of Accommodation
TPCH	The Prince Charles Hospital
WIP	Work in progress

15. Gratitude and Thanks

The Review would not have been possible without the support of the Office of the Director General of Health, and in particular the cheery and outstanding support provided to the Review by Melleesa Cowie and Marcia Cock. Our sincere thanks and gratitude go to these individuals.

In addition, large numbers of Health Department senior executives, HHS CEOs and executives and the HIQ team afforded the Review with significant diary time, often at short notice. The HIQ team have also provided a significant volume of data and documents structured in a highly accessible manner and have responded swiftly to information requests from the Review.

Finally, industry participants were very generous with their time in supporting the Review, and as set out in section 8 above, numerous MCs have provided the Review with new thinking, concepts and revised designs with very short timeframes and loose specifications. Thanks to all of the MC teams that have provided their time and significant efforts to assist the Review.

